AmeriHealth Caritas Next

AmeriHealth Caritas Next and First Choice Next Provider Orientation

June 2026

Exchange Provider Orientation

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Who We Are

AmeriHealth Caritas Next

Who We Are

AmeriHealth Caritas is one of the nation's leaders in health care solutions for those most in need.

- Operating in 13 states and the District of Columbia, AmeriHealth Caritas serves millions of Medicaid, Medicare, Children's Health Insurance Program (CHIP), and Health Insurance Marketplace® members through its integrated managed care products, pharmaceutical benefit management and specialty pharmacy services, and behavioral health services.

- Headquartered in Pennsylvania, AmeriHealth Caritas is a mission-driven organization with more than 40 years of experience serving low-income and chronically ill populations.

- AmeriHealth Caritas Next provides affordable health insurance on and off the Exchange. We are certified as a Qualified Health Plan (QHP) issuer.

- AmeriHealth Caritas Next will deliver high quality, locally-based health care services to its members, with our providers benefiting from enhanced collaboration and strategic care coordination programs.

For more information about AmeriHealth Caritas, visit our Corporate site, www.amerihealthcaritasnext.com.

Who We Are

Participating in AmeriHealth Family of Companies provider networks aligns with our vision to empower those in need across their full life journey.

Medicare and Dual Eligible Plans

Older residents in your communities deserve the best care possible. That's why we provide solutions for dual-eligible members who qualify for both Medicaid and Medicare. These proven programs offer supplemental benefits, preventative services, and improved care coordination.

Medicaid Managed Care

We have expertise in treating America's chronically ill and low-income populations. With our Medicaid managed care health plans, you can provide innovative, cost-effective care to the people in your community who need it most.

Individual and Family Health Plans

The Exchange helps more Americans find affordable health care insurance. AmeriHealth Caritas Next and First Choice Next (referred to as "the Plan" herein) offers families many ways to save, both on and off the Exchange, with a choice of quality health plans to meet their individual needs — today, tomorrow, and for whatever is next.

The Exchange

(Health Insurance Marketplace®)

AmeriHealth Caritas Next

The Exchange

Individuals and families can enroll for coverage online or with assistance from one of our brokers at www.amerihealthcaritasnext.com.

Determine eligibility for all health insurance programs, including Individual and Family Health Plans, Medicaid, Medicare and the Children's Health Insurance Program (CHIP).

Provide direction for applying for Medicaid, Medicare or CHIP.

Help members shop for the plan that is right for them.

Help members enroll in Individual and Family Health Plan coverage.

Determine eligibility for financial help (subsidies) with premiums and out of pocket costs.

The Exchange

Benefit plans have cost shares in the form of copays, coinsurance, and deductibles.

Some members will qualify for assistance with their cost shares based on their income level and family size. This assistance would be paid directly from the government to the member's health plan. There are no cost shares for American Indian/Native American members (income between 100% and 300% FPL) when they see an Indian Health Care Provider (IHCP).

Subsidies come in the form of:

Advanced Premium Tax Credit (APTC)

- a federal tax credit for individuals that reduces the amount members pay for monthly health insurance premiums when they buy health insurance on the Exchange.

Cost Share Reductions (CSR)

- a discount that lowers the amount that the member has to pay for deductibles, copayments and co-insurance.

For Plan co-pays, co-insurance, and deductibles, visit "View Our Plans" at www.amerihealthcaritasnext.com > Pick Your State > View Our Plans > View Our "Metal" Plans.

Please note: Members who purchase insurance off-exchange are not eligible for subsidies and cost shares.

Affordable Care Act
Essential Health Benefits (EHBs)

Essential health benefits are minimum requirements for all Exchange plans.

Specific services covered in each broad benefit category can vary based on state requirements.

10 EHBs that all plans must include in their insurance plans
1. **Ambulatory Patient Services**: Outpatient services, producers, and tests
2. **Emergency Services**
3. **Hospitalization**
4. **Pregnancy, Maternity, & Newborn Care**
5. **Mental Health and Substance Use Disorder Services including Behavioral Health**
6. **Prescription Drugs**
7. **Rehabilitative Services:** Devices and short-term disability services while recovering from injury
8. **Lab Services**
9. **Preventive & Wellness Services including chronic disease management**
10. **Pediatric Services:** Including oral* and vision care for ages up to 19

*AmeriHealth Caritas Next does not offer dental services but will inform consumers of the availability of stand-alone pediatric dental plans during the plan selection and enrollment process.

Essential Health Benefits- No Cost Sharing

There is no member cost-sharing (i.e., $0 Copayment) for preventive services identified under the Affordable Care Act and provided to members by a network provider. A complete list of preventive services with $0 member cost sharing can be found on the CMS website: HealthCare.gov.

