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# Administrative Procedures

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## The NaviNet® web portal

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NaviNet, a HIPAA-compliant Web-based connectivity solution offered by NaviNet, Inc., is a fast and efficient way to interact with us to streamline various administrative tasks associated with your AmeriHealth patients' health care. By providing a gateway to back-end systems at AmeriHealth, NaviNet enables you to submit and receive information electronically with increased speed, efficiency, and accuracy. The portal also supports HIPAA-compliant transactions.

NaviNet is available only to Participating Providers and enhancements are regularly communicated through our monthly Provider newsletter, *Partners in Health Update*<sup>SM</sup>.

If you are a current NaviNet user and need technical assistance, contact NaviNet at 1-888-482-8057 or our eBusiness Provider Hotline at 215-640-7410. If you are not already NaviNet-enabled, you can register for access to NaviNet by visiting their website at [www.navinet.net](http://www.navinet.net).

### NaviNet transactions

#### *Inquiries*

- Accepted Claim Status Inquiry
- Authorization Status Inquiry
- CAP Rosters PCP only
- Claim INFO Adjustment Inquiry
- Clinical Alerts
- Clinical Care Report
- Diagnosis Code Inquiry
- Eligibility and Benefits Inquiry
- Fee Schedule Inquiry
- Online SOR Inquiry
- Procedure Code Inquiry
- Referral Inquiry
- Rejected Claim Status Inquiry
- Report Inquiry

#### *Submissions*

- Chemotherapy/Infusion
- Claim INFO Adjustment Submission
- Drug Preauthorization
- EFT Registration
- Encounter Submission
- Medical/Surgical Authorization – acute care and ambulatory surgery centers (ASC)
- OB/GYN Referral Submission
- Provider Change Form
- Referral Submission
- Speech Therapy – speech therapy Providers and facility-based speech therapy departments
- User Permission Manager (Security Officer only) – EFT and Online SOR Registration

## Links

- Clear Claim Connection™
- Select Drug Program® Formulary
- Medical Policy
- Provider Directory
- AIM Specialty Health<sup>SM</sup> (AIM)

## NaviNet functionality

- **Access to Medical Policy** – View medical and claim payment policies.
- **AIM Radiology Precertification** – Follow the NaviNet link to AIM’s website to complete online precertification requests. *Note: All Providers must register with AIM prior to using the AIM website.* **Authorization - Authorization Status Inquiry** – View inpatient, outpatient, and concurrent authorizations. When applicable, edit admission or service dates for approved authorizations.
- **Benefit Snapshot** – View a summary of Member benefits, including Copayments.
- **Claim Inquiry and Maintenance** – With your tax or Group Provider ID number, search for and retrieve up to two years of historic claims data (including paid, rejected, denied, remit cycle, and in process/pended claims). Providers are required to use NaviNet or the Provider Automated System to obtain status of a claim.

**Clinical Alerts** – These alerts are a clinical practice tool providing Member-specific information to Providers regarding their patients through the Eligibility and Benefits Inquiry transaction. Our *Clinical Alerts Overview* document, located in the Administrative Tools & Resources section of NaviNet Plan Central, provides you with all of the information you need to take advantage of this tool.

- **Eligibility Detail** – This function allows you to view Member demographics, group number, additional Copayment information, Coordination of Benefits, pre-existing clause information, Primary Care Physician (PCP) demographics, PCP-selected specialty sites, and annual service and dollar accumulator information.
- **Encounters** – This function reports Covered Services performed by PCPs.
- **ePayment - Electronic Fund Transfer (EFT) and Online Statement of Remittance (SOR)**
  - Register and maintain your EFT account and receive claim payments electronically. An EFT account is designed to allow for the transfer of funds by electronic means, rather than conventional, sometimes time-consuming, paper-based payment methods. EFT account transactions often result in faster payments and eliminate the need for manual deposits. Once registered, use this feature to view all remittances issued to Providers in your group and to search for an SOR using your office’s internal patient account number. SOR information can be viewed for a 13-month rolling calendar.
  - Appropriate levels of security can be set by your designated Security Officer to restrict users’ ability to register, view, and edit an EFT account. Detailed information is available through the ePayments option in the Plan Transactions menu. Additional information, including instructions about how to manage EFT accounts, can be found in the User Guides section on AmeriHealth Plan Central under Administrative Tools & Resources.
- **Fee Schedule Inquiry Tool** – View complete contract rate information, showing the allowed amount or percentage of amount billed, per your agreement with AmeriHealth. You can use a billing Provider, servicing Provider (in some cases), procedure code (CPT® and HCPCS), procedure code modifier, diagnosis code (optional), product (line of business), and procedure service date to search

for the fee schedule. In addition, a quarterly update to our Injectable and Vaccine Fee Schedule is available using the Fee Schedule Lookup Tool. These updates reflect changes in market price (i.e., average sales price [ASP] and average wholesale price [AWP]) for vaccines and injectables.

