Table of Contents

Rendering services

Be sure to verify Member eligibility and cost-sharing amounts (i.e., Copayments, Coinsurance, and Deductibles) each time a Member is seen.

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 Primary Care Physician's (PCP) capitation/eligibility roster, ask the Member for a copy of his or her Enrollment/Change Form or temporary insurance information printed from *www.amerihealthexpress.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 the NaviNet® web portal or the Provider Automated System for all Member eligibility inquiries.
- A guide and webinar are available for guidance on where to obtain Member eligibility through NaviNet. You can find these materials at *www.amerihealth.com/pnc/changes* in the NaviNet Transaction Changes section.

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 the event that there is a question about the Member's eligibility or panel assignment, check NaviNet. 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. 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.

New Jersey: Burlington, Camden, Gloucester, Hunterdon, Mercer, Salem, and Warren counties

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:

- 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.
- A Provider must notify a Member if the office provides services where the Member may be billed by more than one Provider. For example, the office must inform the Member when he or she will be

charged a Copayment for a Physician service and a Copayment for an ancillary service, such as radiology. If two services are billed on the same date of service, two Copayments may be required.

- 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.
- On NaviNet, Copayments are listed on the Eligibility Details screen when using the Eligibility and Benefits Inquiry transaction.
- 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.
- **Preventive care services.** As required by the Patient Protection and Affordable Care Act of 2010 (Health Care Reform), 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, which includes the list of applicable preventive codes, is available on NaviNet or at *www.amerihealth.com/medpolicy*.

  Note: 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 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 cost-sharing.
- **Out-of-pocket maximums.** As required by Health Care Reform, Members should not be charged any cost-sharing (i.e., Copayments, Coinsurance, and Deductibles) once their annual limit has been met. These limits are based on the Member's benefit plan but may not exceed $6,350.00 for an individual, and $12,700.00 for a family. To verify if Members have reached their out-of-pocket maximum, Providers should use the Eligibility and Benefits Inquiry transaction on NaviNet.
- **Medicare-eligible Members.** AmeriHealth coordinates benefits for commercial Pennsylvania Members who are Medicare eligible, have not enrolled in Medicare Parts A or B, and for whom Medicare would be the primary payer. If a Member is eligible to enroll in Medicare Parts A or B but has not done so, AmeriHealth will pay as the secondary payer for services covered under an AmeriHealth HMO/PPO commercial group Benefits Program, even if the Member does not enroll for, pay applicable premiums for, maintain, claim, or receive Medicare Parts A or B benefits. This affects any Pennsylvania Member who is Medicare-eligible and for whom Medicare would be the primary payer.

  It is important that you routinely ask your Medicare-eligible Members to show their Medicare ID cards. If you have identified a Pennsylvania Member who is eligible to enroll in Medicare Parts A or B, but has not done so, you may collect the amount under "Member Responsibility" on the SOR, which includes any cost-sharing plus the amount Medicare would have paid as the primary payer.

- **Members of non-profit religious organizations**. Under Health Care Reform, AmeriHealth is required to pay the cost of certain contraceptive services for eligible Members within these organizations. These Members will receive a separate ID card that indicates "Contraceptive Coverage." Using this ID card, contraceptive methods approved by the U.S. Food and Drug Administration will be covered at an in-network level with no cost-sharing under the medical benefit and covered with no cost-sharing for generic products and for those brand products for which we do not have a generic equivalent under the pharmacy benefit at retail and mail order pharmacies. Please note these contraceptive services are covered under the pharmacy benefit only if the Member has an AmeriHealth prescription drug plan.

AmeriHealth routinely audits the claims we adjudicate to ensure they are paid accurately and in accordance with the Member's benefit plan. Audits include, but are not limited to, ensuring appropriate application of cost-sharing.

