



Welcome To Ambetter from Buckeye Health Plan

Your Partner In Better Healthcare
2025 Provider Orientation



PROVIDER ORIENTATION

2025

AGENDA

OVERVIEW

- ~ Who We Are
- ~ Affordable Care Act
- ~ The Health Insurance Marketplace
- ~ Our Networks

WHAT YOU NEED TO KNOW

- ~ Key Contact Information
- ~ Provider Manual
- ~ Provider Engagement
- ~ Public Website and Secure Portal
- ~ Verification of Eligibility, Benefits and Cost Shares
- ~ Referrals
- ~ Prior Authorization
- ~ Claims, Billing and Payments
- ~ Complaints, Grievances and Appeals
- ~ Specialty Companies and Vendors

QUESTIONS & ANSWERS





2025 Provider Orientation

OVERVIEW

WE ARE AMBETTER

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

#1 carrier

on the health insurance marketplace*

4.4M+

members insured

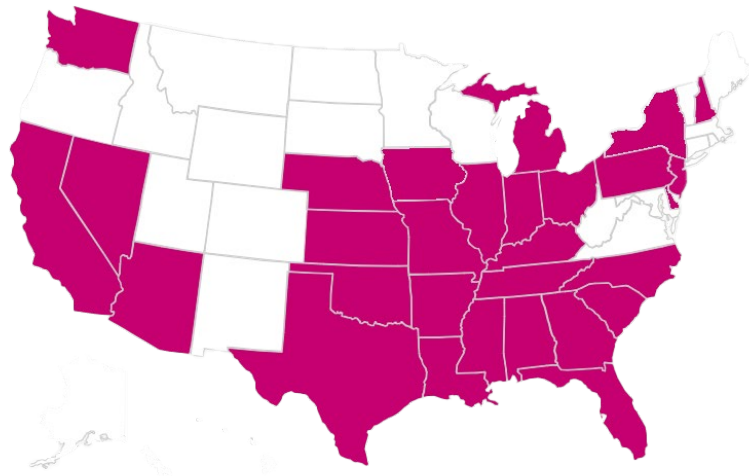
**Statistical claims and the #1 Marketplace Insurance statement are in reference to national on-exchange marketplace membership and based on national Ambetter data in conjunction with findings from 2023 Rate Review data from CMS, 2023 State-Level Public Use File from CMS, state insurance regulatory filings,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

2014

Year that Ambetter began

28

states



LOCAL APPROACH TO CARE

Ambetter delivers high quality, locally-based healthcare services to its members, with our providers benefiting from enhanced collaboration and strategic care coordination programs.

Confidential and Proprietary Information

We

~ Target a focused demographic

~ Lower income, underinsured and uninsured



PARTNERSHIP

- The **Ambetter plan design philosophy** is to provide affordable care to individuals or families that need to purchase healthcare coverage on their own.
- **Our products** focus on various cost shares — many with low or no copay amounts — to meet the budget and utilization needs of these consumers. This gives our members the peace of mind that they have full comprehensive medical coverage.
- Additionally, the **emphasis on reducing barriers and improving access to care** mitigates the risk of individuals showing up without insurance (uncompensated care). Ambetter's generous cost-sharing initiatives lower patient financial responsibility while also reducing the amount that providers need to collect at time of service.
- Most importantly, Ambetter plans encourage members to establish relationships with their primary care providers to **achieve favorable health outcomes**.

We are proud to be your partner.

AFFORDABLE CARE ACT

AFFORDABLE CARE ACT (ACA): Key Objectives

- Increase access to quality health insurance
- Improve affordability

ADDITIONAL PARAMETERS:

- Dependent coverage to age 26*
- No lifetime maximum benefits
- Preventative care covered at 100%
- Insurer minimum loss ratio (80%* for individual coverage)

**May be greater based on state requirements*



AFFORDABLE CARE ACT

REFORM OF THE COMMERCIAL INSURANCE MARKET

- No more underwriting – guaranteed issue
- There is no longer a federal tax penalty associated with not having minimum essential coverage*
- Minimum standards for coverage: essential health benefits and cost sharing limits
- The ACA created premium tax credits (also known as subsidies) and cost-sharing reductions (CSR) to help reduce costs for eligible consumers who buy a plan through the Marketplace
- Subsidies may be available to eligible individuals/families who have a household income between 100 and 400 percent of the Federal Poverty Level (FPL), based on the taxpayer's family size
 - ~ Currently, the subsidy cap has been eliminated through Plan Year 2025, but that may be extended
- CSRs are available to eligible individuals/families who have a household income between 100 and 250 percent of the FPL, based on the taxpayer's family size

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

HEALTH INSURANCE MARKETPLACE

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

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

Potential members can:

- Register for the Exchange
- Determine eligibility for all health insurance programs (including Medicaid)
- Shop for plans
- Enroll in a plan
- Exchanges may be state-based, federally facilitated, or a federal-state hybrid — **Ohio is a federally facilitated Marketplace**

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



HEALTH INSURANCE MARKETPLACE

FINANCIAL COMES IN THE FORM OF:

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

ALL BENEFIT PLANS HAVE COST SHARES IN THE FORM OF COPAYS, COINSURANCE AND DEDUCTIBLES

- Some members qualify for assistance with their cost shares based on income level

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





2025 Provider Orientation

OUR NETWORKS

OUR NETWORKS

- Ambetter offers a robust suite of innovative networks that give members more coverage options to fit their needs and budget.
- By offering increased product options, Ambetter also benefits providers by giving them exclusive access to new patient populations.
- Each Ambetter network is designed to offer members a unique type of coverage option specific to their state. This means that member plans and benefits can vary, and there may be referral or prior authorization requirements for certain types of care to be covered.
- As a provider, it is important you confirm which network and plan a member is in before extending care. This information is located on the member's ID card and can also be confirmed when verifying the member's eligibility.

