Welcome To Ambetter from Sunflower Health

Your Partner In Better Healthcare

2026 Provider Orientation

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 Member Eligibility, Benefits and Cost Shares
- Referrals
- Prior Authorization
- Claims, Billing and Payments
- Complaints, Grievances and Appeals
- Specialty Companies and Vendors

QUESTIONS & ANSWERS

2026 PROVIDER ORIENTATION

OVERVIEW

WE ARE AMBETTER HEALTH

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

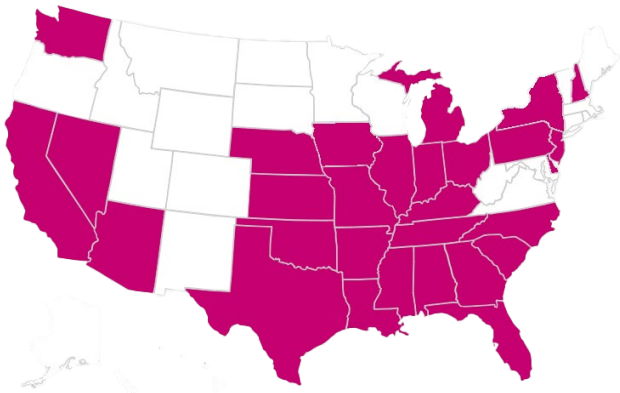
#1 carrier
on the Health Insurance Marketplace*

5.7M+
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
Ambetter launched its first Marketplace plans

29
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.

We

- **Target a focused demographic**
- **Lower-income, previously uninsured or Medicaid-eligible individuals and families**

PARTNERSHIP

- The Ambetter Health plan designs are built to support subsidy-eligible individuals and families purchasing coverage through the Health Insurance Marketplace.
- Ambetter Health products offer a range of cost-sharing options, including plans with low or no copays, tailored to meet the financial and healthcare needs of our members.
- The emphasis on reducing barriers and improving access to care mitigates the risk of individuals showing up without insurance (uncompensated care). Ambetter Health's cost-sharing lowers member costs and eases provider collections at care.
- 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

Key Objectives:

- Expand access to affordable, quality health coverage for individuals & families
- Make healthcare more affordable through subsidies and cost-sharing reductions

Additional Parameters:

- Coverage for dependents up to age 26*
- No lifetime maximum benefits
- Preventative care covered at 100% when provided by in-network providers
- 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 federal tax penalty for not having minimum essential coverage; however, some states may impose their own penalties.
- 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).
- Cost-Sharing Reductions (CSRs) are available to eligible individuals/families with household incomes between 100% and 250% of the Federal Poverty Level (FPL) and are available only on silver-level enrolled in a qualified health plan.

*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 —Kansas 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)

The amount of cost shares such as copays, coinsurance, and deductibles vary by plan type and subsidy eligibility.

- CSR eligibility is determined by household income relative to FPL and family size, as defined in ACA statute and regulations.
- Eligible individuals can receive financial assistance in the form of Advanced Premium Tax Credits (APTCs) and CSRs when purchasing Qualified Health Plans (QHPs) through Healthcare.gov or approved direct enrollment platforms.

2026 PROVIDER ORIENTATION

OUR NETWORKS

OUR NETWORKS

- Ambetter Health offers a diverse suite of network options tailored to meet the coverage and budget needs of Marketplace members.
- By offering increased product options, Ambetter also benefits providers by giving them exclusive access to new patient populations.
- Each Ambetter Health network is designed to meet the specific coverage needs of members in their respective states. Plan structures, covered benefits, and referral requirements may vary by state and network type. 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.
- Providers must confirm the member's network and plan before delivering services to ensure coverage and compliance with referral or authorization requirements. This information is located on the member's ID card and can also be confirmed when verifying the member's eligibility.

Networks Built 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.
- ***New in 2026*** - SOLUTIONS*: Ambetter Health Solutions is designed to support individuals enrolled through an individual coverage health reimbursement arrangement (ICHRA). This arrangement enables employers to contribute tax-free funds toward employees' individual health insurance premiums. Employees can use these funds to purchase coverage from any carrier offering individual plans in their area. Ambetter Health Solutions is an off-exchange product built on the existing Ambetter network and benefits, leveraging established provider relationships. It is available to individuals using ICHRA to obtain coverage.

*Network availability varies by state.