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. Referrals can be accessed from 5 a.m. until 10 p.m., Monday through Saturday. Referrals can be accessed from 9 a.m. until 9 p.m. on Sunday. Submitting Referrals in a timely manner helps to prevent claim denials for "no Referral."

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

Issuing encounters/Referrals

If you are not certain whether a specialist is a participant in our network, use the Find a Doctor tool that is available at *www.amerihealth.com*. A link to the Provider Directory can also be found on NaviNet by selecting *Reference Tools* from the Plan Transactions menu.

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* section of this manual for additional information.
- For AmeriHealth New Jersey Members in southern New Jersey*, all radiology Referrals should be made to the PCP's capitated site.

- AmeriHealth New Jersey Members may choose to select a site other than the PCP's capitated site for these specialty services. Should the Member choose to receive services you have authorized from a Participating Provider or facility other than the PCP's capitated site, you will need to issue a Referral and may refer to any Participating Provider; Preapproval is not required.
- AmeriHealth New Jersey Members do not need a Referral for behavioral health services.
- AmeriHealth HMO and AmeriHealth 65® NJ 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.
- Members enrolled in "Plus" and EPO products are exempt from all Referral requirements.
- PCPs in the AmeriHealth New Jersey Value Network should only issue referrals to specialists who are participating in the AmeriHealth New Jersey Value Network. A list of participating providers can be found online by using the Provider Finder tool at *www.amerihealthnj.com*.

**Counties that represent southern New Jersey are: Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Mercer, Salem, and Ocean.*

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 Specialty Health® (AIM)
- dialysis

POS Members may need Preapproval for some specialty services. When requesting Preapproval 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. 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 *Referrals*.

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 Preapproval 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 Preapproval.

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

AmeriHealth 51+ HMO Plus Coinsurance

AmeriHealth New Jersey launched AmeriHealth HMO Plus Coinsurance for 51+ groups – a no-Referral product that uses Deductibles and Coinsurance. Under this plan, Members must select a PCP but can access care within the AmeriHealth New Jersey network without a Referral. There are three plan options offering a variety of Deductible, Copayment, and Coinsurance options and out-of-pocket maximums.

AmeriHealth HMO Plus and POS Plus

- AmeriHealth HMO Plus and POS Plus require Members to select a PCP for their primary and Preventive Care. However, AmeriHealth HMO and POS Plus Members may use any Participating PCP, regardless if they are included on a PCP's roster. AmeriHealth HMO Plus and POS Plus Members are exempt from all Referral requirements. Members may access care from any Participating Provider without a Referral from their PCP and receive the highest level of coverage.
- AmeriHealth POS Plus Members may seek care from a nonparticipating Provider but will be responsible for higher out-of-pocket costs and penalties.

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.amerihealth.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℠ 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

A referral is required for ancillary services or for consultation with a specialist for Members residing in long-term care (LTC) or nursing homes. In such cases, Preapproval is not 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

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*, 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 AmeriHealth 65 NJ 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.

Product offerings

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 grid outlines the products offered through AmeriHealth New Jersey to assist you in quickly identifying our Members. For a complete list of alpha prefixes that correspond to these products, refer to our payer ID grids at *www.amerihealth.com/edi*.

Health Maintenance Organization HMO and Small Employer Health (SEH) HMO
51+ HMO Plus Coinsurance
Point-of-Service (POS), SEH POS, and POS Plus
Preferred Provider Organization (PPO)
SEH PPO
SEH Comprehensive Major Medical (CMM) Plans
Medicare Advantage HMO: AmeriHealth 65® NJ HMO and AmeriHealth 65® Preferred HMO
Medicare Advantage POS
CMM
Value Network
Exclusive Provider Organization (EPO)
Cooper Advantage and Tier 1 Advantage (EPO tiered products)

Preapproval guidelines

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.

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 should 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.
- NaviNet-enabled Providers 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 *Clinical Services* section of this manual for more information on Preapproval requirements. Preapproval requirements are also available on our website at *www.amerihealth.com/preapproval*.

