Tailored Plan Managed Care Claims and Prior Authorizations Submission: Frequently Asked Questions – Part 2

Question	Alliance Response	Eastpointe Response	Partners Response	Sandhills Response	Trillium Response	Vaya Response
What are the options (electronic, facsimile, paper) for filing a claim with the Tailored Plan?	**Electronic Claims Submission:** Alliance Health will receive claims via Electronic Data Interchange EDI submissions (837) and via the (ACS) Provider Portal. Claims may be keyed directly into the web-based ACS Provider Portal. Within the ACS portal, claims can be submitted using a CMS 1500 or UB04. ACS Portal Link: https://acs.alliancehealthplan.org/portallogin. Electronic submissions can be submitted by EDI for both In-network and Out-of-network providers using Alliance Health Payer ID 23071. Prior to sending EDI files, providers will need to submit a Trading Partner Agreement and Connectivity Form: https://www.alliancehealthplan.org/document-library/60057. **Paper Claims Submission:** Paper claim submission is available with prior approval (using Paper Claims Submission Request form) while providers gain access to the ACS Provider Portal or set up their EDI	Eastpointe accepts electronic, paper, and direct entry claims. **Electronic Claims Submission:** Electronic claims can be submitted by EDI. Eastpointe's EDI Payer ID 08044. Providers that need assistance in enrollment can contact our Provider Operations Provider Service Line at 888-977-2160. Please visit the Eastpointe Provider page for additional on submitting claims. Claims can be submitted through the iTransact Portal, claims can be faxed to 910-272-1299 or submitted via secure email to claimsfunding@eastpointe.net **Paper Claims Submission:** Claims Department 450 Country Club Road Lumberton, NC 28360	Providers may submit claims electronically or by mail. **Electronic Claims Submission:** Providers will access Provider Connect for claim submission at: https://id.partnersbhm.org/ Alpha+ - Medicaid Tailored Plan Behavioral Health and State Benefit Availity - Medicaid Tailored Plan Physical Health **Paper Claims Submission:** Electronic submission is preferred, an OON provider may also submit a paper claim by mail. Medicaid Tailored Plan Physical Health should be mailed to: P.O. Box 8002 Farmington, MO 63640-8002 Medicaid Tailored Plan Behavioral Health and State Benefit should be mailed to: 901 S New Hope Road Gastonia, NC 28054 Payer ID: Partners payer ID is 13141.	Providers may submit all claims electronically, through Portal or paper. All claims will come through Change Healthcare. **Electronic Claims Submission:** Providers can key claims in Change Healthcare provider portal or submit 837P or 837I. Providers will have different Payer options based off the services they provide Sandhills EDI Tailored Plan Payer ID's: Physical Health only: Payer Id 14816 Behavioral Health only: Payer Id SHC30 Both Physical and Behavioral: Payer ID SHC00 **Paper Claims Submission:** Sandhills Center Tailored Plan PO Box 981746 El Paso, Tx 79998-1746	Providers may submit claims by 1) Secure Provider Portal for Behavioral Health Claims or Secure Provider Portal for Physical Health Claims, 2) secure FTP, 3) utilizing a clearinghouse, 4) paper. For questions or more information, please contact Trillium Health Resources' Provider Support Services Line at 855-250-1539.	**Electronic Claims Submission:** Network Providers are required to submit claims to Vaya Health electronically using the Vaya Provider Portal or a HIPAA-compliant 837 EDI file. Vaya does not accept paper claims from contracted Network Providers. Paper claims received from contracted Network Providers will be returned with instructions for re-submitting electronically. Vaya is contracted with the following vendors: • Modivcare, LLC for Non-Emergency Medical Transportation (NEMT) • Avesis LLC for Vision • Navitus Health Solutions, LLC for point-of-sale pharmacy benefit management (PBM). Instructions for how to file claims with these vendors is detailed below. To take advantage of faster claims processing and payment turnaround, Out-Of-Network providers delivering non-emergency services should submit claims

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	submissions. If approved the claims may be submitted by mail with copy of the approved request to: 5200 W. Paramount Parkway, Suite 200, Morrisville, NC 27560 Emergency Department (ED) and Out of Network (OON) Providers may submit paper claims to: Claims Department, 5200 W Paramount Parkway, Ste 200, Morrisville, NC 27560. Any required documentation for claims processing should accompany the paper claim. Sending a fax is not an accepted submission format. Alliance Claims submission support is available via Phone 919-651-8500 or Email:claims@alliancehealthplan.org					electronically unless they have an approved exception. Out-of-Network providers who need technical assistance or want to request an exception should contact claims@vayahealth.com. Out-of-Network providers delivering emergency services may submit paper claims. Prior to claim submission, all providers must submit a completed IRS W-9 form and (EFT) form. **Paper Claims Submission:** Vaya does not accept paper claims via facsimile. Out-of-Network providers must submit paper claims using an accurate CMS1500 or UB04 billing form to the following address: Vaya Health Attn: Claims and Reimbursement 200 Ridgefield Court, Suite 218 Asheville, NC 28806 For more information about submitting claims to Vaya, see the Vaya Claims Submission webpage.
Where should a provider submit behavioral health claims?	Providers may route claims to the ACS in one of three ways: **Electronic Claims Submission:** 1. The provider may request a provider portal login with a link to ACS by submitting	Eastpointe accepts electronic, paper, and direct entry claims. **Electronic Claims Submission:** Claims can be submitted by EDI. Eastpointe's EDI Payer ID 08044. Providers that need assistance in	Providers will access Provider Connect for electronic claim submission at: https://id.partnersbhm.org/	Providers may submit all claims electronically, through Portal at https://support.sandhillscenter.org or paper. All claims will come through Change Healthcare. Providers are able to key claims in Change Healthcare provider	Behavioral Health and Intellectual Developmental Disabilities (I/DD) claims are defined as those for Mental Health/Substance Use Disorders (/SUD), I/DD services and TBI services. I/DD	**Electronic Claims Submission:** Network Providers are required to submit behavioral health claims to Vaya Health electronically using Vaya Provider Portal or a HIPAA-compliant 837 (EDI) file. Vaya

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	a Provider Portal Login request form. This form is available on https://alliancehealthplan.org. The login credentials will be provided to the user via an email from OKTA after the Provider Portal Login request has been approved. The credentialed provider portal user may access ACS at https://acs.alliancehealthplan.org/portallogin. The ACS provider portal has claims entry screens for CMS-1500 for Professional claims entry and the UB-04 for Institutional Claims Entry. 2. The provider may request EDI connectivity with Alliance by submitting a Trading Partner Agreement and Connectivity Form. This form is available on https://alliancehealthplan.org/. Once the TPA has been processed the user requesting the connection will be provided with the SFTP credentials which the provider may utilize to submit 837P or 837I x12 forms. The TPA form may also be submitted to establish the relationship between a clearinghouse or billing vendor for which Alliance has previously established an EDI connection, so that the clearinghouse or vendor may submit 837 files on behalf of the provider. **Paper Claims Submission**: 3. Paper claim submission is available with prior approval	enrollment can contact our Provider Operations Provider Service Line at 888-977-2160. Please visit https://www.eastpointe.net/providers/ for additional info on submitting claims. Claims can be submitted through the iTransact Portal; claims can be faxed to Fax to 910-272-1299 or submitted via secure email to claimsfunding@eastpointe.net **Paper Claims Submission:** Claims Department 450 Country Club Road Lumberton, NC 28360		portal or submit 837P or 837I. Providers will have different Payer options based off the services they provide. Physical Health only: Payer Id 14816 Behavioral Health only: Payer Id SHC30 Both Physical and Behavioral: Payer ID SHC00 **Paper Claims Submission:** Sandhills Center Tailored Plan PO Box 981746 El Paso, Tx 79998-1746	benefits include intermediate care facilities for individuals with intellectual disabilities (ICF-IID), Innovations waiver services and other home and community-based services will be billed to Trillium for reimbursement. Mental Health, Substance Use Disorder and I/DD services will be billed using the appropriate primary ICD-10-CM diagnosis codes to the highest level of specificity that meets medical necessity in the range of F10-F99 with the exception of the services listed in the Claims Submission Protocol table found in the Tailored Plan Provider Manual. **Electronic Claims Submission:** Behavioral Health and I/DD claims for Tailored Plan Medicaid and State Funded claims may be submitted to Trillium using HIPAA Standard Electronic Transaction set, and this can be accomplished three ways: through web portal by using the Behavioral Health I/DD Secure Provider Portal - Provider Direct, via secure FTP, or a provider can submit their claims through a clearinghouse. If submitting claims through a clearinghouse, Trillium has an agreement to utilize Change Healthcare formerly known as Emdeon and The SSI Group. Trillium's Medical Payer ID is	does not accept paper claims from contracted Network Providers. Paper claims received from contracted Network Providers will be returned with instructions for re-submitting electronically. To take advantage of faster claims processing and payment turnaround, Out-Of-Network providers delivering non-emergency behavioral health services should submit claims electronically unless they have an approved exception. Out-of-Network providers who need technical assistance or want to request an exception should contact claims@vayahealth.com . Out-of-Network providers delivering emergency services may submit paper claims. Prior to claim submission, all providers must submit a completed IRS W-9 form and EFT form. **Paper Claims Submission:** Vaya does not accept paper claims via facsimile. Out-of-Network providers must submit paper claims using an accurate CMS1500 or UB04 billing form to the following address: Vaya Health Attn: Claims and Reimbursement 200 Ridgefield Court, Suite 218