- **Injectables Preauthorization Submission** – Submit drug preauthorization requests to the Pharmacy Services department for determination within 48 hours. All drug preauthorization forms are available through NaviNet and include improved criteria questions written to assist you in the submission process.

The preauthorization forms for those oral and injectable drugs that can be administered by the Member or family are accessible from the Plan Transactions menu under Drug Pre-Authorization and Formulary.

Preauthorization requests for injectable drugs that are administered as an infusion (either in a Physician’s office, by a home infusion Provider, or as an outpatient) can be made by selecting *Authorizations* from the Plan Transaction menu, and then *Chemotherapy/Infusion*.

- **Member Eligibility and Benefits Inquiry** – Confirm Member ID number, product, date of birth, relationship to the insured, and coverage status. Providers are required to use NaviNet or the Provider Automated System to confirm Member eligibility.
- **Preauthorization Submission**
  - Submit preauthorizations for the following, but not limited to: inpatient/outpatient, outpatient speech therapy, and medical/surgical admissions to be performed in an acute care facility or ASC. Chemotherapy and infusion procedures to be performed in an acute care facility, ASC, or in office can be preauthorized as well.
  - The following authorization types must be requested through NaviNet: medical/surgical procedures; cardiac rehabilitation; chemotherapy/infusion therapy; durable medical equipment (DME); emergency hospital admission notification; home health (dietitian/home health aide/occupational therapy/physical therapy/skilled nursing/social work/speech therapy); home infusion; outpatient speech therapy; pulmonary rehab.
- **Provider Change Form** – Submit changes to your practice information. Refer to [page 3.17](#) for more information about completing the *Provider Change Form*.
- **Referral Inquiry** – You can look at all Referrals (generated through NaviNet or the Provider Automated System) from your office during the previous two weeks, or you can enter a specific Member ID number and see a list of all Referrals for that Member during the previous 12 months.
- **Referral Submission** – PCPs and OB/GYN Providers must submit Referrals electronically to AmeriHealth and to NaviNet-enabled specialists and facilities. There is also a fax and print option available through NaviNet.
- **Additional functionality** – This includes A/R aging reports, procedure and diagnosis code inquiries, report inquiries, and user permissions manager.

## Referrals/Authorizations

If a Referral or precertification request is initiated through the portal, those logs can be viewed by selecting *Referral/Authorization Log* under the *Office Central* drop-down menu (*Note: Does not apply to AIM requests*).

On the Referral/Authorization Log screen, you can conduct a search based on a variety of criteria, including patient’s name, Member ID number, specialist’s name and referring Provider’s name. Selecting *Advanced Search* will provide additional search options. Records can be reviewed by clicking on the

patient's name. Once on screen, records with a status authorization code of "Incomplete" can be updated and submitted to AmeriHealth.

*Note:* Records noted with a status authorization code of "Incomplete" signify that the request was initiated but was not submitted to AmeriHealth.

Members may view and print Referrals submitted through NaviNet by logging on to our secure Member website at [www.amerithealthexpress.com](http://www.amerithealthexpress.com).

### ***Tips for submitting authorizations***

Requests for medical/surgical procedures can be made up to six months in advance on NaviNet, and in most cases, requests for Medically Necessary care are authorized immediately. In some instances, Providers can modify the date of service previously approved by selecting *Authorizations* from the Plan Transactions menu, and then *Authorization Status Inquiry*. It is recommended that Providers check Member eligibility when submitting authorization requests. For detailed information on how to check Member eligibility, see [page 3.8](#) of this section.

NaviNet submissions that result in a pended status can take up to two business days to be completed. These may include requests for additional clinical information as well as requests that may result in a duplication of services. If the authorization remains pended beyond two business days, or if the authorization request is urgent, call [1-800-275-2583](tel:1-800-275-2583) for assistance.

*Note:* This information does not apply to Providers contracted with Magellan Behavioral Health, Inc. Magellan-contracted Providers should contact their Magellan Network Coordinator at [1-800-866-4108](tel:1-800-866-4108) for authorizations.

### **Capitation rosters**

PCPs can view, print, and download electronic copies of their capitation rosters through NaviNet. To view your capitated roster list, select *ePayment* from the Plan Transactions menu, then select *CAP Rosters*. Next, fill out either the Provider ID or Tax ID field in combination with a specific month. This will generate an accurate CAP report for the specified month. Once generated, all rosters will be accessible for 13 months.