Networks Build To Offer More

OUR NETWORKS

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

SOLUTIONS*: Ambetter's dedicated 'off-exchange only' product designed to meet the needs of individuals purchasing individual health insurance through a defined contribution / HRA (Health Reimbursement Arrangement), such as ICHRA** (individual coverage Health Reimbursement Arrangement) or QSEHRA** (Qualified Small Employer Health Reimbursement Arrangement). ***ICHRA and QSEHRA are forms of HRAs that allow organizations to reimburse their employees, tax free, for their individual health insurance premiums.*

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

**Network availability varies by state.*

Our Innovative Networks

HOW TO IDENTIFY A MEMBER'S NETWORK

All members receive an Ambetter member identification card. The ID card includes new information that includes:

- The **Ambetter Plan** the member has selected
- The **Provider Network** the member belongs to
- **Referral requirements** based on the member's plan selection.

Note: Presentation of a member ID card is not a guarantee of eligibility. Providers must verify eligibility on the same day services are rendered.

The diagram shows the front of an Ambetter Health member ID card. It is divided into two main sections: 'PREMIER' on the left and 'SOLUTIONS' on the right. Both sections have the 'ambetter HEALTH' logo at the top and 'REFERRAL NOT REQUIRED' on the right. The 'PREMIER' section contains fields for MEMBER, Subscriber, Policy, Plan, Network, RXBIN, and Effective Date. The 'SOLUTIONS' section contains fields for MEMBER, Subscriber, Policy, Plan, Member ID, Network Name, Network Coverage Only, RXBIN, RXPCN, RXGROUP, and Effective Date. Below these sections are 'COPAYS' and 'COST SHARES' sections. A pink arrow points from the text 'The Ambetter Plan the member has selected' to the 'PREMIER' section. Another pink arrow points from 'The Provider Network the member belongs to' to the 'SOLUTIONS' section.

| PREMIER | SOLUTIONS |
|--|--|
| MEMBER: [Jane Doe] Subscriber: [John Doe] Policy: [XXXXXX] Plan: [Plan name] Network: [Network Name] RXBIN: [003858] Effective Date: [00/00/00] | MEMBER: [Jane Doe] Subscriber: [John Doe] Policy: [XXXXXX] Member ID: [XXXXXXXXXXXX] Plan: [Plan name] [Network Name] Network Coverage Only RXBIN: [003858] RXPCN: [A4] RXGROUP: [2CUA] Effective Date: [00/00/00] |
| COPAYS PCP: [\$10 copay after ded.] Specialist: [\$25 copay after ded.] Urgent Care: [20% coin. after ded.] ER: [\$250 copay after ded.] | COST SHARES INN DED Ind/Fam: [\$7,965/\$18,000] OON DED Ind/Fam: [\$22,500/\$45,000] INN MOOP Ind/Fam: [\$9,200/\$25,000] OON MOOP Ind/Fam: [\$25,000/\$45,000] |

Back of Member ID Card

AmbetterHealth.com

| | |
|--|---|
| Member/Provider Services: 1-800-XXX-XXXX (TTY TTY) | Medical Claims Address: Ambetter Health Attn: CLAIMS PO Box 5010 Farmingington, MO 63640-5010 |
| 24/7 Nurse Line: 1-800-XXX-XXXX | |
| Numbers below for providers: Pharmacist Only: 1-800-XXX-XXXX EDI Payer ID: 680689 Centene Vision Services: 1-800-XXX-XXXX Centene Dental Services supported by United Concordia: 1-800-XXX-XXXX | |

AMB64-State-C-00040 State Copyright Disclaimer



2025 Provider Orientation

WHAT YOU NEED TO KNOW

KEY CONTACT INFORMATION

Ambetter from Buckeye Health Plan

PHONE

1-877-687-1189

TTY/TDD

1-877-941-9236

WEB

Ambetter.BuckeyeHealthPlan.com

PORTAL

[Ambetter Secure Portal](#) or [Availity Essentials](#)



AMBETTER PROVIDER MANUAL

THE PROVIDER MANUAL IS YOUR COMPREHENSIVE GUIDE TO DOING BUSINESS WITH AMBETTER FROM BUCKEYE HEALTH PLAN.

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

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

The Provider Manual can be found in the [Provider Resources](#) section of the Ambetter from Buckeye Health Plan [website](#).



PROVIDER SERVICES

The **Ambetter from Buckeye Health Plan**

Provider Services team includes trained staff available to respond quickly and efficiently to all provider inquiries, or requests, including:

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

By calling **Ambetter from Buckeye Health Plan** Provider Services at **1-877-687-1189**, providers are able to access real time assistance for all their service needs.



PROVIDER ENGAGEMENT

- As an **Ambetter from Buckeye Health Plan** provider, you will have a dedicated Provider Engagement Account Manager available to assist you.
- Our Provider Engagement Account Managers serve as the primary liaisons between our health plan and the provider network
- Your Provider Engagement Account Manager is here to help you operate your practice and address needs, such as:



- ✓ **Inquiries related to administrative policies, procedures, and operational issues**
- ✓ **Performance pattern monitoring**
- ✓ **Contract clarification**
- ✓ **Membership/provider roster questions**
- ✓ **Secure Portal registration and PaySpan**
- ✓ **Provider education**
- ✓ **HEDIS/care gap reviews**
- ✓ **Financial analysis**
- ✓ **EHR Utilization**
- ✓ **Demographic information updates**
- ✓ **Initiate credentialing of a new practitioner**



PROVIDER NETWORK OPERATIONS

- Providers should submit updates to demographic data to OHIOCONTRACTING@CENTENE.COM within 30 days of the data change becoming effective.
- Forms to add new practitioners can be found on our website and should be submitted along with all credentialing documentation to OHIOCONTRACTING@CENTENE.COM
- Enrollments are effective 30 days from the date all clean documents are received by Ambetter.