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	(using Paper Claims Submission Request form) while providers gain access to the ACS Provider Portal or set up their EDI submissions. If approved the claims may be submitted by mail with copy of the approved request to: 5200 W. Paramount Parkway, Suite 200, Morrisville, NC 27560 ED and OON Providers may submit paper claims to: Claims Department, 5200 W Paramount Parkway, Ste 200, Morrisville, NC 27560. Any required documentation for claims processing should accompany the paper claim.				43071 when using The SSI Group or sending directly to Trillium and 56089 when using Change Healthcare (Emdeon). **Paper Claims Submission:** For Behavioral Health and I/DD paper claims, please submit to: Trillium Health Resources PO Box 240909 Apple Valley, MN 55124	Asheville, NC 28806
Where should a provider submit physical health claims?	Providers may route claims to the ACS in one of three ways: **Electronic Claims Submission:** 1. The provider may request a provider portal login with a link to ACS by submitting a Provider Portal Login request form. This form is available at https://alliancehealthplan.org. The login credentials will be provided to the user via an email from OKTA after the Provider Portal Login request has been approved. The credentialed provider portal user may access ACS at https://acs.alliancehealthplan.org/portallogin. The ACS provider portal has claims entry screens for CMS-1500 for Professional	Eastpointe accepts electronic, paper, and direct entry claims. **Electronic Claims Submission:** Electronic claims can be submitted by EDI. Eastpointe's EDI Payer ID 08044. Providers that need assistance in enrollment can contact our Provider Operations Provider Service Line at **888-977-2160**. Please visit https://www.eastpointe.net/providers for additional on submitting claims. Claims can be submitted through the iTransact Portal; claims can be faxed to Fax to 910-272-1299 or submitted via secure email to claimsfunding@eastpointe.net **Paper Claims Submission:** Claims Department	Providers will access Provider Connect for electronic claim submission at: https://id.partnersbhm.org/ Availity - Medicaid Tailored Plan Physical Health	Providers may submit all claims electronically, through Portal or paper. All claims will come through Change Healthcare. **Electronic Claims Submission:** Providers can key claims in Change Healthcare provider portal or submit 837P or 837I. Providers will have different Payer options based off the services they provide. Sandhills EDI Tailored Plan Payer ID's: Physical Health only: Payer Id 14816 Behavioral Health only: Payer Id SHC30 Both Physical and Behavioral: Payer ID SHC00	Physical health claims for Tailored Plan Medicaid beneficiaries are inclusive of physical health and Long-term Services and Supports, including nursing facility services, home health services, private duty nursing services, personal care services and hospice services. Physical Health services will have a primary medical ICD-10 diagnosis code to the highest level of specificity that meets medical necessity excluding the range of F10-F99 with the exception of the services listed in the Claims Submission Protocol table found in the Tailored Plan Provider Manual.	**Electronic Submission:** Network Providers are required to submit physical health claims (except for claims submitted to Vaya's vision, NEMT, and PBM vendors) to Vaya Health electronically using the Vaya Provider Portal or a HIPAA-compliant 837 EDI file. Vaya does not accept paper claims from contracted Network Providers. Paper claims received from contracted Network Providers will be returned with instructions for re-submitting electronically. To take advantage of faster claims processing and payment turnaround, Out-Of-Network providers delivering

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	claims entry and the UB-04 for Institutional Claims Entry. 2. The provider may request EDI connectivity with Alliance by submitting a Trading Partner Agreement and Connectivity Form. This form is available on https://alliancehealthplan.org. Once the TPA has been processed the user requesting the connection will be provided with the SFTP credentials which the provider may utilize to submit 837P or 837I x12 forms. The TPA form may also be submitted to establish the relationship between a clearinghouse or billing vendor for which Alliance has previously established an EDI connection, so that the clearinghouse or vendor may submit 837 files on behalf of the provider. **Paper Claims Submission** 3.– Paper claim submission is available with prior approval (using Paper Claims Submission Request form) while providers gain access to the ACS Provider Portal or set up their EDI submissions. If approved, the claims may be submitted by mail with copy of the approved request to: 5200 W. Paramount Parkway, Suite 200, Morrisville, NC 27560 ED and OON Providers may submit paper claims to: Claims Department, 5200 W Paramount Parkway, Ste 200,	450 Country Club Road Lumberton, NC 28360		**Paper Claims Submission:** Paper Claims: Sandhills Center Tailored Plan PO Box 981746 El Paso, Tx 79998-1746	**Electronic Claims Submission:** Physical health claims and physician-administered (professional) drug claims are processed through Trillium's partner, Carolina Complete Health (CCH) and may be submitted using HIPAA Standard Electronic Transaction set and can be accomplished by a secure web-based Provider Portal at https://www.trilliumhealthresources.org/for-providers via secure FTP, or a provider can submit their claims through a clearinghouse. CCH utilizes the clearinghouse Availity. As long as the provider's clearinghouse has a connection to Availity, then the claim can be passed on to CCH. **CCH's Medical Payer ID is 68069.** **Paper Claims Submission:** Please submit to: Carolina Complete Health Attn: Claims PO Box 8040 Farmington, MO 63640-8040	non-emergency physical health services should submit claims electronically unless they have an approved exception. Out-of-Network providers who need technical assistance or want to request an exception should contact claims@vayahealth.com. Out-of-Network providers delivering emergency services may submit paper claims. Prior to claim submission, all providers must submit a completed IRS W-9 form and EFT TFH form. **Paper Claims Submission:** Vaya does not accept paper claims via facsimile. Out-of-Network providers must submit paper claims using an accurate CMS1500 or UB04 billing form to the following address: Vaya Health Attn: Claims and Reimbursement 200 Ridgefield Court, Suite 218 Asheville, NC 28806

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	Morrisville, NC 27560. Any required documentation for claims processing should accompany the paper claim.					
Where should a provider submit pharmacy health claims?	The process for **Physician Administered Drug Program (PADP) Claims** is same as the regular Physical claims processing. Providers may route Pharmacy claims to the ACS in one of three ways: **Electronic Claims Submission** 1. The provider may request a provider portal login with a link to ACS by submitting a Provider Portal Login request form. This form is available on https://alliancehealthplan.org. The login credentials will be provided to the user via an email from OKTA after the Provider Portal Login request has been approved. The credentialed provider portal user may access ACS at https://acs.alliancehealthplan.org/portallogin. The ACS provider portal has claims entry screens for CMS-1500 for Professional claims entry and the UB-04 for Institutional Claims Entry. 2. The provider may request EDI connectivity with Alliance by submitting a Trading Partner Agreement and Connectivity Form. This form is available on https://alliancehealthplan.org.	PADP – Pharmacy Health claims – will be submitted directly to Eastpointe: **Electronic Claims Submission** • Electronic claims can be submitted by EDI. Eastpointe's EDI Payer ID 08044. Providers that need assistance in enrollment can contact our Provider Operations Provider Service Line at 888-977-2160. • Please visit https://www.eastpointe.net/providers/ for additional on submitting claims. • Claims can be submitted through the iTransact Portal, claims can be faxed to Fax to 910-272-1299 or submitted via secure email to claimsfunding@eastpointe.net **Paper Claims Submission:** Claims Department 450 Country Club Road Lumberton, NC 28360	Pharmacy – Outpatient Pharmacy claims will be processed by CVS on behalf of Partners beginning Oct. 1, 2023. These POS claims will be paid, denied or pended for additional information within 14 calendar days of receipt. PADP pharmacy professional claims will be processed with the medical and behavioral claims as designated below.	PerformRx Pharmacy & Prescriber Services: at https://www.performrx.com/who-we-help/providers/provider-resources.aspx 888-846-1062 Pharmacy RxBIN: 019595 Pharmacy RXPCN: PRX10810 Behavioral and Medical auths would go through JIVA. Pharmacy auths would be handled by Perform RX.	Pharmacy claims are defined as those claims submitted for rendered pharmaceuticals or pharmacy services, including outpatient pharmacy (point-of-sale claims). Pharmacy POS claims are processed through Trillium's partner, PerformRx and may be submitted electronically using the most current NCPDP HIPAA- approved format with Rx BIN Number 019595 and PCN – PRX10811 using the most current NCPDP HIPAA-approved format with Rx BIN Number 019595 and PCN – PRX10811 We do not accept pharmacy paper claims.	**Pharmacy Claims Submission:** Medical claims for physician administered medications should be submitted directly to Vaya. Vaya Health Attn: Claims and Reimbursement 200 Ridgefield Court, Suite 218 Asheville, NC 28806 POS pharmacy claims should be submitted to the pharmacy's preferred billing switch intermediary that will route their claims to Navitus if the appropriate billing code (BIN 610602 PCN: MCD) is used. **Paper Claim Submission:** Out-of-Network pharmacies can mail claims for Direct Member Reimbursement to the following address: Navitus Health Solutions, LLC P.O. Box 999 Appleton, WI 54912-0999