The $0 copayment does not apply to problem-focused services. Problems that can easily be assessed and dealt with as part of the preventive services, such as blood pressure or cholesterol management, do not meet the criteria for collection of a copayment. However, if the member is experiencing a problem that requires a problem-focused service that cannot be handled as part of the preventive services, such as a breast mass, uncontrolled diabetes requiring adjustment of medications, or follow-up at a shorter interval than would be normally anticipated, it would allow for application of a copayment.

ACA Requires all individual and small group ACA-compliant plans to cover preventive services as required by the U.S. Department of Health and Human Services (HHS) at zero cost-sharing even if the policyholder has not met their deductible.

Provider Network Management and Administrative Provider Support

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Provider Network Management

When you join the Plan, a local Provider Network Management Account Executive experienced in physical and behavioral health care is assigned to your area.

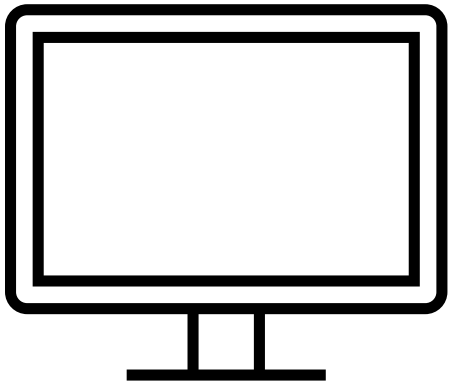
Your dedicated Account Executive meets with you in person for orientations, education, and support. To find your Account Executive, go to www.amerihealthcaritasnext.com > Pick Your State > For Providers > Providers Homepage.

Provider Services and the local Medical Management team can also help. Contact information is found in the Provider Reference Guide at www.amerihealthcaritasnext.com > Pick Your State > For Providers > Providers Homepage > Read the Provider Reference Guide.

Getting Started

During onboarding, you will receive a letter advising that you have been credentialed and it will contain useful information for getting started as a Plan provider.

The Welcome Letter will include information regarding the following:



- Confirm that you have been successfully credentialed.
- An official welcome as a network provider.
- Directions for secure portal setup on NaviNet.
- Efficient claims processing.
- Payment options and setup.
- How to navigate our website for important information such as:
  - **Provider Manual**: A guide to assist practices in serving our members.
  - **Provider Reference Guide:** An all-in-one resource containing important contacts and information on prior authorization and referral requirements.
  - **Drug formulary** and **pharmacy prior authorization** process**.**
  - **Claims, billing, and payment** guidance.

Online Provider Data Information Form

Providers must review their provider directory listing and submit any updates or corrections through the Provider Data Intake Form (PDIF) in our provider portal, NaviNet. Updates will be reflected in the online provider directory within 14 business days; if not reflected within 30 business days, contact your Provider Network Account Executive.

Validation requests are sent every 90 days, and providers have 30 days to attest to the information's accuracy or submit changes. Failure to respond in the specified time frame may result in claim denials.

Providers are contractually required to provide written notice at least 30 days in advance of any changes to key provider demographic information.

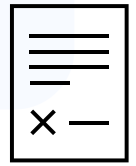
For step-by-step directions, visit NaviNet; for additional guidance, contact Provider Services. Contact information can be found in the Provider Reference Guide located at www.amerihealthcaritasnext.com > Pick Your State > For Providers > Providers Homepage > Read the Provider Reference Guide.

Finalizing Participation in our Network

Please be certain that you have received the following from the Plan before you start seeing members:

A letter from the Plan saying that you have been successfully credentialed.

An executed contract and/or addendum back from the Plan.



Provider Credentialing – CAQH

The Plan uses Council for Affordable Quality Healthcare (CAQH®) ProView®, formerly the Universal Provider Datasource®, which is designed to simplify and streamline the data collection process for credentialing and re-credentialing. ProView users send credentialing information to a single repository via a secure internet site to fulfill the credentialing requirement.

If you are registered with CAQH:
Please contact your Provider Network Account Executive to grant authorization to the Plan to view your information in ProView.

If you are not a CAQH participating provider:
We highly encourage you to subscribe by going to CAQH . We will be glad to assist you in that process as needed.

There is no cost to submit an application or participate with CAQH.

Public Website

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The Plan's Public Website

Excellent provider communication and service is an organization-wide priority!

The Plan recognizes how busy our participating providers are. We are dedicated to supporting you and ensuring you have the information you need at your fingertips through the provider-focused section of our website.