Please send the following items to OHIOCONTRACTING@CENTENE.COM:

- **Contract Clarification**
- **Demographic information updates**
- **Initiate credentialing of a new practitioner**
- **Inquiries related to the status of a new practitioner or Join Our Network request**





2025 Provider Orientation

PUBLIC WEBSITE AND SECURE PORTAL

Ambetter.BuckeyeHealthPlan.com



AMBETTER PUBLIC WEBSITE

WHAT'S ON THE PUBLIC WEBSITE?

- Provider Manual
- Quick Reference Guides
- Important Forms (Notification of Pregnancy, Prior Authorization Fax forms, etc.)
- The Pre-Auth Needed Tool
- The Pharmacy Preferred Drug Listing

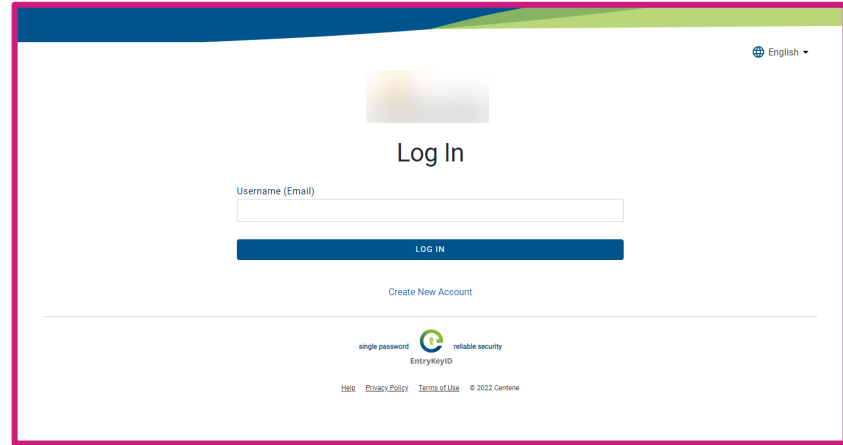
Ambetter Public Website

SECURE PROVIDER PORTAL

REGISTRATION IS FREE AND EASY!



Contact your Provider Engagement representative to get started!



The screenshot shows the login interface of the Secure Provider Portal. At the top right, there is a language selector set to 'English'. The main heading is 'Log In'. Below it is a text input field labeled 'Username (Email)'. Underneath the input field is a blue 'LOG IN' button. Below the button is a link that says 'Create New Account'. At the bottom, there is a logo for 'EntryKeyID' with the tagline 'single password reliable security'. Below the logo are links for 'Here', 'Privacy Policy', 'Terms of Use', and a copyright notice '© 2022 Centene'.

Secure Provider Portal

SECURE PROVIDER PORTAL

WHAT'S ON THE SECURE PROVIDER PORTAL?

- Member eligibility and patient listings
- Health records and care gap information
- Authorizations
- Claims submissions and status
- Corrected claims and adjustments
- Payment history
- Monthly PCP cost reports
- Provider analytics reports
- PCP Referrals for Value plans



SECURE PROVIDER PORTAL

INSIGHTFUL REPORTS

PCP reports available on **Ambetter from Buckeye Health Plan** Secure Provider Portal are generated monthly and can be exported into a PDF or Excel format.

PCP REPORTS INCLUDE:

- Patient List with HEDIS Care Gaps
- Emergency Room Utilization
- Rx Claims Report
- High-Cost Claims



AVAILITY ESSENTIALS

Ambetter from Buckeye Health Plan has chosen [Availity Essentials](#) as its new, secure provider portal. Starting January 20, 2025, providers can validate eligibility and benefits, submit claims, check claim status, submit authorizations, and access payer resources, via Availity Essentials.

Our current [Secure Provider Portal](#) is still available for other functions that providers use today.

For providers new to Availity Essentials, getting their Essentials account is the first step toward working with Buckeye on Availity.

- The provider organization's designated Availity administrator is the person responsible for registering their practice in Essentials, managing user accounts, and should have legal authority to sign agreements for their organization.
- Administrators can [Register and Get Started with Availity Essentials](#).
- Providers needing additional assistance with registration can call Availity Client Services at **1-800-AVAILITY (282-4548)**, Monday through Friday, 8 a.m. – 8 p.m. ET.
- For general questions, providers can reach out to their health plan Provider Engagement representative.





2025 Provider Orientation

VERIFICATION OF ELIGIBILITY, BENEFITS AND COST SHARES

MEMBER ID CARD

ambetter
HEALTH®

REFERRAL NOT REQUIRED

PREMIER
MEMBER: [Jane Doe]
Subscriber: [John Doe]
Policy: [XXXXXXXXXX] **Member ID:** [XXXXXXXXXXXXXX]
Plan: [Plan name]
[Network Name] Network Coverage Only
RXBIN: [003858] **RXPEN:** [A4] **RXGROUP:** [2CUA]
Effective Date: [00/00/00]

COPAYS
PCP: [\$10 copay after ded.]
Specialist: [\$25 coin. after ded.]
Urgent Care: [20% coin. after ded.]
ER: [\$250 copay after ded.]