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	Once the TPA has been processed the user requesting the connection will be provided with the SFTP credentials which the provider may utilize to submit 837P or 837I x12 forms. The TPA form may also be submitted to establish the relationship between a clearinghouse or billing vendor for which Alliance has previously established an EDI connection, so that the clearinghouse or vendor may submit 837 files on behalf of the provider. **Paper Claims Submission** 3. Paper claim submission is available with prior approval (using Paper Claims Submission Request form) while providers gain access to the ACS Provider Portal or set up their EDI submissions. If approved the claims may be submitted by mail with copy of the approved request to: 5200 W. Paramount Parkway, Suite 200, Morrisville, NC 27560 ED and OON Providers may submit paper claims to: Claims Department, 5200 W Paramount Parkway, Ste 200, Morrisville, NC 27560. Any required documentation for claims processing should accompany the paper claim. The process for **Pharmacy Claims** is for pharmacies to submit claims directly from their					

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	point of sale (POS) dispensing software via a third-party adjudication network or "switch". The BIN: 610602 and the PCN: MCD plus the member's MID # is the information needed by the pharmacy.					
Where should a provider submit vision claims?	Providers can submit Vision claims in one of three ways: Avesis web portal, electronically by EDI through a clearinghouse, or by mail. Avesis Provider Portal Providers can log into the Avesis provider portal via http://www.avesis.com **Electronic Claim Submission** Please use Avesis Payer ID 87098. Avesis clearing house vendors include Change Healthcare or Trizetto. Providers may contact Change Healthcare at 615-932-3000 or http://www.changehealthcare.com. Providers may contact Trizetto at 800-869-1222 or www.trizetto.com. **Paper Claim Submission** Submit paper claims to: Avēsis Third Party Administrators, LLC Attention: Eye Care Claims P.O. Box 38300 Phoenix, AZ 85069-8300	**Electronic Claims Submission:** Envolve https://visionbenefits.envolvehealth.com/logon.aspx **Paper Claims Submission:** Envolve Vision, Inc. PO Box 7548 Rocky Mount, NC 27804	**Electronic Claims Submission:** Envolve Vision Provider Web Portal at: https://visionbenefits.envolvehealth.com/logon.aspx Change HealthCare Payer ID# 56190 **Paper Claims Submission** Envolve Vision, Inc. PO Box 7548 Rocky Mount, NC 27804	Providers may submit all claims electronically, through Portal or paper. All claims will come through Change Healthcare. **Electronic Claims Submission:** Providers can key claims in Change Healthcare provider portal or submit 837P or 837I. Providers will have different Payer options based off the services they provide. Physical Health only: Payer Id 14816 Both Physical and Behavioral: Payer ID SHC00 **Paper Claims Submission:** Sandhills Center Tailored Plan PO Box 981746 El Paso, Tx 79998-1746	**Electronic Claims Submission:** Vision claims for Medicaid Tailored Plan beneficiaries are processed through Envolve, a subsidiary of CCH and may be submitted using HIPAA Standard Electronic Transaction set or can be submitted in a secure web-based Provider Portal ((https://visionbenefits.envolvehealth.com/logon.aspx). Claims may also be submitted through a clearinghouse. Envolve utilizes the clearinghouse Change Healthcare. As long as the provider's clearinghouse has a connection to Change Healthcare, then the claim can be passed on to Envolve. **Envolve's Payer ID is 56190** **Paper Claims Submission:** Service: Envolve Vision, Inc. PO Box 7548 Rocky Mount, NC 27804 Hardware: Nash Optical Plant P.O. Box 600 2869 US Highway Alternate 64 West Nashville, NC 27856	Vaya Health partners with Avesis LLC to provide vision benefits to Medicaid members. Vision providers can submit vision claims in one of three ways: the Avesis web portal, electronically through a clearinghouse using a HIPAA-compliant 837EDI file, or by mail. **Electronic Claims Submission:** **Avesis Provider Portal** Providers can log into the secure Avesis web portal for electronic submission at: https://www.avesis.com/Commercial3/Providers/Index.aspx . **Clearinghouse Submission:** Avesis clearinghouse vendors include Change Healthcare and Trizetto. Providers may contact Change Healthcare at 615-932-3000 or www.changehealthcare.com. Providers may contact Trizetto at 800-869-1222 or www.trizetto.com. Please use Avesis Payer ID AVS01. **Paper Claim Submission:**

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						Providers should submit paper claims to Avesis at the following address: Avesis Third Party Administrators, LLC Attention: Eye Care Claims P.O. Box 38300 Phoenix, AZ 85069-8300 For more information on submitting claims to Avesis, visit: https://www.avesis.com/Commercial3/Providers/Index.aspx .
Where should a provider submit claims for durable medical equipment (DME)?	DME Electronic claims (preferred) must be routed to Northwood (DME vendor). Northwood's national EDI payer ID is NWOOD. **Electronic Claims Submission:** Electronic claims must be completed according to HIPAA 837 transaction requirements detailed on Northwood's website https://northwoodinc.com. **Paper Claims Submission:** (CMS-1500) may be mailed to: Northwood, ATTN: Alliance Health Plan Claims, P.O. Box 510, Warren, MI 48090-0510.	Eastpointe accepts electronic, paper, and direct entry claims. Electronic claims can be submitted by EDI. Eastpointe's EDI Payer ID 08044. Providers that need assistance in enrollment can contact our Provider Operations Provider Service Line at **888-977-2160**. Please visit https://www.eastpointe.net/providers for additional on submitting claims. **Electronic Claims Submission:** Claims can be submitted through the iTransact Portal, claims can be faxed to Fax to 910-272-1299 or submitted via secure email to claimsfunding@eastpointe.net **Paper Claims Submission:** Claims Department 450 Country Club Road Lumberton, NC 28360	Providers will access Provider Connect for electronic claim submission at: https://id.partnersbhm.org/ Paper claims: Partners P.O. Box 8002 Farmington, MO 63640-8002	Providers may submit all claims electronically, through the Portal at https://protect-us.mimecast.com/s/CsPCCZ69pvHmMy0Izt71-?domain=physician.connectcenter.changehealthcare.com or paper. All claims will come through Change Healthcare. **Electronic Claims Submission:** Providers are able to key claims in Change Healthcare provider portal or submit 837P or 837I. Providers will have different Payer options based off the services they provide. Sandhills EDI Tailored Plan Payer ID's: Physical Health only: Payer Id 14816 Behavioral Health only: Payer Id SHC30 Both Physical and Behavioral: Payer ID SHC00	DME claims are processed through Trillium's partner, Carolina Complete Health (CCH) and may be submitted using HIPAA Standard Electronic Transaction set and can be accomplished by a secure web-based Provider Portal (Physical Health Secure Provider Portal), via secure FTP, or a provider can submit their claims through a clearinghouse. CCH utilizes the clearinghouse Availity. As long as the provider's clearinghouse has a connection to Availity, then the claim can be passed on to CCH. **CCH's Medical Payer ID is 68069.** **Paper Claims Submission:** Trillium P.O. Box 8003 Farmington, MO 63640-8003	**Electronic Claims Submission:** DME claims should be submitted directly to Vaya Health in the same manner as other physical health claims. Network Providers are required to submit DME claims to Vaya electronically using the Vaya Provider Portal or a HIPAA-compliant 837 EDI file. Vaya does not accept paper claims from contracted Network Providers. Paper claims received from contracted Network Providers will be returned with instructions for re-submitting electronically. To take advantage of faster claims processing and payment turnaround, Out-Of-Network providers delivering non-emergency services should submit claims electronically unless they have an approved exception. Out-