We keep you informed through several communication vehicles:

Website address: www.amerihealthcaritasnext.com > Pick Your State > For Providers

- Provider Manual
- Claims and Billing Manual
- Provider Reference Guide
- Provider education and training on:
  - Claims and billing
  - Electronic payment options
  - Prior authorization and the Prior Authorization Lookup Tool
  - Member Rights and Responsibilities

And provide searchable online tools:

- Online provider directory
- Drug formularies
- Online pharmacy locator

NaviNet: Our Secure Provider Portal

Supports Patient Care Management

Our secure provider portal, NaviNet, offers web-based solutions that allow providers and the health plan to share critical administrative, financial, and clinical data in one place. This tool can help you manage patient care with quick access to:

Member eligibility and benefits information, including member ID cards and member in pending status	Panel roster reports	Care gap reports to identify needed services	Member clinical summaries
Social determinants of health information	Admission and discharge reports	Medical and pharmacy claims data	Electronic submission of prior authorization requests

Rendering Services to Members

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Verification of Eligibility

Prior to rendering services, providers are responsible for verifying member eligibility, benefits, and cost-shares. These can be checked the following ways:

- By logging into our secure provider portal, NaviNet. This web-based application allows providers and health plans to share critical administrative, financial, and clinical data in one place. The portal can also be accessed through the Plan website using the following path:

  www.amerihealthcaritasnext.com > Pick Your State > For Providers > Tools and Services > NaviNet > Log in to NaviNet. For more information or to sign up for NaviNet access, go to NaviNet or call NaviNet Customer Support at **1-888-482-8057**.

- By contacting Provider Services. Contact information for Provider Services can be found at www.amerihealthcaritasnext.com > Pick Your State > For Providers > Providers Homepage > Read the Provider Reference Guide.

- Using EDI eligibility verification transactions available from your clearinghouse or practice management system. This service supports batch access to eligibility verification and system-to-system verification, including point of service devices.

Member ID Card

Member ID cards include key information (e.g., name, ID number, prefix, and coverage type), and details may vary by plan.

You can view the member's ID card and confirm eligibility in NaviNet under the Eligibility and Benefits Inquiry section.

If the member cannot Produce an ID card and/or is not on the PCP roster, request a copy printed from the member portal on our secure member website.

If there are questions about eligibility, panel assignment, or premium delinquency status, confirm the member's status in NaviNet under the Eligibility and Benefits Inquiry.

A temporary ID card may be accepted as proof of coverage until the permanent card is received; it is valid for up to ten calendar days from the print date.

Eligibility verification is not a guarantee of payment. The Plan would not pay for any claims, regardless of emergency status, if the member was not eligible at the time of service.

Grace Periods for Missed Premiums

Providers are responsible for checking the member's eligibility status prior to rendering services.

If the member pays their outstanding balance before the end of the grace period, we will process and adjudicate pended claims.

If a member does not pay their outstanding balance before the end of the grace period, then we will terminate coverage as of the last day of the last month of which the premium was paid.

To identify when an APTC member is in a delinquent payment status on his or her monthly insurance premiums, please see the **Eligibility and Benefits** detail screen on NaviNet.

For further details regarding member eligibility status and delinquent status messaging, please visit www.amerihealthcaritasnext.com > Pick Your State > For Providers > Tools and Services > NaviNet.

If a member has lost coverage due to non-payment, and the provider provides services, the Plan will deny claims submitted for those services.

Billing the Member for Co-Pays, Co-Insurance, and Deductibles

Copays, co-insurance, and any unpaid portion of the deductible may be collected at the time of service.

Deductible information, including the amount that has been paid toward the deductible so far, can be accessed via the secure provider portal at NaviNet.

If the amount collected from the member is higher than the actual amount owed upon claim adjudication, the provider must reimburse the member within 45 days.

Virtual Care, Vision, and Dental Care

Virtual Care- Virtual care services are covered at no cost to the member when received through a Plan Virtual Care 24/7 in-network provider. Certain specialty services including pediatrics are not eligible for Plan Virtual Care 24/7. For coverage and cost-sharing, please visit the members Evidence of Coverage.

Vision Care- Routine eye exam, one pair of glasses per year, and medical and surgical vision benefits are covered for children ages 0 – 19.

Dental Care- The Plans do not offer embedded dental coverage as there are stand-alone dental plans available in the exchange for purchase. The Plan will inform consumers of the availability of stand-alone pediatric dental plans during the plan selection and enrollment process.

For coverage details, refer to the members Evidence of Coverage located at www.amerihealthcaritasnext.com > Pick Your State > For Members > Forms and Documents > Evidence of Coverage.

Outpatient Laboratory Services

We use many outpatient labs for Plan member diagnostics, including Quest Diagnostics and DrugScan. You can contact us for more information on other in-network lab providers or you can find them in our searchable online provider directory.