Additionally, you can narrow your search by using the Quick Search drop-down menu. After selecting the *Quick Search* category, enter a corresponding value (e.g., the patient's last name, unique subscriber ID number), and select the *Search* button. These results can be sorted by selecting the column headers. You can also print or download the capitated roster list by selecting the appropriate button along the bottom of the screen.

### **Claim adjustments**

The Claim INFO Adjustment Submission transaction allows Providers to submit claim adjustments through NaviNet for claims in a paid or denied status. Claims data is available for up to two years prior to the current date.

The Claim INFO Adjustment Inquiry transaction enables Providers to review the status of submitted requests. Both transactions can be viewed by selecting *Claim Inquiry and Maintenance* from the Plan Transactions menu.

Additional information on Claim INFO transactions can be found in the User Guides section on AmeriHealth Plan Central under Administrative Tools & Resources.

Your designated Security Officer can control access to these transactions by following these steps:

1. Select *NaviNet Administration*, located in the NaviNet Central menu.
2. Select *User Management* from the drop-down menu on the left, and then select *User Transaction Management*.
3. Search for the appropriate user by entering a last and first name, and then select *Search*.
4. Select the appropriate user from the list that populates. Then select *Edit Access* to view the list of transactions. Designated transactions can be enabled or disabled as needed.

In addition, NaviNet users can access user guides by selecting *Customer Support*, then one of the topics offered under User Guides.

Interactive training demos are also available to all users on NaviNet. Simply select *Customer Support* from the top navigation menu, and then select *Customer Care*.

*Note:* Participating Providers are required to use either the Provider Automated System or NaviNet for all Member eligibility inquiries, encounter and Referral submissions, Referral inquiries, authorization status inquiries, maternity delivery notifications, and authorization cancellations.

## iEXCHANGE®

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AmeriHealth Administrators, which offers third-party administration services to self-funded health plans throughout the United States, provides you with an additional online service called iEXCHANGE, a MEDecision product. iEXCHANGE supports the direct submission and processing of health care transactions, including inpatient and outpatient authorizations, treatment updates, concurrent reviews, and extensions. Certain services require precertification to ensure that your patients receive the benefits available to them through their health benefits plan. With just a click of the mouse, you can log into iEXCHANGE, complete the precertification process, and review treatment updates.

### *Available transactions:*

- inpatient requests and extensions
- other requests and extensions (outpatient and ASC)
- treatment searches
- treatment updates
- Member searches

After registering, you can also access iEXCHANGE through NaviNet for AmeriHealth Administrators plan Members. For more information or to get iEXCHANGE for your office, visit [www.amerihhealth-tpa.com/providers](http://www.amerihhealth-tpa.com/providers) or contact the iEXCHANGE help desk at AmeriHealth Administrators by calling 1-888-444-4617.

## Provider Automated System

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Providers can use the Provider Automated System, our speech-enabled, automated phone service, to retrieve Member eligibility information for HMO, POS, and PPO Members, submit encounters and Referrals, inquire about Referrals, and receive authorization status updates. You can also cancel an existing authorization or submit a maternity delivery notification. The Provider Automated system can be accessed 24 hours a day, 7 days a week, at 1-800-275-2583. You can also request that certain information be faxed to your office through the Provider Automated System.

A guide that contains step-by-step instructions on how to use all of the menu prompts available through Customer Service, including transactions in the Provider Automated System, is available at [www.amerihhealth.com/providerautomatedsystem](http://www.amerihhealth.com/providerautomatedsystem).

*Note:* For behavioral health services, Providers should still call the number on the Member's ID card under Mental Health/Substance Abuse.

## Member eligibility

It is extremely important to properly identify the Member's type of coverage. All Member ID cards carry important information, such as name, ID number, alpha prefix, and coverage type. The information on the card may vary based on the Member's plan. Eligibility is not a guarantee of payment. In some instances, the Member's coverage may have been terminated.

### How to check eligibility

- Always check the Member's ID card before providing service. If a Member is unable to produce his or her ID card and/or is not listed on the PCP's capitation/eligibility rosters, ask if the Member has a copy of his or her Enrollment/Change Form or temporary insurance information printed from [www.amerihhealthexpress.com](http://www.amerihhealthexpress.com), our secure Member website. This form is issued to Members as temporary identification until the actual ID card is received and may be accepted as proof of coverage. The temporary ID card is valid for a maximum of ten calendar days from the print date.
- Participating Providers are required to use either NaviNet or the Provider Automated System for all Member eligibility inquiries.