COST SHARES
INN DED Ind/Fam: [\$7,965/\$18,000]
OON DED Ind/Fam: [\$22,500/\$45,000]
INN MOOP Ind/Fam: [\$9,200/\$25,000]
OON MOOP Ind/Fam: [\$25,000/\$45,000]

For detailed benefit information, please visit AmbetterHealth.com/copays

Plans can include:

- PREMIER
- SELECT
- VALUE
- SOLUTIONS

Certain plans may have a referral requirement. Please note:

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

Provider Services
Contact Information

AmbetterHealth.com

Member/Provider Services: 1-8XX-XXX-XXXX
(TTY 711)
24/7 Nurse Line: 1-8XX-XXX-XXXX

Medical Claims Address:
Ambetter Health
Attn: CLAIMS
PO Box 5010
Farmington, MO
63640-5010

Numbers below for providers:
Pharmacist Only: 1-8XX-XXX-XXXX
EDI Payor ID: 68069
[Centene Vision Services: 1-8XX-XXX-XXXX]
[Centene Dental Services supported by United Concordia: 1-8XX-XXX-XXXX]

AMB24-S...C-00040

State Copyright Disclaimer

Pharmacy Benefit
Information

Navigating the Member ID Card

ELIGIBILITY, BENEFITS AND COST SHARE

PROVIDER MUST VERIFY MEMBER ELIGIBILITY

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

PANEL STATUS

- PCPs should confirm that a member is assigned to their patient panel. This can be done via our Secure Provider Portal.
- PCPs can still administer service if the member is not on their panel and they wish to have the member assigned to them for future care

Verification of Eligibility, Benefits and Cost Share

ELIGIBILITY, BENEFITS AND COST SHARE

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

- ✓ Ambetter Secure Portal or Availity Essentials

If you are already a registered user of the Ambetter from Buckeye Health Plan secure portal, you do NOT need a separate registration!


- ✓ **24/7 Interactive Voice Response System**


Enter the Member ID Number and the month of service to check eligibility


Contact Provider Services: 1-877-687-1189


Verification of Eligibility, Benefits and Cost Share


VERIFICATION OF ELIGIBILITY ON THE PORTAL





 Manage Practice


 Eligibility


 Patients

 PCP Referrals

 Authorizations

 Claims

 Messaging



Viewing Eligibility For : TIN Plan Type

We are currently experiencing issues displaying the 'PCP Referrals Made' list. Please search for the Member in order to see their referrals or call provider services for more information.

Required Action! Providers seeing members enrolled in Ambetter VALUE or VIRTUAL ACCESS products will need to ensure that PCP Referrals are created prior to providing care. Providers who are outside of the members Primary Provider Group will require a referral for services to be covered. Claims will deny if the referral is not in place.

Date of Service (mm/dd/yyyy) Member ID or Last Name DOB

VERIFICATION OF COST SHARES ON THE PORTAL

Viewing Patients For: TIN Plan Type

[Back to Patient List](#) **Smith** [Print Cost Sharing](#)

Cost Sharing

Overview

Cost Sharing

Benefits Usage

Assessments

Health Record

ADT

Care Plan

Authorizations

Pharmacy PDL

Care Management Referrals

PCP Referrals

Coordination of Benefits

Claims

Benefit Documents

Document Resource Center

Notes

Deductible

The fixed amount of money that you are responsible for paying before your insurance starts to pay. Whether or not you meet your deductible depends on how much healthcare you need throughout the year.

| Type | Total Amount | Meet Year To Date* | Remaining |
|--------|--------------|--------------------|-------------|
| Family | \$15,000.00 | \$0.00 | \$15,000.00 |
| Person | \$7,500.00 | \$0.00 | \$7,500.00 |

Co-insurance and Copayment information are contained in Schedule of Benefits.
[Schedule of Benefits](#)

Out-Of-Pocket Limit

The total amount you will spend for healthcare, after which the insurance company pays for all your medical care until the year ends.

| Type | Total Amount | Meet Year To Date* | Remaining |
|--------|--------------|--------------------|-------------|
| Family | \$18,000.00 | \$163.81 | \$17,836.19 |
| Person | \$9,000.00 | \$163.81 | \$8,836.19 |

* These values will start at zero on January 1st. The following counts towards your deductible: medical costs, physician services, hospital services, EHB covered services, including pediatric, vision and mental health services, drug benefits.

VERIFICATION OF BENEFITS ON THE PORTAL

The screenshot displays the Ambetter Health portal interface. At the top, a navigation bar includes the Ambetter logo and icons for Manage Practice, Eligibility, Patients, PCP Referrals, Authorizations, Claims, and Messaging. Below this, a search bar allows users to view patients by TIN and Plan Type (currently set to Ambetter), with a green 'GO' button and an orange 'Find Patient' button. The main content area shows a patient profile for 'Smith'. On the left is a sidebar menu with options: Overview, Cost Sharing, Benefits Usage, Assessments, Health Record, ADT, Care Plan, Authorizations, Pharmacy PDL, Care Management Referrals, PCP Referrals, Coordination of Benefits, Claims, Benefit Documents (highlighted), Document Resource Center, and Notes. The main content area for the patient profile includes links for 'Schedule of Benefits' and 'Summary of Benefits and coverage', followed by the text: 'For additional Benefit Coverage information go to AmbetterHealth.com or call provider services'.