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				Paper Claims Submission: Sandhills Center Tailored Plan PO Box 981746 El Paso, Tx 79998-1746		of-Network providers who need technical assistance or want to request an exception should contact claims@vayahealth.com. Prior to claim submission, all providers must submit a completed IRS W-9 form and Electronic Funds Transfer (EFT) form. **Paper Claims Submission:** Vaya does not accept paper claims via facsimile. Out-of-Network providers must submit paper claims using an accurate CMS1500 or UB04 billing form to the following address: Vaya Health Attn: Claims and Reimbursement 200 Ridgefield Court, Suite 218 Asheville, NC 28806 For more resources on submitting claims to Vaya, visit: https://providers.vayahealth.com/authorization-billing/claims/claims-submission/
Where should a provider route NEMT claims to?	NEMT claims will be submitted via Modivcare and not Alliance Health. **Electronic Claims Submission:** Providers can bill electronically through Modivcare's web portal, by an Automated	Each Transportation Provider will have access to the MTM claims online portal. In the claims portal, once the Transportation Providers submits a claim (e.g. within MTM Link) they will be able to follow it Realtime through the different statuses. Transportation Providers	**Electronic Claims Submission:** Modivcare transportation providers can submit claims via the Transportation Provider Portal (providers are given credentials for the portal when they contract with Modivcare) or via the	**Electronic Claims Submission:** ModiveCare is Sandhills NEMT provider, providers will submit billing digitally through an ATMS platform or the Modivcare TP Portal at https://www.modivcare.com/login.	Modivcare is Trillium's contractor to facilitate Non Emergency Medical Transportation (NEMT) and Non Emergent Ambulance Transportation (NEAT) services in North Carolina. Modivcare responsibilities	Vaya Health partners with Modivcare, LLC to provide NEMT benefits to Vaya Medicaid members. Providers may submit claims via Modivcare's Transportation Provider Portal. For more information about how to set

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	Transportation Management System (ATMS), or by submitting paper claims. **Paper Claims Submission:** Paper submissions are allowed and Completed forms can be sent by mail to: 798 Park Avenue NW, Norton, VA 24273	can submit claims, view statuses, appeal denials and search within claims portal 24/7. If a claim is denied, the Transportation Provider will be able to appeal the denial directly in the portal, which also allows the Transportation Provider to submit additional documentation in support of the appeal, if necessary. Please contact your MTM's Client Executive for all client questions and concerns. If you have general claims questions, please send to Claimsanalysis@mtm-inc.net. **Paper Claims Submission:** **Ambulance Claims**: Email: Ambulanceclaims@mtm-inc.net or; Mail: 16 Hawk Ridge Circle, Lake St. Louis, MO 63367 **All other NEMT Claims:** Email: Invoiceproviders@mtm-inc.net or; Mail: 16 Hawk Ridge Circle, Lake St. Louis, MO 63367 **Gas Mileage Reimbursement (GMR) Claims:** Mobile App (*where applicable*) Email: Payme@mtm-inc.net Mail: 16 Hawk Ridge Circle, Lake St. Louis, MO 63367	transportation provider's ATMS digital platform. Providers who have billing questions may contact the Provider Line at 855-397-3604. Modivcare Web Portal at: https://transportationco.logisticare.com/ **Paper Claims:** 798 Park Ave NW 4th Floor Norton, VA 24273		include booking of reservations/rides and to process claims for NEMT/NEAT providers. **Electronic Claims Submission:** Providers can bill electronically through Modivcare's web portal, by an ATMS, or by submitting paper claims. For any questions on how to bill, Providers should refer to Modivcare's Orientation and Training resources. For claims related questions, please contact Modivcare's Claims Department at 800-930-9060. For any other Provider related questions specific to Modivcare rides, please contact: 855-397-3604. Additional NC resources may be found in Transportation Provider Manual that will be linked from the Trillium website. **Paper Claims Submission:** Modivcare accepts paper claims for mileage reimbursement only 789 Park Ave NW Norton, VA 24273.	up access and submit claims to Modivcare, see the following link: https://www.modivcare.com/login. Paper submissions are accepted for milage reimbursement only and can be mailed to the below address: Modivcare 798 Park Ave NW Norton, VA 24273
How does the Tailored Plan comply with the Department's "good faith"	Alliance would be engaged in a minimum of three documented attempts with the provider within the first 30 days to establish a contract. If the	Per our Good Faith Contracting Policy, Eastpointe shall consider all facts and circumstances surrounding a provider's	The Good Faith Effort begins when the provider receives a version of the contract which is consistent with the version approved by the North Carolina Department of	Sandhills Center will consider all facts and circumstances surrounding an OON Medicaid or State-Funded Provider's willingness to contract and to	Trillium follows the Good Faith Contracting Policy. posted on Trillium's website.	Vaya Health developed a Good Faith Provider Contracting policy that outlines the process for ensuring that Vaya made "good faith" efforts to

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contracting requirements for purposes of determining rates?	provider does not engage in the contracting process or does not want to contract the rate of reimbursement would be set a 90%. Alliance would pay 100% to an OON provider if they have not been offered a contract or is still engaged in good faith negotiations. Alliance will pay the rate floor where applicable unless the provider and Alliance have agreed to alternative reimbursement arrangement.	willingness to contract before determining that the provider has refused Eastpointe's good faith contracting efforts. To demonstrate the refusal of good faith contracting efforts, the provider shall submit written notification of refusal of contract. Eastpointe will comply with the Tailored Plan contract as follows: If within 30 calendar days the potential network provider rejects the request or fails to respond either verbally or in writing, Eastpointe may consider the request for inclusion in the NC Medicaid Managed Care network rejected by the provider. If discussions are ongoing, or the contract is under legal review, Eastpointe shall not consider the request rejected. The time period does not begin until the provider has been given a version of the contract which was approved by the Department in order to assure the written offer includes all of the standard provisions from Tailored Plan Contract.	Health and Human Services (NCDHHS) and includes the standard provisions for provider contracts found in Attachment G. Required Standard Provisions of the Behavioral Health I/DD Tailored Plan and Provider Contracts, including the prescribed provisions located therein. This definition applies to qualified providers contracting to provide Medicaid and/or State-funded Services to the full extent required by law or contract with NCDHHS. The initial contract offering will serve as the first effort. If the provider does not execute the first effort, Partners will make a second effort at least 10 calendar days after the first effort, taking into consideration any feedback from the provider. If the provider does not execute the agreement after the second effort, Partners will make a third and final effort, at least 10 calendar days after the second effort, taking into consideration any feedback from the provider from the previous efforts. Partners will have exhausted all good faith contracting efforts after the third and final effort. The good faith contracting effort period must be at least 30 calendar days, but Partners may allow additional time if discussions are ongoing, contract revisions are being made or negotiated, the contract is under legal review by the provider or if in the opinion of Partners, such additional time could lead to an executed contract. If after at least 30 days and the three good faith attempts, the provider	evaluate whether it falls within the plan's Good Faith Contracting effort at https://tp.sandhillscenter.org/contracting-documents. .		contract before determining reimbursement rates: • Vaya will offer to contract with a provider in writing using an NCDHHS approved provider agreement at reimbursement rates no lower than the NC Medicaid fee schedule. • Vaya will make three outreach attempts before determining that the provider has refused our "good faith" contracting effort. The initial offer is the first attempt. Vaya tracks all provider negotiation and contracting efforts and outreach attempts. • Following the initial offer, Vaya will make two more outreach attempts to the provider. Vaya will have exhausted all good faith contracting efforts after the third effort. • The good faith contracting effort period must be at least 30 calendar days, but Vaya may allow additional time if discussions are ongoing, contract revisions are being made or negotiated, the contract is under legal review by the provider, or if in the opinion of Vaya such additional time could lead to an executed contract.