*Note:* For HMO and POS Members, PCPs should refer to their monthly capitation/eligibility roster. Members are listed in alphabetical order, with family Members listed together. In some instances, a Member may have been added to the panel after the monthly capitation/eligibility roster was sent to the Provider. In the event that there is a question about the Member's eligibility or panel assignment, check NaviNet or call the Provider Automated System.

If we are unable to verify eligibility, we will not be responsible for payment of any Emergency or nonemergency services.

### Treating Members of Affiliates

You may find that some of your patients are covered by one of our Affiliates from a neighboring State.

If you or one of your affiliated practices is located in one of the counties listed below, you should treat the patient and use the information in this manual as if the patient were covered by the same plan in your own State. Although you will see the logo of an Affiliate on the Member ID card, you should recognize the name of the product under which the Member receives coverage.

**Delaware:** New Castle county

**Maryland:** Cecil county

**Pennsylvania:** Berks, Lancaster, Lehigh, and Northampton counties



## Product offerings

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Providers are required to use NaviNet or the Provider Automated system to obtain Member eligibility information. Providers may call Customer Service for specific product information.

The following grids outline the products offered through AmeriHealth and provide information to assist you in quickly identifying our Members.

### AmeriHealth Delaware

Product	Alpha prefix
HMO	Q2C
POS	Q2A or Q2P
PPO	Q2B
CMM	Q2T

### AmeriHealth Pennsylvania

Product	Alpha prefix
HMO	Q3B or Q3C
POS	Q3A or Q3P

## Office visits

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### Copayments

Members are responsible for making all applicable Copayments. The Copayment amounts vary according to the Member's type of coverage and benefits plan. In addition, please note the following:

- As required by the Patient Protection and Affordable Care Act of 2010, there is no Member cost-sharing (i.e., \$0 Copayment) for certain preventive services provided to Members. Claim Payment Policy #00.06.02: Preventive Care Services includes the list of applicable preventive codes and is available on NaviNet or at [www.amerihealth.com/medpolicy](http://www.amerihealth.com/medpolicy).

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 significant problem that requires a problem-focused service that could not 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 cost-sharing.
- Copayments may not be waived and should be collected at the time services are rendered. If a Member is unable to pay the Copayment at the time services are rendered and has been provided with prior notice of this requirement, Providers may bill the Member for the Copayment.

PCPs may not charge a Member for a Copayment unless the Member is seen by a Provider. No Copayment is to be charged or collected by the PCP if a Member is only picking up a copy of a Referral or prescription from the office.
- If the Member's specified Copayment is greater than the allowable amount for the service, only the allowable amount should be collected from the Member. However, if the allowable amount for the service is greater than the Copayment, the specified Copayment should be collected in full from the

Member. In the event that a Copayment is collected and the practice subsequently determines that the allowable amount is less than the Copayment, the difference between the Copayment and the allowable amount must be refunded to the Member within a reasonable period of time (i.e., 45 days) at no charge/cost to the Member.

- For HMO and POS Members, the PCP Copayment is noted on the monthly capitation roster.
- For NaviNet-enabled offices, Copayments are listed on the Eligibility Details screen when using the Eligibility and Benefits Inquiry transaction. Additional Copayment information is listed on NaviNet Plan Central in the Administrative Tools & Resources section.
- Radiology, physical therapy, and occupational therapy services may also be subject to Copayment amounts that may differ from the specialist Copayment amount identified on the Member's ID card.
- For Providers without access to NaviNet, Copayment information can be obtained through the Provider Automated System by calling 1-800-275-2583.

## Referrals

One of the most important functions a PCP performs is coordinating the care a Member receives from a specialist. By coordinating Referrals, PCPs help to make the process of patient care appropriate and continuous.

Participating specialists and facilities must receive PCP Referrals through NaviNet or the Provider Automated System. Referrals can be accessed from 5 a.m. until 10 p.m., 7 days a week. Submitting Referrals in a timely manner helps to prevent claim denials for "no Referral." Referrals may also be submitted electronically through other vendors.

Because Referrals submitted through NaviNet are electronic, you are not required to mail hard copies of these Referrals to AmeriHealth.

### Issuing encounters/Referrals

#### *HMO and POS plans*

Physicians must issue a Referral for managed care patients covered under our HMO or POS plans when referring them for specialty care, including nonemergency specialty and hospital care. HMO Members are required to have a Referral from their PCP to access specialty care. Referrals are valid for 90 days and do not guarantee active eligibility on the date of service.

Referrals are valid for active HMO and POS Members. Members who are not eligible on the date of service are responsible for payment. The PCP must submit an encounter/Referral for all nonemergency, specialty, and hospital services. Nonemergency Services (other than Direct Access services) that have not been referred by the PCP are not covered.