The searchable online provider directory can be found at www.amerihealthcaritasnext.com > Pick Your State > For Providers > Find a Provider, Pharmacy, or Drug > searchable online provider directory.

Contact information for Provider Services can be found at www.amerihealthcaritasnext.com > Pick Your State > For Providers > Providers Homepage > Read the Provider Reference Guide.

Balance or Surprise Billing

Member are protected from balance billing for:

Certain services at an in-network hospital or ambulatory surgical center

When a member gets services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill the member is the Plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. Providers can't balance bill the member and may not ask the member to give up their protections not to be balance billed.

Emergency services

If a member has an emergency medical condition and gets emergency services from an out-of-network provider or facility, the most the provider or facility may bill the member is the members plan's in-network cost-sharing amount (such as copayments and coinsurance). A member can't be balance billed for these emergency services. This includes services the member may get during post-stabilization services unless the attending physician states that the patient can safely travel to an in-network facility within reasonable distance or the member gives written consent and gives up their protections not to be balanced billed for these post-stabilization services.

Balance or Surprise Billing

Member are protected from balance billing for:

Out of network providers

Out-of-network providers must seek prior authorization for non-emergency services and in limited circumstances may be approved to provide care for a member if there is no in-network option for the member to obtain that care. If the out-of-network provider is approved for service, that provider may balance bill for amounts above what the plan will pay. If the out-of-network provider does not seek prior authorization or is not approved, the member will be responsible for the entire charge. It is the out-of-network provider's responsibility to advise the member and to obtain the members acknowledgment in writing if the provider does not receive authorization to provide the care so that the member understands that they are liable for costs.

Member Rights

The Plan complies with applicable federal civil rights laws and does not discriminate on the basis of race; ethnicity; color; sex; religion; national origin; creed; marital status; age; Vietnam era or disabled veteran status; income level; gender identity; the presence of any sensory, mental, or physical handicap; or any other status protected by federal or state law.

The Plan is committed to complying with all applicable requirements under federal and state law and regulations pertaining to member privacy and confidentiality rights.

A member has the right to:

- Receive information about the health plan, its benefits, services, included or excluded, from coverage policies, and network providers' and members' rights and responsibilities. Written and web-based information provided to the member must be readable and easily understood.
- Be treated with respect and be recognized for their dignity and right to privacy.
- Participate in decision-making with providers about their health care. This right includes candid discussions of appropriate or medically necessary treatment options for their condition, regardless of cost or benefits coverage.
- Voice grievances or appeals about the health plan or care provided and receive a timely response. The member has a right to be notified of the disposition of appeals or grievances and the right to further appeal, as appropriate.

Member Rights

- Make recommendations about our member rights and responsibilities policies by contacting Member Services.
- Choose providers within the limits of the provider network, including the right to refuse care from specific providers.
- Have confidential treatment of personally identifiable health or medical information; the member also has the right to have access to their medical record per applicable federal and state laws.
- Be given reasonable access to medical services.
- Receive health care services without discrimination based on race; color; religion; sex; age; national origin; ancestry; nationality; citizenship; alienage; marital, domestic partnership, or civil union status; affectional or sexual orientation; physical ability; pregnancy (including childbirth, lactation, and related medical conditions); cognitive, sensory, or mental disability; human immunodeficiency virus (HIV) status; military or veteran status; whistleblower status (when applicable under federal or state law depending on the locality and circumstances); gender identity and/ or expression; genetic information (including the refusal to submit to genetic testing); or any other category protected by federal, state, or local laws.
- Formulate advance directives. The Plan will provide information concerning advance directives to members and providers and will support members through our medical record-keeping policies.

Member Rights

- Obtain a current directory of network providers, on request. The directory includes addresses, phone numbers, and a listing of providers who speak languages other than English.
- File a grievance or an appeal about the health plan or care provided with the applicable regulatory agency and receive an answer from the health benefit plan to those grievances and appeals within a reasonable period of time.
- Appeal a decision to deny or limit coverage through an independent organization. The member also has the right to know that their provider cannot be penalized for filing a grievance or appeal on the member's behalf.
- Members with chronic disabilities have the right to obtain help and referrals to providers who are experienced in treating their disabilities.
- Have candid discussions of appropriate or medically necessary treatment options for their condition, regardless of cost or benefits coverage, in terms that the member understands. This includes an explanation of their medical condition, recommended treatment, risks of treatment, expected results, and reasonable medical alternatives. If the member is unable to easily understand this information, they have the right to have an explanation provided to their designated representative and documented in the member's medical record. The Plan does not direct providers to restrict information regarding treatment options.