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			does not respond to the efforts verbally or in writing, the request to join the network will be considered rejected. In summary, Good Faith negotiation and contracting efforts are tracked in our database. We will not reimburse the OON provider more than 90% of the Medicaid fee-for-service rate if the provider refuses to contract or fails to meet objective quality standards.			• The 30-day period begins when the provider has received a copy of the contract that is consistent with the version of the contract approved by NCDHHS. • If after at least 30 days and the three good faith attempts, the provider fails to respond to the efforts verbally or in writing, or fails to meet Vaya's objective quality standards, the request to join the network will be considered rejected. • Vaya will consider all facts and circumstances surrounding a provider's willingness to contract before determining that the provider has refused our “good faith” contracting effort. Note that Vaya will not reimburse OON providers who refuse our “good faith” contracting effort more than 90% of the Medicaid fee-for-service rate unless a documented exception is approved by Vaya. Providers with questions about contracting, rates, or Vaya's objective quality standards should email provider.info@vayahealth.com.

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What information is needed from the provider to file a claim?	Providers may enter claims directly into the ACS Provider Portal. All claim required fields should be completed, including (as applicable):
	• member's name,
	• member's plan ID number,
	• member's date of birth,
	• member's address,
	• other insurance information,
	• amounts paid by other insurances (with uploaded matching EOBs),
	• information determining if condition is related to employment/auto accident/liability suit,
	• dates of service,
	• admission date,
	• discharge date,
	• primary/secondary/tertiary ICD-10-CM/PCS diagnosis codes,
	• name of referring physician,
	• HCPCS/Procedure codes,
	• CPT procedure codes with appropriate modifiers,
	• CMS place of service code, line charges, number of days/units,
	• Provider federal tax ID number,
	• Billing NPI,
	• Billing Taxonomy, Rendering NPI,
	• Rendering Taxonomy,
	• Provider name,
	• Provider address/zip+4,
	• Provider telephone number,
		Electronic claims submission via an 837-transaction set to Eastpointe must be in the ANSI ASC X12N format, version 5010A.
		Professional services must be submitted to Eastpointe using the ANSI 837P (professional) or, if billing through the provider portal or paper, the CMS1500 form.
		Institutional services must be submitted to Eastpointe using the ANSI 837I (institutional) or, if billing through the provider portal or paper, the UB04 form.
		Claims must include the following information:
		• Billing provider's name, address, NPI Number and taxonomy code
		• TIN
		• Member's (patient) name
		• Member's ID number
		• Member's date of birth, gender, and address
		• Providers are required to use proper procedure and diagnosis codes when submitting claims to Eastpointe. Code sets approved by HIPAA
		  ○ ICD-10 – International Classification of Diseases 10th edition
		  ▪ Principal Diagnosis
		  ▪ Other Diagnosis code
		  ○ HCPCS – Health Care Common Procedure Coding System
			Generally speaking, all claims must have complete and compliant data to include:
			• Member's (patient's) name
			• Member's Plan ID number
			• Member's date of birth and address
			• Other insurance information: company name, address, policy and/or group number
			• Amounts paid by other insurance (with copies of matching EOBs)
			• Information advising if member's condition is related to employment, auto accident or liability suit
			• Assignment of Benefits
			• Date(s) of service, admission, discharge
			• Primary, secondary, tertiary and fourth ICD-10-CM/PCS diagnosis codes, coded to the full specificity available, which may be 3, 4, 5, 6, or 7 digits
			• Name of referring physician, if appropriate
			• HCPCS procedures, services or supplies codes
			• CPT procedure codes with appropriate modifiers
			• Place of service
			• Charges (per line and total)
			• Days and units
			• Federal Tax Identification Number
			• National Practitioner Identifier (NPI) of billing and rendering provider, or Atypical Provider Identification Number, where applicable
			• Taxonomy codes of billing provider, attending and
				Information needed in order to submit a claim:
				• Member Name,
				• Member Plan ID,
				• Member Date of Birth and address,
				• Other insurance information including amount paid,
				• Date of Service,
				• admission,
				• discharge,
				• ICD-10-CM/PCS diagnosis codes,
				• HCPCS, procedures, services or supplies code
				• CPT procedure codes with appropriate modifiers
				• CMS place of service,
				• Charges, Days and Units,
				• Physician/supplier Federal Tax Id or Social Security Number
				• NPI of billing and rendering provider or atypical number,
				• Taxonomy of billing, attending and rendering provider,
				• Billing name, address, zip code, telephone number
				• NDC's required for physician administered injectables,
				• Name and address of facility where services were rendered,
				• Invoice Date,
				• Provider Signature
					Key information submitted on claims should include but is not limited to all required fields of the CMS 1500 and UB04 claim forms. All fields on the CMS 1500 claim form should be completed in accordance with the Instruction Manual by the National Uniform Claim Committee. All fields on the UB04 claim form should be completed in accordance with the UB04 Data Specifications Manual by the American Hospital Association and the National Uniform Billing Committee. Claims submitted via 837I and 837P must comply with HIPAA Standard Electronic Transaction set requirements. Reference documents on 837I and 837P can be located on the Trillium Health Resources web page on the 'For Providers' Tab and the 'Documents and Forms' sub tab 837I Institutional Health Care Claim and 837P Professional Health Care Claim. Additional reference documents on 837I and 837P can also be located in the CCH Billing Guide on the CCH website, https://network.carolinacompletehealth.com/resources/claims-and-billing.html.	Electronic claim submissions must include all applicable required data in standardized Accredited Standards Committee (ASC) X12N 837 formats as well as following the Companion Guides available on our website https://providers.vayahealth.com/authorization-billing/claims/claims-submission
						
						Paper claims must be submitted using original and complete CMS claim forms.
						
						a. For professional claims, it is the CMS 1500 form
						b. B. The institutional form name is the UB-04 form
						
						Pharmacy providers must use the following billing information when submitting claims electronically to their preferred billing switch intermediary: BIN 610602 PCN: MCD.

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	• Name and Address of facility where services were rendered, • NDCs- if required. Refer to the link below for additional information: https://www.alliancehealthplan.org/?s=Companion%20Guide.	○ CPT – Current Procedure Terminology ○ Appropriate modifiers ○ NDC – National Drug Codes (where applicable) ○ Revenue code (institutional claims only) ○ ICD-10 PCS • Date of service(s) • Place of service • Days or units • Charge amounts (line amounts and totals) • Rendering provider's NPI and taxonomy code, where applicable • Inpatient claims require: ○ Admission date ○ Admission hour ○ Admission/visit type ○ Source code ○ Discharge status ○ Occurrence codes and dates, when applicable ○ Value codes and amounts, when applicable ○ Condition codes, when applicable ○ Admitting diagnosis ○ DRG (diagnostic-related group) • Coordination of benefits/other insurance information when applicable:	rendering provider when submitted on claim • Physician/supplier billing name, address, zip code, and telephone number • Name and address of the facility where services were rendered			

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		○ Company's name, address, policy number ○ The amount paid, and patient responsibilities listed from the other insurance • Indication if the condition is related to an accident: employment, auto accident or liability suit				
How can a provider enroll to use EFT for payment?	The provider will complete the forms in the Vendor Setup Packet which contains a vendor profile form, EFT and W9. The packet will be provided to the provider during contracting or can be found on Alliance's website. Completed forms will be sent to vendorsetup@alliancehealthplan.org.	Provider can submit "Electronic Funds Transfer (EFT) Authorization Agreement for Automatic Deposit" form located on our website with official bank letter or voided check. https://mco.eastpointe.net/DocumentBrowser/file/CAPFSContracting/Electronic%20Funds%20Transfer%20Form.pdf Providers complete an Enrollment Application and send in the EFT Form , W9 Form, Trading Partner Agreement to networkoperations@eastpointe.net . Providers must be enrolled and active in NCTracks to be enrolled at Eastpointe.	**Medicaid Tailored Plan Physical Health** - See EFT section located at: https://network.carolinacompletehealth.com/resources/claims-and-billing.html **Medicaid Tailored Plan Behavioral Health and State Benefit** To set up EFT in our software system download and complete a Trading Partner Agreement. The Trading Partner Agreement must be submitted to the following address with original signatures: Partners Health Management 901 South New Hope Road Gastonia, NC 28054 Attn: IT Department The TPA is also located at: www.partnersbhm.org (follow the steps below) 1. Provider Knowledge Base 2. Provider Tools 3. Alpha+, ZixMail and Billing Set-up Providers must complete banking information forms before payment can be received. Banking information forms can be requested	Behavioral Health Providers will find the ACH Direct Deposit Form on our website https://www.sandhillscenter.org/for-providers/provider-forms. Physical health Providers can sign up for EFT https://enrollments.echohealthinc.com/efteradirect/enroll	For Behavioral Health, a new provider will go through our Contracts department process of signing up for EFT payment. Existing providers can make changes or enroll using the FinanceForms@trilliumnc.org email. Physical health, providers must register with Payspan at https://www.trilliumohp.com/content/dam/centene/trillium/ProviderResources/PaySpan_Info_Sheet.pdf. Providers may register directly with Payspan or contact CCH Provider Relations at https://network.carolinacompletehealth.com/about-us/provider-relations-and-support-team.html for assistance.	A provider can enroll for EFT payments with Vaya by completing an EFT payment enrollment form and submitting to Vaya for processing. The form can be found on the Vaya web site in the Provider Learning Lab in the forms section. https://providers.vayahealth.com/resources/eft-authorization-form/.