2025 Provider Orientation

REFERRALS

AMBETTER PCP REFERRAL REQUIREMENTS

- Some Ambetter plans have referral requirements.
- For services to be covered under these plans, they must be provided by or referred by a PCP.
- If a referral is not initiated, services performed outside of the member's assigned provider or primary care group will be denied.
- Prior authorization requirements will also apply, as necessary.
- Referral requirements are reiterated throughout the Ambetter Guide and member plan materials to ensure members understand the rules associated with their plan.
- Referring providers can use our Secure Provider Portal to initiate referrals on behalf of members.

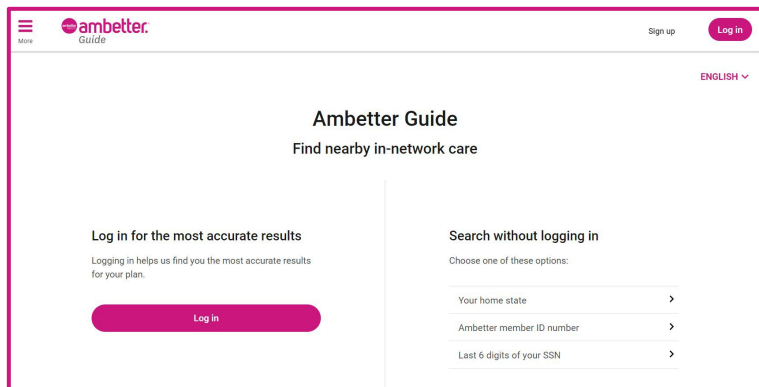


AMBETTER REFERRAL REQUIREMENTS

| Ambetter Plan | Referral Requirement? |
|---------------|-----------------------|
| PREMIER | No |
| SOLUTIONS | No |



MAKING AN AMBETTER VALUE REFERRAL FOR A SPECIALIST



The screenshot shows the Ambetter Guide website interface. At the top, there is a navigation bar with the Ambetter logo, a 'More' link, a 'Sign up' link, and a 'Log in' button. Below the navigation bar, the main heading is 'Ambetter Guide' with the subtext 'Find nearby in-network care'. There are two main sections: 'Log in for the most accurate results' on the left, which includes a 'Log in' button, and 'Search without logging in' on the right, which includes a 'Choose one of these options:' section with three dropdown menus: 'Your home state', 'Ambetter member ID number', and 'Last 6 digits of your SSN'. A language selector 'ENGLISH' is visible in the top right corner.

1. Go to [Ambetter Guide](#)
2. Click the option for “Your Home State”
3. On the next screen, set the state field to the member’s home state. If a year field is present (e.g., during Open Enrollment), select the plan year. Click the button to advance.
4. On the next screen, select the Ambetter Value option. Click the button to advance.
 - a. If you do not see an Ambetter Value option, go back to the prior screen and make sure you have the state (and year, if present) set correctly.
5. The next screen includes fields for (1) a search term and (2) the search location.
 - a. The search term field has no default. Enter the member-facing name of the appropriate medical group (e.g., Community Medical Group in FL, Ambetter Value Medical Group in TX, USHS in NV).
 - b. The search location field defaults to the location set by your internet service provider. Set the search location to a ZIP or city appropriate for the member.
6. Submit the search.
7. On the results page, use the “Specialty” filter to narrow the results to the specific specialty you need.
8. Click through on any result to see full details about the provider, including their NPI.



MAKING A REFERRAL: SECURE PROVIDER PORTAL

ONCE YOU IDENTIFY THE SPECIALIST'S NAME AND NPI,
SUBMIT THE INFORMATION ON THIS SCREEN.

1. Click on **“PCP Referrals”** tab at the top of the screen.
2. Click the **“Create Referral”** button.
3. Complete the fields on the PCP Referral form.

Tip: Please utilize the Helpful Information section for assistance / guidance.

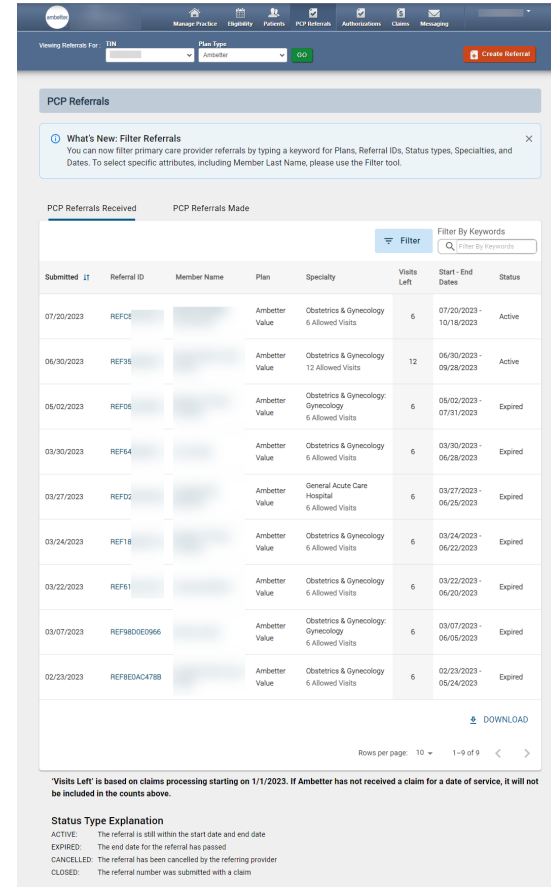
The screenshot shows the 'Create Referral' form in the Ambetter Health Secure Provider Portal. The form is titled 'Create Referral' and includes the following sections:

- Patient Information:** Patient Name (Smith), Birth Date, Member ID, Plan (Ambetter Value), and Primary Provider Group.
- Referral Date:** Start Date (08/16/2023) and End Date (11/16/2023). A note states: 'Select a Start Date to determine the type of referral required. All Referrals require except Notes and Attachments'.
- Helpful Information:** A link to the Ambetter Guide and a list of specialities for which no referral is necessary: Anesthesiology, Behavioral Health/Substance Use Disorder, Labs, Obstetrics and Gynecology, Radiology (X-ray, Imaging), and Urgent or Emergent Services.
- Referring Provider:** A search bar for the Referring Provider's name, TIN, and Phone.
- Referral Type & Visits:** A dropdown for 'Select Referral Type' (Consult & Treatment) and a field for 'Visits' (1).
- Referred To Provider:** A search bar for the Referred To Provider's name, TIN, and Phone.
- Referred To Provider's Specialty:** A dropdown for 'Select Specialty'.
- Notes (optional):** A text area for notes.
- ATTACHMENTS:** A section for uploading files, with options to 'Drag & Drop Files', 'Select Files From Your Computer', or 'Upload PDF or Word Doc'. A note specifies '5 KB minimum and 25 MB maximum per file'.

At the bottom of the form, there is a note: 'Note: Payment of claims is dependent on eligibility, covered benefits, provider contracts, correct coding and billing practices. For specific details, please refer to the provider manual.' and buttons for 'CANCEL' and 'NEXT'.

RECEIVING A REFERRAL

1. Once you receive a referral for care from the member's PCP, the member will schedule an appointment with you.
2. Log in to the Secure Provider Portal.
3. Navigate to 'Referrals' tab at the top.
4. Click on 'Referrals Received' to see the referral tracking table.
5. When you are ready to submit a claim for the referred service, reference this table for the referral ID/REF#.
6. Submit claims form with the REF#.
7. Claim form **MUST** include a REF# if a referral is required for the service. **If no REF# is submitted, the claim will be denied.**



The screenshot shows the Ambetter Secure Provider Portal interface. At the top, there's a navigation bar with tabs for 'Manage Practice', 'Specialty', 'Referrals', 'PCP Referrals', 'Authorizations', 'Claims', and 'Messaging'. The 'Referrals' tab is selected. Below the navigation bar, there's a section for 'PCP Referrals' with a 'Filter Referrals' button. A message box states: 'What's New: Filter Referrals. You can now filter primary care provider referrals by typing a keyword for Plans, Referral IDs, Status types, Specialties, and Dates. To select specific attributes, including Member Last Name, please use the Filter tool.' Below this, there are two tabs: 'PCP Referrals Received' (selected) and 'PCP Referrals Made'. The 'PCP Referrals Received' tab displays a table with the following columns: Submitted, Referral ID, Member Name, Plan, Specialty, Visits Left, Start-End Dates, and Status. The table contains 10 rows of referral data. At the bottom of the table, there is a 'DOWNLOAD' button and a pagination bar showing 'Rows per page: 10' and '1-9 of 9'.

| Submitted | Referral ID | Member Name | Plan | Specialty | Visits Left | Start-End Dates | Status |
|------------|--------------|-------------|----------------|--|-------------|-------------------------|---------|
| 07/20/2023 | REF01 | | Ambetter Value | Obstetrics & Gynecology 6 Allowed Visits | 6 | 07/20/2023 - 10/18/2023 | Active |
| 06/30/2023 | REF35 | | Ambetter Value | Obstetrics & Gynecology 12 Allowed Visits | 12 | 06/30/2023 - 09/28/2023 | Active |
| 06/03/2023 | REF06 | | Ambetter Value | Obstetrics & Gynecology: Gynecology 6 Allowed Visits | 6 | 06/02/2023 - 07/31/2023 | Expired |
| 03/30/2023 | REF64 | | Ambetter Value | Obstetrics & Gynecology 6 Allowed Visits | 6 | 03/30/2023 - 06/28/2023 | Expired |
| 03/27/2023 | REF02 | | Ambetter Value | General Acute Care Hospital 6 Allowed Visits | 6 | 03/27/2023 - 06/26/2023 | Expired |
| 03/24/2023 | REF18 | | Ambetter Value | Obstetrics & Gynecology 6 Allowed Visits | 6 | 03/24/2023 - 06/22/2023 | Expired |
| 03/22/2023 | REF61 | | Ambetter Value | Obstetrics & Gynecology 6 Allowed Visits | 6 | 03/22/2023 - 06/20/2023 | Expired |
| 03/07/2023 | REF9800E0966 | | Ambetter Value | Obstetrics & Gynecology: Gynecology 6 Allowed Visits | 6 | 03/07/2023 - 06/05/2023 | Expired |
| 02/23/2023 | REF8EDAC4789 | | Ambetter Value | Obstetrics & Gynecology 6 Allowed Visits | 6 | 02/23/2023 - 05/24/2023 | Expired |

DOWNLOAD

Rows per page: 10 1-9 of 9

Visits Left is based on claims processing starting on 1/1/2023. If Ambetter has not received a claim for a date of service, it will not be included in the counts above.

Status Type Explanation

ACTIVE: The referral is still within the start date and end date

EXPIRED: The end date for the referral has passed

CANCELLED: The referral has been cancelled by the referring provider

CLOSED: The referral number was submitted with a claim



2025 Provider Orientation

PRIOR AUTHORIZATION

HOW TO SECURE A PRIOR AUTHORIZATION

NEED PRIOR AUTHORIZATION?

It can be requested in the following ways:

- ✓ Secure Web Portal or Availity (These are the preferred and fastest methods.)
- ✓ Phone
1-877-687-1189
- ✓ Fax
1-888-241-0664

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



IS PRIOR AUTHORIZATION NEEDED?