Member Rights

- Have available and accessible services when medically necessary, including availability of care 24 hours a day, seven days a week, for urgent and emergency medical conditions.
- Call **911** in a potentially life-threatening situation without prior approval from the Plan, and to have the Plan pay per contract for a medical screening evaluation in the emergency room to determine whether an emergency medical condition exists.
- Continue receiving services from a provider who has been terminated from the Plan's network (without cause) in the time frames as outlined. This continuity of care allowance does not apply if the provider is terminated for reasons that would endanger the member, public health, or safety, or which relate to a breach of contract or fraud.
- Have the rights afforded to members by law or regulation as a patient in a licensed health care facility, including the right to refuse medication and treatment after possible consequences of this decision have been explained in language the member understands.
- Receive prompt notification of terminations or changes in benefits, services, or the provider network.
- Have a choice of specialists among network providers following an authorization or referral as applicable, subject to their availability to accept new patients.

Member Responsibilities

A member has the responsibility to:

- Communicate, to the extent possible, information that Plan and participating providers need in to care for them;
- Follow the plans and instructions for care that they have agreed on with their providers**.** This responsibility includes consideration of the possible consequences of failure to comply with recommended treatment.
- Understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible;
- Review all benefits and membership materials carefully and to follow the rules pertaining to the health plan;
- Ask questions to assure understanding of the explanations and instructions given;
- Treat others with the same respect and courtesy they expect to receive.
- Keep scheduled appointments or give adequate notice of delay or cancellation.

Plan Offerings

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Plan Offerings

Plans offered on the Exchange can be found at www.amerihealthcaritasnext.com > Pick Your State > View Our Plans.

The Plan does not require referrals for in-network providers.

Covered health services must be administered by a network provider unless there is an emergency. Emergency Room, Urgent Care, and Ambulance will not require prior authorization and care can be received out-of-network.

Premium payment, if applicable, is required for the policy to become effective and stay in force.

Pharmacy

AmeriHealth Caritas Next

Pharmacy

The Plan strives to provide members with high-quality and cost-effective drug coverage.

Our plans cover certain drugs listed on our **formulary** (the “drug list”). To confirm coverage, review the member’s **Evidence of Coverage** for program details, the formulary, and prior authorization requirements. Look-up tools, including a printable formulary document, searchable drug list and formulary guides are available on our website to help members and practitioners understand their specific drug program, drug restrictions and formulary. For mail-order and retail cost sharing, review the member’s **Schedule of Benefits**.

Formulary:
For the most up-to-date formulary information, visit www.amerihealthcaritasnext.com > Pick Your State > For Providers > Find a Provider, Pharmacy, or Drug.

Evidence of Coverage:
To confirm coverage, refer to the members Evidence of Coverage located at www.amerihealthcaritasnext.com > Pick Your State > For Members > Forms and Documents > Evidence of Coverage.

Schedule of Benefits:
For mail order and retail cost share on prescriptions, visit www.amerihealthcaritasnext.com > Pick Your State > View Our Plans > select the applicable metal tier > Schedule of Benefits.

Please note: The formulary is occasionally subject to change.

Pharmacy

The Plan reviews prior authorizations for drugs on the formulary that require prior authorization.

Prior authorization requests may be submitted using one of several available options:

- **Electronically** - please submit an Electronic Prior Authorization (ePA) through your Electronic Health Record (EHR) software or either of the following online portals:
  - CoverMyMeds
  - Surescripts
- **By phone** - Call our Pharmacy Clinical Prior Authorization department. Their contact information can be found at www.amerihealthcaritasnext.com > Pick Your State > For Providers > Prior Authorizations.
- **By fax** -
  - For medical pharmacy drug prior authorization requests (buy-and-bill), please complete the Healthcare Common Procedure Coding System (HCPCS) Authorization Form (PDF).
  - For all other pharmacy prior authorization requests please complete the Pharmacy Prior Authorization Form (PDF).

  These forms can be found at www.amerihealthcaritasnext.com > Pick Your State > For Providers > Prior Authorizations.
- **Through** NaviNet - access the Pharmacy Prior Authorization portal to submit and check real-time prior authorization statuses.

Claims, Billing, and Payment

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Claims and Billing

Claims and billing guidelines describe how providers should submit claims, verify member eligibility and cost sharing, and use self-service tools (such as NaviNet) to check claim status, request investigations or adjustments, and address payment questions.

Providers must also comply with Plan requirements for filing deadlines, corrected claims, remittance and payment options, and member billing (including copayments, coinsurance, deductibles, and applicable balance-billing limits).

See the Claims and Billing Manual for additional guidance.