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			from April Cash at acash@partnersbhm.org.			
Does the Tailored Plan charge any clearinghouse or EFT fees?	There are no clearinghouse or EFT fees	No	No	No	**Behavioral Health claims** – providers using Change Healthcare or The SSI Group clearinghouses to submit claims and receive payments will not incur additional fees. **Physical Health claims** – providers using the Availity clearinghouse to submit claims will not incur additional fees. Payments can be received via EFT using PaySpan, the Availity or Change Healthcare clearinghouses without additional fees. **Vision Claims** - providers using the Change Healthcare clearinghouse to submit claims will not incur additional fees. Payments can be received via EFT using PaySpan without additional fees. **NEMT Claims** – Providers can submit claims using the Modivcare portal or ATMS at no charge. Payments from Modivcare are direct deposit with no additional fees.	No - Vaya Health does not charge clearinghouse or EFT fees. However, if providers choose to use a clearinghouse that charges fees, the provider will be solely responsible for any fees charged by a clearinghouse. To learn more, please visit https://providers.vayahealth.com/resources/vaya-health-tested-clearinghouses .
Under what circumstances does the Tailored Plan offer an Out-of-Network agreement?	Physical health Providers: Services would be considered OON if the provider is not contracted with Alliance. Physical Health providers are not required to have an OON agreement, but would be paid at 90% of the Network Contract	An OON agreement would be needed for a non-contracted provider to provide a specific service to a specific member for a designated period and specific location. OON are for members for which their unique needs, geographical location, or continuity	In instances where the provider is not interested in contracting with us for a full contract or they are only serving one member for a specialized service, we would offer an Out-of-Network agreement.	The circumstance under which we would offer an Out-of-Network agreement include: • A fully contracted network provider is not available to serve a member for a medically justified service.	Trillium would complete a Single Case Agreement (SCA) when a provider is not in our Network and the service meets medical necessity. For additional information please review Out of Network/Single Case Agreement section at	Vaya only offers an Out-Of-Network agreement when there is no network provider available to deliver a medically necessary service to a Vaya Health plan member or recipient. In that situation, the provider should submit an

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	rate as indicated in Alliance's Good Faith Contracting Policy Behavioral Health Providers- Alliance operates a closed Network for Behavioral Health Services. An OON (OON) agreement would be needed for a non-contracted provider to provide a specific service to a specific member for a designated period and specific location. OON are for members for which their unique needs, geographical location, or continuity of care needs cannot be met by an in- network provider.	of care needs cannot be met by an in- network provider.		• Member lives out of the Sandhills Center catchment area with no contracted providers for that service in their area. In cases of continuity of continuity of care, i.e., a member's Medicaid County changed in the middle of treatment with a non-contracted provider. • A contracted provider offers a service needed by a member that is not included in their Sandhills Center contract. This can include continuity of care or no contracted for providers of that service in the area.	https://www.trilliumhealthresources.org/for-providers/provider-documents-forms/documents-contracts.	Out-Of-Network request as outlined on our website at Provider Enrollment | Vaya Health. If the Out-Of-Network request is approved, the provider will need to execute the Out-Of-Network agreement prior to delivering services.
What is the first date the Tailored Plan intends to start issuing medical and pharmacy payments after Managed Care Launch? **What is the payment cycle for medical and pharmacy claims?**	**Alliance**: The first payment for medical and pharmacy payments after Managed Care Launch will be Oct. 10, 2023. Payments will be issued on a weekly basis going forward. A checkwrite schedule is available on the Alliance website that includes the claims cutoff date, checkwrite date and the date the RA is available. **DME** Payments: Oct. 9, 2023 (It is anticipated that the first DME payments would occur the week of Oct. 9, 2023). The payment cycle for DME claims is weekly.	The first payment issue date would be Oct. 10.Payment cycles are weekly for claims received Wednesday to Tuesday of the previous week. Claims received from Oct. 1, 2023 to –Oct. 3, 2023 would be included in the first check write on Oct. 10, 2023	**Medicaid Tailored Plan Behavioral Health and State Benefit** – Oct. 10, 2023, is the first checkwrite. **Pharmacy** - Pharmacy claims will be processed by CVS on behalf of Partners beginning Oct. 1, 2023. Claims will be paid, denied, or pended for additional information within 14 calendar days of receipt.	For medical claims the first cutoff after the Oct. 1, 2023, Go Live date is Oct. 4, 2023, with the first check write on Oct. 6, 2023. Behavioral health claims will continue to follow their current checkwrite schedule, cutoffs and checkwrites on Tuesdays. Pharmacy cutoffs are four-day cycles and payment is the 7th day. First check after Oct. 1, 2023, Go Live will be Oct. 8, 2023.	The first date Bbhavioral health claims will be paid is Oct. 3, 2023, and Trillium's payment cycle follows the DHB checkwrite schedule and can be found on Trillium's website www.trilliumhealthresources.org under For Providers and Billing Codes & Rates |Check-Write Schedule. CCH will be running weekly physical health checkwrites starting on Wednesday, Oct. 11, 2023. For Pharmacy POS claims processing, PerformRx will have the first payment to pharmacies on Oct. 7, 2023.	Medical payments: Vaya anticipates issuing the first payments for medical service claims on Oct. 12, 2023. Vaya check runs are scheduled weekly on Thursdays. Pharmacy payments: Navitus anticipates issuing the first payments for pharmacy services by Oct. 10, 2023, or sooner. Navitus check runs are scheduled weekly on Tuesdays.
What is the first date the Tailored Plan intends to start issuing vision	Vision: Avesis anticipates issuing the first payment to vision providers on Oct. 11, 2023 (dependent on	Vision: Vision-closeouts will happen on Wednesdays. First one should be	Vision: The first payment for claims will be Oct. 5, 2023. After the first	Vision: Vision will follow the Medical Claims checkwrite schedule.	Vision: The first Vision checkwrite will be on Wednesday, Oct. 11, 2023.	Vision: Avesis anticipates issuing the first payment to vision providers on Oct. 11, 2023. Check runs for vision