- Use the [Pre-Auth Needed Tool](#) to quickly determine if a service or procedure requires prior authorization.
- Available on the provider section of the Ambetter from Buckeye Health Plan [website](#).

Are Services being performed in the Emergency Department?
YES ☐ NO ☒

| Types of Services | YES | NO |
|---|-----------------------|----------------------------------|
| Is the member being admitted to an inpatient facility? | <input type="radio"/> | <input checked="" type="radio"/> |
| Is the member having observation services? | <input type="radio"/> | <input checked="" type="radio"/> |
| Are anesthesia services being rendered for pain management or dental surgeries? | <input type="radio"/> | <input checked="" type="radio"/> |
| Is the member receiving hospice services? | <input type="radio"/> | <input checked="" type="radio"/> |
| Are services, other than DME, orthotics, prosthetics, and supplies, being rendered in the home? | <input type="radio"/> | <input checked="" type="radio"/> |

Enter the code of the service you would like to check:

69436

N
No **69436 - TYMPANOSTOMY GEN ANES**
No authorization required.



REQUIREMENTS

PROCEDURES / SERVICES THAT NEED PRIOR AUTHORIZATION INCLUDE*:

- Potentially cosmetic
- Experimental or investigational
- High-tech imaging (e.g. CT, MRI, PET)
- Infertility
- Pain Management

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

Prior Authorization Requirements

REQUIREMENTS

INPATIENT AUTHORIZATION IS NEEDED FOR THE FOLLOWING*:

- All elective/scheduled admission notifications requested at least 5 days prior to the scheduled date of admit including:
 - ~ All services performed in out-of-network facilities
 - ~ Behavioral Health Services:
 - *Partial Hospitalization Program (PHP) and/or Intensive Outpatient Program (IOP)
 - *Residential Treatment (Mental Health/Substance Use)
 - ~ Newborn deliveries must include birth outcomes
 - ~ Hospice care
 - ~ Rehabilitation facilities
 - ~ Transplants, including evaluation
- Observation stays more than 23 hours require Inpatient Authorization
- Urgent/Emergent Admissions within 1 day following the date of admission

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

Prior Authorization Requirements

REQUIREMENTS

ANCILLARY SERVICES THAT NEED PRIOR AUTHORIZATION INCLUDE*:

- Air ambulance transport (non-emergent fixed-wing airplane)
- Durable medical equipment (DME)
- Home health care services, including:
 - ~ Home infusion
 - ~ Skilled nursing
 - ~ Therapy
 - ~ Private duty nursing
 - ~ Adult medical day care
 - ~ Hospice
 - ~ Furnished medical supplies and DME

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

Prior Authorization Requirements

TIMEFRAMES

| Service Type | Timeframe |
|--|---|
| Scheduled admissions | Prior Authorization required five (5) business days prior to the scheduled admission date |
| Elective outpatient services | Prior Authorization required five (5) business days prior to the elective outpatient admission date |
| Emergent inpatient admissions | Notification within one (1) business day |
| Observation –48 hours or less | Notification within one (1) business day for non-participating providers |
| Observation – greater than 48 hours | Requires inpatient prior authorization within one (1) business day |
| Emergency room and post stabilization, urgent care and crisis intervention | Notification within one (1) business day |
| Maternity admissions | Notification within one (1) business day |
| Newborn admissions | Notification within one (1) business day |
| Neonatal Intensive Care Unit (NICU) admissions | Notification within one (1) business day |
| Outpatient Dialysis | Notification within one (1) business day |

Prior Authorization Timeframes

TIMEFRAMES

| Type | Timeframe |
|------------------------|---|
| Prospective/Urgent | Three (3) calendar days |
| Prospective/Non-Urgent | Fourteen (14) calendar days |
| Emergency services | 60 minutes (1 hour) |
| Concurrent/Urgent | Twenty-four (24) hours (1 calendar day) |
| Retrospective | Thirty (30) calendar days |

Utilization Determination Timeframes

CORRECT CODING

PRIOR AUTHORIZATION WILL BE GRANTED AT THE CPT CODE LEVEL

- If a claim is submitted that contains CPT codes that were not authorized, the services will be denied.
- If additional procedures are performed during the procedure, the provider **must** contact the health plan to update the authorization in order to avoid a claim denial.
- It is recommended that this be done within 72 hours of the procedure. However, it **must** be done prior to claim submission or the claim will deny.
- Ambetter will update authorizations but will **not** retro-authorize services.
 - ~ The claim will deny for lack of authorization.
 - ~ If there are extenuating circumstances that led to the lack of authorization, the claim may be appealed.

CORRECT CODING FOR PRIOR AUTHORIZATION



2025 Provider Orientation

CLAIMS, BILLING AND PAYMENTS

CLAIMS

WHAT IS A CLEAN CLAIM?

- A claim that is received for adjudication in a nationally accepted format in compliance with standard coding guidelines and does not have any defect, impropriety, lack of any required documentation, or particular circumstance requiring special treatment that prevents timely payment.

ARE THERE ANY EXCEPTIONS?