For additional information and to view the Claims and Billing Manual, visit our Claims, Billing, and Payment webpage at www.amerihealthcaritasnext.com > Pick Your State > For Providers > Claims and Billing.

Claim Filing Deadlines

Type of Claim	Description & Time Frame
Original Claim	Must be submitted to the Plan within **180 calendar days** from the date services were rendered or compensable items were provided.
Rejected Claim	Is not registered in the claim processing system and can be resubmitted as a new claim. The claim can be corrected and submitted within **180 calendar days from the date of service.**
Denied Claims	Are those that were processed in the claims system. They may have a partial payment attached or may have been denied. A corrected claim may be submitted within **365 calendar days** of the original date of service to have the claim reprocessed.
Out-of-Network providers	Must be submitted to the Plan within **180 calendar days** from the date services were rendered or compensable items were provided.

For more information, please refer to the Claims and Billing Manual.

Integrated Care

AmeriHealth Caritas Next

An Integrated Approach to Care

Our multifaceted approach addresses the needs of our members, connecting them with the health care and services they need to get well and stay well.

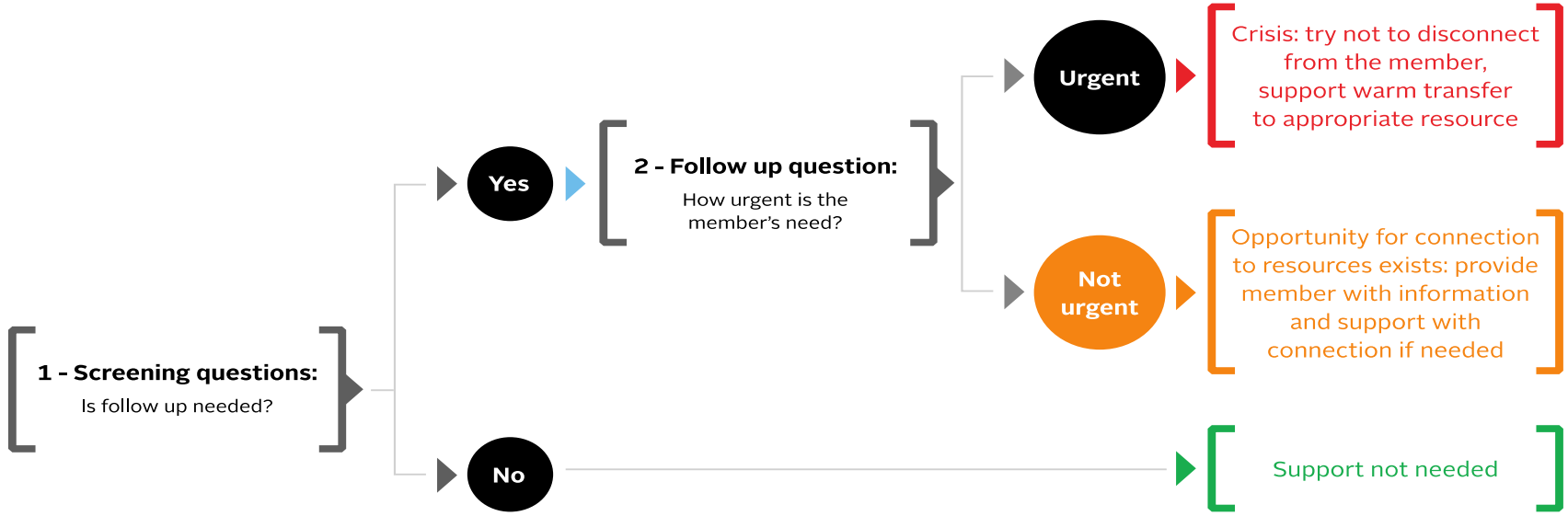
Our approach includes:

- Engaging, educating, and empowering members to actively participate in improving their health outcomes.
- Providing members with the information they need when they need it through our use of personal outreach and member portals.
- Providing person-centered treatment planning in which the member identifies their care team members, including natural and professional supports of their choosing.
- Using and supporting the growth of community-based services.

Social Determinants of Health (SDOH)

The Plan will assess, identify, and address health care and social determinants of health needs in the populations we serve, enabling them to live healthier lives and achieve maximum independence.

The Plan administers universal SDOH screenings with escalation pathways for actionable member support.



Risk Score Integration

Risk scores are used to guide care management outreach and as triggers for the level of intervention.
International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) Z codes refer to factors influencing health status.