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and NEMT payments after Managed Care Launch? What is the payment cycle for vision and NEMT claims?	provider claims submissions). Check runs for vision claims are weekly on Wednesdays. NEMT: Payments anticipated start date, Oct. 13, 2023; Cycles start on Wednesdays; Claims are paid weekly. Payment Schedule available on the Transportation Provider Portal.	Oct. 4, 2023, for claims that come in on Oct. 1, 2023. NEMT: Payments for NEMT claims to transportation providers are NET 30 from submission date. NEMT payments will be made two weeks after Managed Care Launch, with a payment cycle of every two weeks. Starting on Oct. 16, 2023,	payments are issued, the check run cycle will be every Thursday. NEMT: The first payment for claims will be Oct. 13, 2023. After the first payments are issued, the check run cycle will be every Friday.	NEMT: NEMT (Modivcare), first billing after Go Live will be due Oct. 5, 2023, with a check date of Oct. 15, 2023.	NEMT: Payments for NEMT are processed in a weekly checkwrite and will start the week of Oct. 13, 2023.	claims are weekly on Wednesdays. NEMT: Modivcare will issue the first payments on Oct. 13, 2023. Check runs for NEMT claims are weekly on Saturdays.
What message will providers see in the Provider Portal regarding individual claim status prior to first payments being released?	Providers can go to download Queue (From ACS Provider Portal) to see denials and Adjudicated amounts to be paid. ACS Provider Portal: https://acs.alliancehealthplan.org/portallogin. The download queue is available within the ACS Provider Portal.	Status will reflect: • "Completed" for approved claims with the approved amount • "Denied" for denied claims • "Processing" for claims in pre-adjudication stage or pending review	Approved, denied, pended/medical review required.	Providers will see if the claims approved/denied/pended.	For Behavioral Health, a status of "Processed" and status "Pended" will be displayed. For Physical Health, a status of "In Progress" and status "Pending" will be displayed.	Network providers will be able to check the status of all submitted claims in the Vaya health provider portal. The portal will display the claims status reflected in Vaya's claims system, and the status will indicate whether each line in the claim will pay.
How can providers determine which services require prior authorization for a health plan?	Providers will search by procedure code for prior authorization requirements. Details on Prior Authorization Submission Process will be posted at: https://www.alliancehealthplan.org/tp/providers/clinical-resources/v	The provider will use the "Look-up Tool" located on our website. The provider enters the service code and the tool will report if a PA request is needed (as well as a link to where the PA request can be submitted, if required). https://www.eptestitransact.com/HSP_HT/iTransact/Provider/AuthorizationLookup.aspx	The Benefit Grids outline service codes, service limits, level of care and documentation requirements needed for service authorization requests (SARs). The requirements for unmanaged services are also outlined in the Benefit Grids. The Benefit Grids can be located at: https://providers.partnersbhm.org/benefit-grids	There is a list of services that require prior authorization in the provider handbook and on the website. Right now we use a "master grid," which tells the PA requirements, but that will be re-worked for Tailored Plans. https://www.sandhillscenter.org/for-providers/provider-forms	Trillium Health Resources benefit plan will include all services and which services need a prior authorization. The benefit plan will be available at www.trilliumhealthresources.org under For Providers, Benefit Plans | Service Definitions	Providers can determine the services that require prior authorization by reviewing Vaya's authorization guidelines, available at https://providers.vayahealth.com/authorization-billing/authorization-info/authorization-guidelines/.
How can providers submit a prior authorization to a Tailored Plan? Does this process	Providers can use one of the following PA submission process: Portal, Fax or Telephone. Behavioral Health, Physical Health, Durable Medical	The provider will use the "Look-up Tool" located on our website for all claim types. The provider enters the service code and the Tool will report if a PA request is needed (as well as a link to where the PA request can be submitted, if	Prior authorization requests for Physical Health, Behavioral Health, and PADP are submitted through ProAuth which is linked from ProviderCONNECT under SSO.	Providers will enter all authorizations into our JIVA program. Access to JIVA will be controlled through Alpha +. https://alphaplusshc.com/portallogin	For Behavioral Health UM Prior Authorization - Authorization request for mental health, substance use disorder and I/DD services will be requested using the appropriate primary ICD-10-	The process to submit requests for prior authorization may differ depending on the claim type. Physical and behavioral health providers should submit claims/authorizations through

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differ based on claim type?	Equipment, Pharmacy, Non-Emergency Medical Transportation Prior Approval requests may be submitted via phone, fax, or portal entry. Vision Prior Approval requests may be submitted via fax or portal entry.	required). The provider will click the PA link which will take them to the applicable PA request form.	Prior authorization request for radiology are submitted through RadMD which can be accessed through ProviderCONNECT under SSO.	Pharmacy claims will not be submitted on paper.	CM diagnosis codes to the highest level of specificity that meets medical necessity in the range of F10-F99 dx using the Trillium Business System (TBS). For physical health UM Prior Authorization- Authorization request for physical health will be requested with a primary medical ICD-10 diagnosis code to the highest level of specificity that meets medical necessity excluding the range of F10-F99 dx using Trillium Physical Health prior authorization portal. **Imaging Services Prior Authorization** - Prior authorization is required for non-emergent, advanced, outpatient imaging services. Prior Authorization requests for advanced imaging services are submitted to National Imaging Associates (NIA). Only non-emergent procedures performed in an outpatient setting require Authorization with NIA. This does not include hospital inpatient,	Vaya's Provider Portal. Vision, NEMT, and pharmacy providers should submit to the respective vendor portal. Instructions and links to vendor portals are shared in Vaya's Provider Portal and included below for reference. **Medical and Behavioral Health** - Vaya Provider Portal: https://providerportal.vayahealth.com/ **Pharmacy Benefit Management**: Navitus offers an electronic portal and review system for pharmacy UM request submission. The Navitus portal can be accessed from Vaya's portal. Requests may also be submitted via phone (800-540-6083), fax (855-673-6507), or U.S. mail: Navitus Health Solutions LLC Attn: Prior Authorizations 1025 West Navitus Drive, Suite 600 Appleton, WI 54913 **Vision** - Avesis Provider Portal: www.avesis.com/Government3/Provider/Index.aspx **NEMT** - Modivcare Provider Portal: Upon contracting with Modivcare, providers will need to set up login credentials to Modivcare's portal, which can be accessed at: https://www.modivcare.com/login

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					observation, or the Emergency Room. Services managed and authorized by NIA include outpatient: CT/CTA - CCTA - MRI/MRA - PET Scan - MUGA Scan - Myocardial Perfusion Imaging (MPI) - Stress Echocardiography - Echocardiography Prior authorization requests can be made online at: www.RadMD.com **Durable Medical Equipment Prior Authorization** - Prior authorization is required for: DME purchases costing $500 or more - DME rental of $250 or more - Orthotics/Prosthetics billed with an "L" code costing $500 or greater - Orthotics/Prosthetics rental of $250 or greater Prior authorization requests for durable medical equipment are submitted through Trillium Physical Health prior authorization portal.	For additional information on submitting authorizations, see : https://providers.vayahealth.com/authorization-billing/authorization-info/authorization-guidelines/

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					Pharmacy Prior authorization request is submitted to PerformRx, Trillium's Pharmacy Benefits Manager (PBM). Prior authorizations may be submitted via phone 1-855-662-0277 or Fax 1-833-726-7628. PA forms to be faxed will be found on Trillium's website (closer to go-live). **Non-Emergency Medical Transportation Prior Authorization** Any trip over 75 miles one way requires prior authorization Out of state trips-Prior authorization is required for trips over 75 miles on way Commercial air trips require prior authorization Prior Authorization requests and claims for Non-Emergency Medical Transportation are to be submitted to Trillium's transportation broker. Trillium Transportation Services- 1-877-685-2415	
What member ID should be used when submitting claims?	Medicaid ID	Medicaid ID	Providers are able to submit claims with the NC Medicaid ID.	Medicaid ID	Providers are able to submit claims with the NC Medicaid ID.	Providers should use the member's Medicaid ID or Vaya member ID when submitting claims.
How should an out of network provider submit physical health claims?	Alliance Health can receive Claims via Electronic (837) and ACS Portal; Claims may be keyed directly into the ACS Provider Portal. This is a web-based	Providers that use clearinghouse already enrolled with Eastpointe; can submit claims through 837. OON providers can submit paper	Providers will access Provider Connect for electronic claim submission at: https://id.partnersbhm.org/	Providers may submit all claims electronically, through Portal or paper. All claims will come through Change Healthcare. Providers are able to key claims	Physical health claims and physician-administered (professional) drug claims are processed through Trillium's partner, CCH and may be	To take advantage of faster claims processing and payment turnaround, OON providers delivering non-emergency physical health