- A claim for which fraud is suspected
- A claim for which a third-party resource should be responsible



HOW TO SUBMIT A CLAIM

CLAIMS MAY BE SUBMITTED IN THREE WAYS:

1. Secure Provider Portal or Availity
2. **Electronic Clearinghouse**
 - ~ Payor ID 68069
 - ~ Clearinghouses currently utilized by Ambetter will continue to be utilized
 - ~ For a listing of our clearinghouses, visit our [website](#).
3. **Mail**
 - Ambetter
 - P.O. Box 5010
 - Farmington, MO 64640-5010



CLAIM RECONSIDERATIONS AND DISPUTES

CLAIM RECONSIDERATIONS

- For reconsideration requests, providers can use the **Reconsider Claim** button on the Claim Details screen within the [Secure Provider Portal](#)
- A written request from a provider about a disagreement in the manner in which a claim was processed. No specific form is required.
- Must be submitted within 180 days of the Explanation of Payment.
- Mail claim reconsiderations to:
Ambetter from Buckeye
Attn: Claims
P.O. Box 5010
Farmington, MO 63640-5010

CLAIM DISPUTES

- Must be submitted within 180 days of the Explanation of Payment
- A Claim Dispute form can be found on our website under [Provider Resources](#).

Mail completed Claim Dispute form to:

Ambetter from Buckeye
Attn: Claims Disputes/Appeals
P.O. Box 5010
Farmington, MO 63640- 5010



CLAIM SUBMISSION SUSPENDED STATUS

WHAT IF A MEMBER IS IN SUSPENDED STATUS?

- After the first 30 days, the member is placed in a suspended status. The Explanation of Payment will indicate LZ Pend: Non-Payment of Premium
- A provision of the ACA allows members who are receiving Advanced Premium Tax Credits (APTCs) a three-month grace period for paying claims
- While the member is in a suspended status, claims will be pended
- When the premium is paid by the member, the claims will be released and adjudicated
- If the member does not pay the premium, the claims will be released, and the provider may bill the member directly for services



CLAIM SUBMISSION SUSPENDED STATUS

EXAMPLE TIMELINE OF A MEMBER IN SUSPENDED STATUS

- **January 1st**
Member pays premium
- **February 1st**
Premium due – member does not pay
- **March 1st**
Member placed in suspended status
- **April 1st**
Member remains in suspended status
- **May 1st**
If premium remains unpaid, member is terminated.
Provider may bill member directly for services rendered.

Claims for
members in a
suspended
status are not
considered
“clean claims.”



HELPFUL INFORMATION ABOUT CLAIMS

MAKE SURE TO INCLUDE THE RENDERING TAXONOMY CODE!

- Claims **must** be submitted with the rendering provider's taxonomy code
- The claim will deny if the taxonomy code is not present
- This is necessary in order to accurately adjudicate the claim

REMINDER: DO NOT FORGET THE CLIA NUMBER!

- If the claim contains CLIA-certified or CLIA-waived services, the CLIA number **must** be entered in **Box 23** of a paper claim form or in the appropriate loop for EDI claims
- Claims will be rejected if the CLIA number is not on the claim



BILLING THE MEMBER

COPAYS, 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](#).
- 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



CLAIMS PAYMENTS

PAYSPAN®: A FASTER, EASIER WAY TO GET PAID

- Ambetter offers PaySpan® Health, a free solution that helps providers transition into electronic payments and automatic reconciliation
- If you currently utilize PaySpan®, you will need to register specifically for Ambetter
- **Set up your PaySpan® account:**
 - ~ Visit www.payspanhealth.com and click Register
 - ~ You may need your National Provider Identifier (NPI) and Provider Tax ID Number (TIN) or Employer Identification Number (EIN)

ELECTRONIC FUNDS TRANSFER



2025 Provider Orientation

COMPLAINTS, GRIEVANCES AND APPEALS

COMPLAINTS, GRIEVANCES AND APPEALS

CLAIMS

- A provider must exhaust the claims reconsideration and claims dispute process before filing a complaint/grievance or appeal

COMPLAINT/GRIEVANCE

- Must be filed within 180 days of the Notice of Action
- Upon receipt of complete information to evaluate the request, Ambetter will provide a written response within 30 days



COMPLAINTS, GRIEVANCES AND APPEALS

APPEALS

- For Claims, the Claims Reconsideration, Claims Dispute and Complaint/Grievances process must be exhausted prior to filing an appeal

MEDICAL NECESSITY

- Must be filed within 30 days from the Notice of Action.
- Ambetter shall acknowledge receipt within 10 days of receiving the appeal.
- Ambetter shall resolve each appeal and provide written notice as expeditiously as the member's health condition requires but not to exceed 30 days.
- Expedited appeals may be filed if the time expended in a standard appeal could seriously jeopardize the member's life or health. The timeframe for a decision for an expedited appeal will not exceed 72 hours.



COMPLAINTS, GRIEVANCES AND APPEALS

MEMBER REPRESENTATIVES

- Members may designate a provider to act as their representative for filing appeals related to medical necessity
 - ~ Ambetter requires that this designation by the member be made in writing and provided to Ambetter
- No punitive action will be taken against a provider by Ambetter for acting as a member's representative

NEED MORE INFORMATION?

- Full details of the claim reconsideration, claim dispute, complaints/grievances and appeals processes can be found in our Provider Manual, located on our [website](#) under [Provider Resources](#).





2025 Provider Orientation

SPECIALTY SERVICES & VENDORS

SPECIALTY COMPANIES AND VENDORS

| Service | Specialty Company/Vendor | Contact Information |
|----------------------------|-----------------------------|--|
| High Tech Imaging Services | National Imaging Associates | 1-877-687-1189 www.radmd.com |
| Vision Services | Envolve Vision© | 1-866-864-9153 www.envolvevision.com |
| Dental Services | Envolve Dental© | 1-844-621-4581 www.envolvedental.com |
| Pharmacy Services | Pharmacy Services | 1-866-399-0928 (Phone) 1-866-399-0929 (Fax) |

OUR SPECIALTY COMPANIES AND VENDORS



2025 Provider Orientation

Questions & Answers

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