The following self-reported data elements and relevant ICD.10 Z codes enhance AmeriHealth Caritas risk score modeling:

- Distance from PCP office
- Poverty index
- Housing
- Food
- Transportation
- Utilities
- Health literacy
- Legal circumstances
- Physical environment
- Employment status
- Safety (exposure to trauma, stress, or violence)
- Social isolation
- Technology (access)

Please include the appropriate supplemental ICD-10 diagnosis codes on your claim to report SDOH.
Note: SDOH should **not** be used as the admitting or principal diagnosis.

Let Us Know

The ***Let Us Know*** program allows us to collaborate in engaging our Members and managing their health care.

The Plan is eager to partner with the provider community in supporting our members who may require more support. If you have a member who could use support from our Care Management team, here are a few ways to **Let Us Know:**

Let Us Know options	Examples of reasons for referral
• **Call** our Rapid Response and Outreach Team. • **Fax** the Member Intervention Form. • **Visit** NaviNet to submit an electronic referral. For guidance on completing this form or to inquire about a submission, please call the Rapid Response and Outreach Team. Contact information can be found at www.amerihealthcaritasnext.com > Pick Your State > For Providers > Tools and Services > Let Us Know Program.	• Pharmacy consult on controlled substances • Assistance locating a specialty provider • Education on plan benefits and resources • Assistance with appointment scheduling • Unmet resource/SDOH screening or follow-up (e.g., transportation, food pantry, or housing application) • Education on health conditions • Screening for mental health or substance use services • Crisis follow-up resources (recent suicide attempt or bereavement after a death by suicide)

Behavioral Health Crisis Line

988 Suicide & Crisis Lifeline: **988**

911 Emergency

Care Coordination Through Collaboration

Providers needing care management or care coordination for a member should contact the Rapid Response and Outreach Team. These are the core components to our population health program:

Bright Start® (maternity management): This program assists expectant mothers by promoting healthy behaviors and controlling risk factors during pregnancy. The program is based on the Prenatal Care Guidelines from the American College of Obstetricians and Gynecologists (ACOG).

Rapid Response and Outreach Team (RROT): This team of non-clinical Care Connectors address the needs of members and support providers and their staff.

Care Management: This voluntary program serves members identified as needing comprehensive and disease-specific assessments and reassessments, along with the development of person-centered goals with a focus on prevention.

Care Coordination: Care coordination programs address members' health care needs while assessing for and addressing social needs and barriers and providing hands-on coordination.

Utilization Management

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Utilization Management Prior Authorization

Services requiring prior authorizations are subject to change.

Certain services or supplies may be subject to prior authorization to determine whether they are medically necessary and being provided by a network provider. Providers are responsible for obtaining any necessary prior authorization (PA) before rendering services. For questions, please call the Utilization Management Team.

The following services always require prior authorization:

- Elective inpatient services
- Urgent inpatient services
- Services from a nonparticipating provider

A Member does not need prior authorization for emergency services or to see an in-network primary care physician.

Utilization Management contact information can be found at www.amerihealthcaritasnext.com > Pick Your State > For Providers > Prior Authorizations.

Utilization Management Prior Authorization

Please note: The results of the Prior Authorization Lookup Tool are not a guarantee of coverage, authorization, or payment.

Search for an outpatient service in our Prior Authorization Lookup Tool found in the Provider section of the Plan website.

Call the Utilization Management team.

Fax the appropriate Prior Authorization form, found in the forms section of the website.

Submit requests for prior authorization through Jiva™, our web based prior authorization request tool found on NaviNet.

For more information, visit the Prior Authorizations webpage at www.amerihealthcaritasnext.com > Pick Your State > For Providers > Prior Authorizations.

High-Tech Imaging by Evolent

The Plan's radiology benefits vendor, Evolent, provides utilization management review and authorization for non-emergent, advanced, outpatient imaging procedures.

- CT/CTA
- MRI/MRA
- PET Scan
- MUGA Scan
- CCTA
- Myocardial Perfusion Imaging

The ordering facility or provider must obtain the appropriate prior authorization via Evolent's website or by calling Evolent.

To initiate or to check the status of an authorization, please contact Evolent via their website a www.radmd.com or via interactive voice response (IVR) system.

Evolent will request patient symptoms, past clinical history and prior treatment information. The ordering provider should have this information available at the time of initiation.

Evolent's contact information can be found on the Prior Authorizations webpage located at www.amerihealthcaritasnext.com > Pick Your State > For Providers > Prior Authorizations.

Culturally and Linguistically Appropriate Services (CLAS)

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What is CLAS?

The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (The National CLAS Standards) were created to advance health equity, improve quality of care, and eliminate health care disparities.

The Plan recognizes the need to effectively respond to a diverse and multicultural patient population and to understand and address issues that lead to health disparities.