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

The NaviNet® web portal

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.

All Participating Providers, facilities, Magellan-contracted Providers, and billing agencies that support Provider organizations are required to have NaviNet access and must complete the tasks listed below using NaviNet. Detailed guides and webinars are available for many transactions in the NaviNet Transaction Changes section of our System and Process Changes site at *www.amerihealth.com/pnc/changes*.

- **Eligibility and claims status**. All participating Providers and facilities are required to use NaviNet (or call the Provider Automated System) to verify Member eligibility and check claims status information. The claim detail provided includes specific information, such as check date and number, service codes, paid amount, and Member responsibility.
- **Authorizations.*** All participating Providers and facilities must use NaviNet in order to initiate authorizations, including ones for medical/surgical procedures, 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, and outpatient speech therapy.

  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. 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 1-888-YOUR-AH1 for assistance.
- **Claim adjustment.** Providers who call Customer Service to question a claim payment or to request a claim adjustment will be directed to submit the request via NaviNet using the Claim Investigation transaction. Please refer to the *Billing* section for further instruction.

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

If you are a current NaviNet user and need technical assistance, contact NaviNet at 1-888-482-8057 or our eBusiness Provider Hotline at 609-662-2565. If you are not NaviNet-enabled, go to *www.navinet.net* and select *Sign Up* from the top right.

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*.

Capitation rosters

PCPs and specialty capitated Providers can view, print, and download electronic copies of their capitation rosters through NaviNet. For detailed instructions on how to do so, refer to the *PCP and Specialist CAP Rosters Guide*, which is available in the NaviNet Transaction Changes section of our System and Process Changes site at *www.amerihealth.com/pnc/changes*.

iEXCHANGE®

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.amerihealth-tpa.com/providers* or contact the iEXCHANGE help desk at AmeriHealth Administrators by calling 1-888-444-4617.

Provider Automated System

Providers can use the Provider Automated System, our speech-enabled, automated phone service, to retrieve Member eligibility information for HMO, POS, PPO, and EPO Members and receive authorization status updates. You can also cancel an existing authorization. The Provider Automated System is accessible 24/7 at 1-888-YOUR-AH1.

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.amerihealth.com/providerautomatedsystem*.

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

Change of network status

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 of such changes. Detailed instructions are included in the next section, *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.

**This information does not apply to Providers contracted with Magellan. Magellan-contracted Providers should contact their Magellan Network Coordinator at 1-800-866-4108 for updates to their practice information.*

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*. 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 the *Resignation/termination from the AmeriHealth network* 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.

**This information does not apply to Providers contracted with Magellan. Magellan-contracted Providers should contact their Magellan Network Coordinator at 1-800-866-4108 for updates to their practice information*

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.amerihealthexpress.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 New Jersey
259 Prospect Plains Road, Building M
Cranbury, NJ 08512

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 New Jersey
259 Prospect Plains Road, Building M
Cranbury, NJ 08512

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 *Clinical Services* section of this manual.

**This information does not apply to Providers contracted with Magellan. Magellan-contracted Providers should contact their Magellan Network Coordinator at 1-800-866-4108 regarding their resignation from the network.*

Compliance training for Medicare programs

As a provider of health care services for AmeriHealth Medicare Advantage HMO, you and your staff are expected to comply with CMS requirements by completing Medicare compliance training on an annual basis. You must complete the training provided by AmeriHealth, or a similar Medicare compliance training that meets CMS requirements, within 90 days of hire and then annually thereafter. We have posted Medicare compliance training materials for your convenience at *www.amerihealth.com/providers/interactive_tools/compliance.html*.

We suggest that you and your staff maintain records of completion.

Hospital comparison tool

Through an agreement with WebMD®, 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*. Providers can access the Hospital Advisor through NaviNet by selecting *Reference Tools* from the Plan Transactions menu and then selecting *Provider Directory*.