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	portal that allows providers to submit claims to the LME/MCO. Within the ACS portal, claims can be submitted via a CMS 1500/UB04. ACS Portal Link: https://acs.alliancehealthplan.org/portallogin. Electronic submissions can be submitted by EDI (through a clearinghouse) for both In-network and Out-of-network providers with Alliance Health Payer ID 23071. Providers will also need to submit a Trading Partner Agreement and Connectivity Form: https://www.alliancehealthplan.org/document-library/60057. Paper Claim Submission - Although electronic submission is preferred, an OON provider may also submit a paper claim by mail with approved request to: 5200 W. Paramount Parkway, Suite 200, Morrisville, NC 27560 Sending a fax is not an accepted submission format. Alliance claims submission support is available via phone 919-651-8500 or email claims@alliancehealthplan.org	claims, fax the claims or via secure email.	Availity - Medicaid Tailored Plan Physical Health perform	in Change Healthcare provider portal or submit 837P or 837I. Sandhills EDI Tailored Plan Payer ID: SHC00 Providers will have different Payer options based off the services they provide. Physical Health only: Payer Id 14816 Behavioral Health only: Payer Id SHC30 Both Physical and Behavioral: Payer ID SHC00 Paper Claims: Sandhills Center Tailored Plan PO Box 981746 El Paso, Tx 79998-1746	submitted using HIPAA Standard Electronic Transaction set and can be accomplished by a secure web-based Provider Portal (Physical Health Secure Provider Portal), via secure FTP, and a provider can submit their claims through a clearinghouse. CCH utilizes the clearinghouse Availity. As long as the provider's clearinghouse has a connection to Availity, then the claim can be passed on to CCH. **CCH's Medical Payer ID is 68069.**	services should submit claims electronically unless they have an approved exception. OON providers who need technical assistance or want to request an exception should contact claims@vayahealth.com. OON providers delivering emergency services may submit paper claims. Prior to claim submission, all providers must submit a completed IRS W-9 form and EFT form. Paper Submission: Vaya does not accept paper claims via facsimile. OON providers must submit paper claims using an accurate CMS1500 or UB04 billing form to the following address: Vaya Health Attn: Claims and Reimbursement 200 Ridgefield Court, Suite 218 Asheville, NC 28806 For more resources on submitting claims to Vaya, see the following link: https://providers.vayahealth.com/authorization-billing/claims/claims-submission/
Which provider manuals should providers use for each claim type	**Alliance:** Refer to the claims manuals on the Alliance webpage and ACS University for physical and behavioral claims.	The Eastpointe's Provider Manual will be used, and will include all claim types https://mco.eastpointe.net/Docum	**Medicaid Tailored Plan Behavioral Health, State Benefit and Pharmacy**	Sandhills Provider Manual has information regarding all claim types, in addition our billing guide has more detailed	**Behavioral Health** - Trillium Provider Manual Physical Health - CCH Provider Manual (https://network.carolinacom	Behavioral health, physical health, and DME providers should use the Vaya Tailored Plan Provider Operations

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(behavioral health, physical health, vision, pharmacy, DME, NEMT, etc.)	Pharmacy claims will be submitted directly from the pharmacy's system to Navitus. Providers will submit DME, Vision and NEMT claims directly to these vendors. **DME**: Northwood Provider Manual can be found at https://northwoodinc.com/alliance-health-plan/ **Vision:** Vision Provider Manual can be found at https://www.avesis.com/Commercial3/Index.aspx **NEMT**: Modivcare Provider Manual can be found at Modivcare Provider Portal: https://www.modivcare.com/login	entBrowser/file/TPwebsite/Providers/Provider_Manual.pdf	Partners Provider Operations Manual https://providers.partnersbhm.org/wp-content/uploads/partners-provider-operations-manual.pdf **Medicaid Tailored Plan Physical Health, Vision, DME and NEMT** https://network.carolinacompletehealth.com/resources/manuals-and-forms.html	documentation (in review) and will be available soon. Sandhills Center Provider Page	pletehealth.com/resources/manuals-and-forms.htmlv) **Vision** - CCH Provider Manual (https://visionbenefits.envolvehealth.com/docs/forms/OMV-Provider-Manual.pdf) **Pharmacy** - PerformRx Provider Manual (https://www.performrx.com/who-we-help/providers/provider-resources.aspx) **DME** - CCH Provider Manual (https://network.carolinacompletehealth.com/resources/manuals-and-forms.html) **NEMT** - Modivcare Provider Manual - available once provider contract signed	Manual effective Dec. 1, 2022. This manual will be updated on or before Oct. 1, 2023 to reflect any NCDHHS changes. The manual can be found at: https://providers.vayahealth.com/resources/prv15-tp-vaya_provider_ops_manual_final_08-07-22/ Avesis contracted vision providers should use the Avesis (Vision) provider manual: https://www.avesis.com/pdf/Provider%20Manual.pdf NEMT-contracted providers should use the Modivcare NEMT provider manual. To access the Modivcare provider manual, providers should log in using the following link: https://www.modivcare.com/login Pharmacies contracted with Vaya's PBM should use the Navitus provider manual: https://pharmacies.navitus.com/Secured-Pages/Nav/Resources/Pharmacy-Provider-Manual-(1).aspx
How can providers appeal a claim for underpayment, denial, etc.?	**Alliance**: Providers can send an email to "Claimsreconsideration@Alliancehealthplan.org" **DME**: If payment received is other than anticipated Providers may submit a completed Claim	Providers may submit appeals via the online portal with any supporting documentation. Providers that need assistance may contact Grievance and Appeals or the Provider Service Line at 888-977-2160.	Providers have the option to call the Claims Department or email the claims review form prior to an appeal if questioning an underpayment or denial, etc.	Providers may submit a ticket through our Support Portal for help with claim denials or questions. https://support.sandhillscenter.org	To appeal a claims action (denial, underpayment, etc.), providers must submit a detailed, written appeal request, including the corresponding claim number(s), the claim action(s) being appealed, and	Providers may appeal a claim denial and other claims-related adverse actions taken against them. Please refer to Vaya's Provider Operations manual for details and further information.

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	Status Form (see Section XII of the Northwood Provider Manual) within the claim filing limits **Vision**: Providers can submit a vision claim appeal within 30 days from explanation of payment to Avesis Appeals via mail **NEMT**: Denied trips will need to be corrected on the trip logs and resubmitted to virginia.billingoperations@modivcare.com. For payment disputes (short pays), the attached request form must be submitted and sent via Excel format to phxopsspecialist@modivcare.com.		Partners must allow a participating provider to appeal an adverse decision. Appeals from a network provider will be available for the following reasons: • Program Integrity related findings or activities • Finding of waste, or abuse by Partners • Finding of or recovery of an overpayment by Partners • Withhold or suspension of a payment related to waste, or abuse concerns • Termination of, or determination not to renew, an existing contract for Local Health Department care/case management service • Determination to de-certify an Advanced Medical Home+ or CMA (applicable to Medicaid providers only) • Violation of terms between Partners and provider • Appeals from an out-of-network provider will be available for the following reasons: • An out-of-network payment arrangement • Finding of waste or abuse by Partners • Finding of or recovery of an overpayment by Partners https://providers.partnersbhm.org/wp-content/uploads/partners-provider-operations-manual.pdf https://providers.partnersbhm.org/provider-disputes/	If an official appeal is needed, providers can submit an appeal by • Phone: 800-241-1073 • Fax: 336- 389-6543 • Mail: Sandhills Center Appeals Coordinator P.O. Box 9 West End, NC 27376 • In person- 3802 Robert Porcher Way Greensboro, NC 27410 or 185 Grant Street West End, NC 27376.	information that permits member or recipient identification. Additionally, providers may submit any documentation that they feel would assist in the appeal resolution. To submit a claims appeals request, provider may: • Utilize Trillium's on-line Provider Portal, Provider Direct; • Fax the appeal request to 252-215-6879; • Email the appeal, via secure e-mail, to Appeals@trilliumnc.org; or • Mail the appeal, hardcopy, to: Attn: Appeals Department 201 W. 1st St. Greenville, NC 27858	Pharmacy providers may submit appeal requests to Navitus by mail, telephone, or facsimile: Mail: Navitus Health Solutions LLC, Attention: Appeals/Grievance Coordinator, PO Box 999, Appleton, WI 54912-0999 Telephone: 800-540-6083 Fax: 855-673-6507 Vision providers may submit appeal requests to Avesis: Telephone: Avesis Provider Grievance Line: 800-843-0558 Email: Avesis Grievance and Appeals at AG@avesis.com NEMT providers may submit appeal requests to Modivcare via telephone or email: Telephone: Modivcare's Provider Transportation 855-397-3604 Email: Submit the Provider claims dispute form to PHXOpsSpecialist@modivcare.com. All other providers may appeal a claim denial and other adverse actions described in Vaya's Provider Operations Manual directly to Vaya. Network Providers must submit a timely request for an appeal via the Appeals section in the Provider Portal. OON Providers may submit provider appeal requests via email to

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						ClaimsReconsideration@vayahealth.com for appeals of claim denials and to ProviderReconsiderations@vayahealth.com for all other appeals. Vaya does not accept provider appeal requests through any other method.
Where can a provider find your list of Known Issues?	Known Issue Tracker can be found here: www.alliancehealthplan.org/providers/network/issue-tracker/	"Claims Known Issues Tracking Log" at bottom of the page https://www.eastpointe.net/providers/	It will be posted on Partners website under Claims and Rates Information. https://providers.partnersbhm.org/	We will have claim related known issues here: https://tp.sandhillscenter.org/claims-submissions-tp	Trillium's known issue tracker will be available on our website at www.trilliumhealthresources.org On our website, Select For Providers, and it is located in the links.	Providers can find the list of known issues within the Vaya Provider Portal on the "Announcement" page. Vaya Health Sign in (b2clogin.com)