Note the following:

- It is important to be as specific as possible when issuing a Referral. All visits must occur within the 90-day period following the date the Referral is issued.
- For AmeriHealth HMO and POS Members, all short-term rehabilitation and outpatient laboratory Referrals must be referred to the PCP's capitated site. Refer to the *Specialty Programs and Laboratory Services* section of this manual for additional information.
- AmeriHealth Delaware Members do not need a Referral for short-term rehabilitation, laboratory, or behavioral health services.

- AmeriHealth HMO Members must be referred only to Participating Providers. If a Participating Provider cannot provide care, and a Referral to a nonparticipating Provider is contemplated, such a Referral will require Preapproval review.

Referrals are *not* required for the following services:

- vision screenings
- routine, preventive, or symptomatic OB/GYN care
- screening or diagnostic mammography
- behavioral health
- out-of-network care (for POS Members only)
- radiology services preapproved by AIM
- dialysis

POS Members may need preauthorization for some specialty services. When requesting preauthorization through NaviNet for these Members, you will be asked, “Has the Member been referred by the PCP for treatment?” It is very important to answer “Yes” if your office has a Referral on file for the Member to ensure that the highest level of benefits is covered for the Member. Please be sure to check the Member’s chart for a Referral, or verify that an electronic Referral is “on file” through NaviNet by selecting *Encounters and Referrals* from the Plan Transactions menu, and then *Referral Inquiry*.

If you incorrectly answer “No” and the Member has a Referral on file, the system will automatically default to the self-referred benefits level, and the Member will be subject to higher out-of-pocket expenses. In addition, if the system defaults to the self-referred benefits level, you may receive the following message due to the differences in preauthorization requirements: “This Member’s benefits program does not require preauthorization for the procedure(s) requested based upon the information provided.” Claims will be denied for lack of preauthorization.

### ***Direct POS plans***

The AmeriHealth capitated program remains in effect for AmeriHealth Direct POS. As with our AmeriHealth HMO and POS benefits, PCPs must refer AmeriHealth Direct POS Members to capitated Providers for capitated services (i.e., routine radiology, physical/occupational therapy, and laboratory) for Members to receive the highest level of benefits.

*Note:* Mammography services are not capitated, and Direct POS Members may go anywhere in-network for mammography.

How the plan works:

- A Direct POS Member selects a Participating PCP from the AmeriHealth network.
- No Referrals are required for Members to see participating specialists.
- Referrals are required for routine radiology (except mammograms), podiatry, spinal manipulation, and physical/occupational therapy services.
- A requisition form is required for laboratory services.
- The Member is responsible for applicable cost-sharing.
- The Member does not need to file claim forms when services are provided by participating specialists.

*Note:* For services requiring precertification through AIM (CT/CT scans, MRI/MRA, nuclear cardiology services, and PET scans), a separate PCP Referral is not required. Additionally, Referrals are never required for mammography.

## ***PPO plans***

PPO Members may use a nonparticipating Provider, but may be responsible for a higher cost-sharing. If you are not certain whether a specialist is a participant in our network, use the Find a Doctor tool, which is available on our website at [www.amerithealth.com](http://www.amerithealth.com). A link to this tool can also be found on NaviNet by selecting *Reference Tools* and then *Provider Directory* from the Plan Transactions menu. If you do not have access to the Internet, please call Customer Service.

## **OB/GYN Referrals**

Under our Direct Access OB/GYN<sup>SM</sup> Program, HMO and POS Members may see any network OB/GYN specialist or subspecialist without a Referral for Preventive Care visits, routine OB/GYN care, or problem-focused OB/GYN conditions.

Specialties and subspecialties not requiring Referrals include, but are not limited to, the following:

- OB
- GYN (including urogynecologist)
- OB/GYN
- gynecologic oncologist
- reproductive endocrinologist/infertility specialist
- maternal fetal medicine/perinatologist
- midwife

Services not requiring Referrals from PCPs or OB/GYN Providers include, but are not limited to, the following:

- all antenatal screening and testing
- fetal or maternal imaging
- hysterosalpingogram/sonohysterogram

You must continue to use the *OB/GYN Referral Request Form* for the following services:

- pelvic ultrasounds, abdominal X-rays, intravenous pyelograms (IVP), and DXA scans (these tests must be performed at the Member's capitated radiology site);
- initial consultations for HMO Members for endocrinology, general surgery, genetics, gastrointestinal, urology, pediatric cardiology, and fetal cardiovascular studies (visits beyond the initial consultation still require a PCP Referral).