In an effort to deliver culturally competent, respectful, appropriate care to Members who have limited English proficiency (LEP); who are low literacy proficient (LLP); who represent diverse, multicultural backgrounds; or who may have special health needs, the Plan offers ongoing CLAS training.

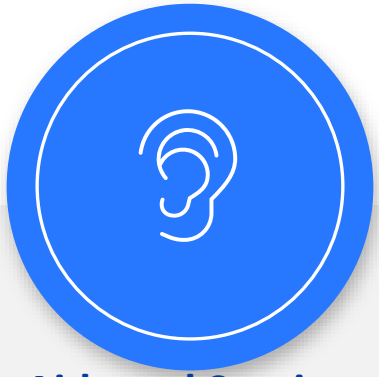
Please refer to the Provider Manual for more information or visit the CLAS web page at www.amerihealthcaritasnext.com > Pick Your State > For Providers > Provider Training.

Interpretation and Translation Services

If a Member needs these services, contact Member Services.

Free Language Services

Barriers in communication can impact quality of care. The Plan offers language services to facilitate better communication between Members and their providers.



Free Aids and Services for Disabled Members

The Plan provides free aids and Services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic and other formats).

Contact Information

The Plan provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

Grievances, Appeals, and Disputes

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Member Grievances and Appeals

The Plan may decide to deny or limit a request the provider makes for the member for benefits or services offered by our plan. We provide processes for filing a grievance or appeals. The member has the right to file a grievance, file an appeal, and right to an external review with respect to certain Adverse Determinations or appeals not decided in their favor.

The member, the member's authorized representative, or provider on a member's behalf, can file a grievance with us at any time. If a provider files a grievance on behalf of the member and we do not have record of the members' consent; the grievance team will need to secure the members consent for the grievance.

For more information regarding member grievances and appeals, please refer to the member's Evidence of Coverage. The Evidence of Coverage can be located at www.amerihealthcaritasnext.com > Pick Your State > For Members > Forms and Documents > Evidence of Coverage.

Provider Disputes

A dispute is a written request from a health care provider to change a decision made by the Plan.

Providers may file a dispute about the Plan's policies or procedures, or any aspects of the Plan's administrative functions, including proposed actions, claims and billing-related issues, and service authorizations. To be deemed timely, claims disputes must be received within 60 calendar days of the subject claim remittance advice or denial. A determination on a claim dispute will be made within 30 calendar days of receipt of such claim dispute by the Plan.

For information or instructions on how to file a Provider Dispute, please visit one of the following:

- Provider Manual located at www.amerihealthcaritasnext.com > Pick Your State > For Providers > Provider Manual.
- Claims and Billing webpage at www.amerihealthcaritasnext.com > Pick Your State > Claims and Billing > Submit a provider dispute.

Providers must exhaust the Plan’s claim dispute process as a prerequisite to arbitration or litigation.

Compliance

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Fraud Prevention Program

As a network provider, you are responsible for reporting suspected fraud, waste and abuse issues.

If you are aware of a potential or actual fraud, waste, or abuse issue, we encourage you to report the issue to the Plan's Special Investigations Unit by:

- Calling the toll-free Fraud Waste and Abuse Hotline at **1-866-833-9718**, which is available 24/7 and allows for the anonymous reporting of issues.
- Emailing fraudtip@amerihealthcaritas.com.
- Complete the anonymous online fraud intake form.
- Mailing a written statement to the AmeriHealth Caritas Next OR First Choice Next address found on the Fraud, Waste, and Abuse Plan webpage located at www.amerihealthcaritasnext.com > Pick Your State > For Providers > Fraud, Waste, and Abuse > Anonymously report suspected fraud, waste, and abuse.

Refer to the Report Fraud, Waste, and Abuse webpage for more information at www.amerihealthcaritasnext.com > Pick Your State > For Providers > Report Fraud, Waste, and Abuse.

Comprehensive Compliance Program

The Plan's Compliance department has implemented a Comprehensive Compliance Program to ensure compliance with all applicable federal and state laws and Marketplace requirements.

If you have a compliance or privacy concern, we encourage you to contact our Compliance department. You can report issues to the Compliance department by:

- Calling the toll-free Compliance Hotline at **1-866-833-9718**, which is available 24/7 and allows for the anonymous reporting of issues.
- Emailing us:

  AmeriHealth Caritas Next Compliance: ACNXcompliance@amerihealthcaritas.com

  AmeriHealth Caritas Corporate Compliance: corpcompliance@amerihealthcaritas.com

  AmeriHealth Caritas Corporate Privacy: privacy@amerihealthcaritas.com

Compliance is a shared responsibility and calls upon us to do the right thing in the right way.

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Questions