*Note:* Certain products have specialized Referral and Preapproval requirements and/or benefits exemptions.

## **Mammography Referrals**

All commercial HMO and POS Members may obtain screening and diagnostic mammography, provided by an accredited in-network radiology Provider, without obtaining a Referral or prescription.

Medicare Advantage HMO Members have access to screening and diagnostic mammography without the need for a Referral or written prescription.

Note the following:

- Certain radiology facilities may still require a Physician's written prescription. This may need to be communicated to your HMO and POS Members asking about mammography. Please continue to provide a prescription for the mammography study if required by the radiology site.
- Proper certification, credentialing, and accreditation are required for in-network Providers to provide mammography services to our Members.

## Hospital Referrals

When referring a Member for a surgical procedure or hospital admission, the PCP needs to issue only one Referral to the specialist or attending/admitting Physician. This Referral will cover all facility-based (i.e., hospital, ASC) services provided by the specialist or attending/admitting Physician for the treatment of the Member's condition. The Referral is valid for 90 days from the date it was issued. The admitting Physician should obtain the required Preapproval. Any pre-admission testing and hospital-based Physician services (e.g., anesthesia) will be covered under the hospital or surgical Preapproval.

*Note:* Certain products have specialized Referral and Preapproval requirements and/or benefits exemptions.

## Referrals for Members in long term/custodial care nursing homes

Preapproval is not required for ancillary services or for consultation with a specialist for Members residing in long-term care (LTC) or nursing homes. In such cases, only a Referral is required. We have established LTC panels for our PCPs who provide care in LTC-participating facilities. The LTC panels do not have capitated sites for ancillary services (i.e., laboratory, physical therapy, or radiology). The completion of a Referral is required for any ancillary service for an LTC panel Member. In addition, a Referral is required for any specialist Physician consultation (and/or follow-up) for an LTC panel Member.

Note the following:

- LTC panel PCPs must issue Referrals for any professional service or consultation for an LTC panel custodial nursing home Member. Examples of services that require a Referral include specialist, podiatry, physical therapy, and radiology.
- All Referrals should be made to AmeriHealth HMO Participating Providers. Referrals should be submitted in advance of the service being provided using NaviNet or the Provider Automated System.
- PCPs should submit Referrals to AmeriHealth in a timely manner to allow for appropriate claims processing. No claim will be authorized for payment without a Referral on file.
- Consultants and ancillary Providers are encouraged to provide Referral information with the claim to assist in processing. Preapproval review is required only for inpatient admission for hospital care, skilled nursing facilities (SNF), short procedure unit cases, or ASC procedures.

During an approved skilled nursing care admission, it is not necessary for the attending Physician to issue a Referral. All Providers giving care to the Member should use our inpatient skilled nursing care authorization number for claims during dates of service within the skilled nursing inpatient stay.

*Note:* Certain products have specialized Referral and Preapproval requirements and/or benefits exemptions.

## Member consent for financial responsibility

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The *Member Consent for Financial Responsibility* form, which is available on our website, is used when a Member does not have a required Referral for nonemergency services or elects to have services performed that are not covered under his or her benefits plan. By signing this form, the Member agrees to pay for noncovered services specified on the form. The form must be completed and signed before services are provided.

The form is available on our website at [www.amerihealth.com/providerforms](http://www.amerihealth.com/providerforms), or Providers may use their own. This form does not supersede the terms of your Professional Provider Agreement, and you may not bill Members for services for which you are contractually prohibited.

### *Medicare Advantage HMO Members*

Providers must furnish Medicare Advantage HMO Members with written notice that noncovered/excluded services are not covered and that the Member will be responsible for payment before services are provided. If the Provider does not give written notice of noncovered/excluded services to the Member, then he or she is required to hold the Member harmless.

## Routine eye care/vision screening

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**HMO and POS Members:** Routine eye exams are covered through HMO and POS medical plans administered by Davis Vision®.

- Members may contact Customer Service to verify eligibility and to locate a Participating Provider for routine services.
- Member Copayments for routine eye care differ depending on the Member's specific benefits. Specialist Copayments are indicated on the Member's ID card.
- For medical conditions, a Referral from the Member's PCP to a participating optometrist or ophthalmologist is required.

**PPO Members:** Routine eye care is not covered. Non-routine care related to the treatment of a medical condition related to the eye is covered, subject to applicable specialist Copayment.

## Hearing aid coverage

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### **For Delaware Members**

Hearing aids are covered for Delaware Members' dependents up to age 24. The Delaware state legislature mandated coverage of up to \$1,000 per individual hearing aid, per year, every three years.

We require a written recommendation from a professional Provider who is certified as an otolaryngologist or a licensed audiologist. The coverage applies to AmeriHealth HMO, POS, PPO, and Comprehensive Major Medical (CMM) Members, with the exception of state-mandated basic and standard small employer health plans.

## Preapproval guidelines

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Preapproval is required to evaluate the Medical Necessity of proposed services for coverage under applicable Benefits Programs. When referring Members to a hospital, the PCP only needs to refer to the admitting/performing Physician, who is then responsible for obtaining Preapproval.

## Responsibilities

### *Responsibilities of the admitting/performing Physician for hospital admissions*

- Make hospital admission arrangements.
- Acquire the following required information:
  - Member name and date of birth
  - Member ID number
  - admission date
  - place of admission
  - diagnosis
  - planned procedure
  - medical information to support the Preapproval request
- For HMO and POS Members, notify the Member's PCP of the diagnosis, planned procedure, and hospital arrangements and request one Referral.
- Contact the hospital with the Preapproval code.

### *Responsibility of the PCP*

Submit one Referral for the admitting/performing Physician through NaviNet or the Provider Automated System.

### *Responsibility of the HMO and POS Member*

- Request a Referral from the PCP.
- POS Members are responsible for obtaining Preapproval, when required, when seeking services without a Referral.

### *Responsibility of the PPO Member for out-of-network care*

Obtain Preapproval for all services requiring Preapproval.

### *Responsibility of the hospital, SNF, freestanding ASC, or rehabilitation facility*

- To initiate Preapproval, Providers can use NaviNet or call the Provider Automated System. Providers can check the status of an authorization using NaviNet by selecting *Authorization Status Inquiry* from the Authorizations option in the Plan Transaction menu.
- Providers registered with NaviNet may submit electronic Preapproval requests to AmeriHealth for services to be rendered at an acute care facility or ASC. Discharge planning questions are presented during the submission process and are optional.

Refer to the *Care Management and Coordination* section of this manual for more information on Preapproval review requirements. Preapproval requirements are also available on our website at [www.amerhealth.com/preapproval](http://www.amerhealth.com/preapproval).

*Note:* Certain products have specialized Referral and Preapproval requirements and/or benefits exemptions.

## Hospital comparison tool

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Through an agreement with WebMD<sup>®</sup>, the Hospital Advisor tool provides hospital quality and safety information. Both Providers and Members can research and compare hospitals based on procedure/diagnosis and location and can review details on process and outcomes results. The search results can also be customized according to which measures (e.g., volume, mortality, complications, and length-of-stay) are most important to the user.

Members can access the tool through our secure member website, [www.amerihealthexpress.com](http://www.amerihealthexpress.com). Providers can access the Hospital Advisor through NaviNet by selecting *Reference Tools* from the Plan Transactions menu and then selecting *Provider Directory*.

## Change of network status

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### Updating your Provider information

When submitting claims, reporting changes in your practice, or completing recredentialing applications, it is essential that the information you transmit is timely and accurate. You are contractually required to notify us in a timely manner when changing key practice information, such as:

- address
- phone number
- fax number
- partner status
- tax ID number
- name of practice
- change from board-eligible to board-certified
- hospital privileges

Please complete the *Provider Change Form* to notify us such changes. Detailed instructions are included in the next section under *Completing the Provider Change Form*. You may also submit this information to us electronically through NaviNet or by calling your Network Coordinator or Customer Service.

Note the following:

- At least 30 days prior written notice is needed to process Provider information changes and/or Member changes.
- At least 60-days prior written notice is needed for closure of a PCP practice to additional patients.
- At least 90-days prior written notice is needed for resignation/termination from our network.
- If you have accepted any payments during the year, we must report that income on the annual 1099 Form. All Providers are reminded that practice demographics should be kept current to receive accurate 1099 Forms.
- Payments will be processed more efficiently if Provider information is current.
- The recredentialing process is another way we keep your Provider information current. Return your recredentialing application packet promptly or update your CAQH application at least quarterly.



## Completing the Provider Change Form

Professional Providers can quickly and easily submit changes to their basic practice information using the Provider Change Form transaction on NaviNet. Simply select *Provider Change Form* from the Plan Transactions menu.

If you are not registered for NaviNet, you can download a copy of the *Provider Change Form* at [www.amerihealth.com/providerforms](http://www.amerihealth.com/providerforms). Please be sure to print clearly, provide complete information, and attach additional documentation as necessary. Fax your completed *Provider Change Form* to Network Data Administration at 215-988-6080 or mail to:

AmeriHealth  
P.O. Box 41431  
Philadelphia, PA 19101-1431

When faxing the form, make sure you receive a confirmation of your fax.

Thirty days advance notice is required for processing. AmeriHealth will not be responsible for changes not processed due to lack of proper notice from provider.

The types of changes you can request vary depending on your Provider type as well as on the lines of business for which you are contracted. Physicians can:

- change address, office hours, total hours, and phone or fax numbers;
- change selection of capitated Providers (for HMO PCPs only);
- add newly credentialed Providers or Participating Providers to a participating group (applicable to group practices only);
- add hospital affiliation.

*Note:* The *Provider Change Form* cannot be used if you are closing your practice or terminating from the network. Refer to [page 3.16](#) of this section regarding policies and procedures when resigning or terminating from the network.

### Authorizing signature and W-9 Forms

A signature from the Physician is required for any change that may result in a change on your W-9 Form. This includes changes to a Provider's name, tax ID number, billing vendor, "pay to" address, or ownership. You must also submit to us a copy of your W-9 Form for these changes to ensure that we provide you with a correct 1099 Form for your tax purposes. If you do not submit a copy of your new W-9 Form, your change will not be processed.

An office manager's signature will suffice for any other changes.

### Closing a PCP practice to additional patients

A Participating PCP must notify his or her Network Coordinator at least 60 days in advance of any intent to close the practice to additional patients. There are three status levels for offices:

- **Open:** Practice is accepting new patients.
- **Current:** Practice is accepting existing patients currently in the practice but covered by other insurance.
- **Frozen/Closed:** Practice is not accepting additions to the HMO or POS panel. Providers in this category do not appear in the Provider directory.

Offices with practices designated as “current” will be listed in the Provider directory as such. Should *existing* patients of one of our Plans switch to another of our Plans through their employer group, they will be able to select a closed office.

*Note:* Close-of-practice notification should be in writing and addressed to your Network Coordinator.

## Age limitations on a PCP practice

If your practice subscribes to minimum and/or maximum age limits for Members, notify your Network Coordinator of this policy in writing. Members have expressed dissatisfaction over choosing a practice and subsequently discovering that the practice limits patients based on age.

PCPs should check their capitation/eligibility rosters to identify Members who fall outside their practice’s age limitations. Contact Customer Service to arrange to have Members who fall outside of your practice’s age limitations notified to choose a new PCP.

## Patient transition from a pediatrician to an adult PCP

Pediatricians should systematically alert adolescents who are approaching the maximum age for patients treated in their practice to allow patients to make a smooth transition to a new PCP who has experience in treating adults.

If Members require further assistance on how to switch from a pediatrician to a new PCP, ask them to call Customer Service at the telephone number on their ID card.

## Changing PCPs

A Member can change his or her PCP through our secure Member website, [www.amerihalthexpress.com](http://www.amerihalthexpress.com), or by calling Customer Service. The change will be effective on the first day of the following month.

*Note:* Providers cannot make a change to a Member’s PCP on the Member’s behalf.

## Discharging a Member from the panel

A PCP must notify the Member and AmeriHealth in writing if discharging a Member from his or her panel. The PCP can notify his or her Network Coordinator, contact Customer Service or address correspondence to:

AmeriHealth  
1901 Market Street, 28th Floor  
Attn: (Network Coordinator’s name)  
Philadelphia, PA 19103

The Provider must also continue treating the Member for 30 calendar days; during this time, we will assist the Member in selecting a different PCP.

## Resignation/Termination from the AmeriHealth network

Providers who choose to resign from the network should first contact their Network Coordinator to discuss the reason for the resignation. In addition to the telephone call, the Provider must give the network at least 90 days advance written notice in order to terminate network participation.

Written notice can be sent to:

AmeriHealth  
Attn: Senior Vice President, Contracting and Provider Networks  
1901 Market Street, 27th Floor  
Philadelphia, PA 19103

In accordance with your contractual obligation to comply with our policies and procedures and professional licensing standards, a specialist or specialty group must notify affected Members if a specialist leaves the group or otherwise becomes unavailable to AmeriHealth Members or if the group terminates its agreement with us.

To help ensure continuity and coordination of care, we notify Members affected by the resignation/termination of a PCP or PCP practice site at least 30 days prior to the effective date of termination and assist them in selecting a different Provider or practice site. This notification of PCP resignation/termination by AmeriHealth does not relieve the PCP from his or her professional obligation to also notify his or her patients of the resignation/termination. Call Customer Service with any questions.

### ***Continuity of care***

If a Provider's contract is discontinued without cause, a Member may continue an ongoing course of treatment with the terminated Provider, at the contracted rate, for up to four months in cases where Medically Necessary. Exceptions are noted under "Continuity of Care" in the *Care Management and Coordination* section of this manual.