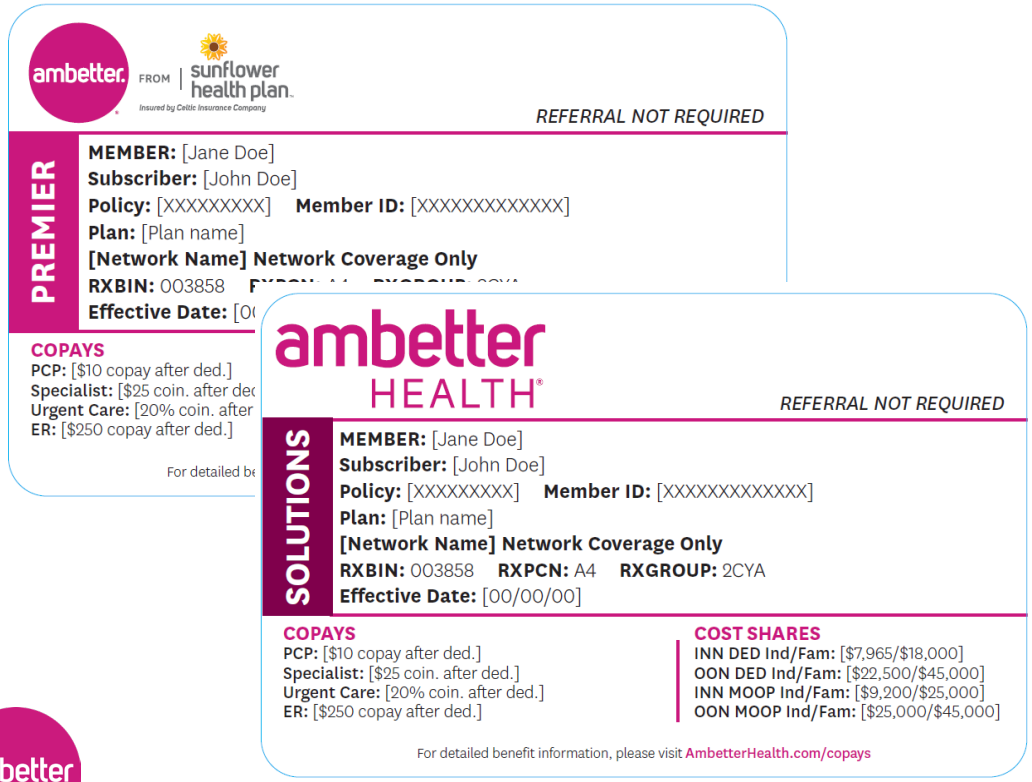
Our Innovative Networks

VIRTUAL 24/7 CARE

- All Ambetter Health members have access to virtual services through Teladoc Health.
- 24/7 help for non-emergency medical issues through Virtual 24/7 Care.
- Ability to connect with experts regardless of physical location.
- Easy way to get fast care when in outlying or rural areas.
- Avoid long wait times at in-person urgent care clinics or physician offices.

Teladoc Health

HOW TO IDENTIFY A MEMBER'S NETWORK



All members receive an Ambetter member identification card. Ambetter member ID cards include key information such as:

- The specific **Ambetter Health plan** selected by the member.
- The **Provider Network** associated with the member's plan.
- **Referral requirements**, if applicable, based on the member's network type.

Note: *Member ID cards do not guarantee eligibility. Providers must verify eligibility on the date of service using the Secure Provider Portal or Provider Services.*

2026 PROVIDER ORIENTATION

WHAT YOU NEED TO KNOW

KEY CONTACT INFORMATION

Ambetter Health

PHONE 1-844-518-9509

TTY 711

WEB
ambetterhealth.com/en/ks/

PORTAL
provider.sunflowerhealthplan.com

AMBETTER PROVIDER MANUAL

THE PROVIDER MANUAL IS YOUR COMPREHENSIVE GUIDE TO DOING BUSINESS WITH AMBETTER FROM SUNFLOWER 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 section of the Ambetter from Sunflower Health Plan website.

HEALTH PLAN NOTIFICATIONS

HOSPITAL RESPONSIBILITIES

Hospitals must:

- Notify the PCP immediately or no later than the close of the next business day after the member's emergency room visit.
- Obtain authorizations for all inpatient and selected outpatient services listed in the Pre-Auth Needed tool available at **ambetterhealth.com/en/ks/**, except for emergency stabilization services;

Notify the Medical Management department:

- By either calling or sending an electronic file of the ER admission within **one business day**; the information required includes the member's name, member ID, presenting symptoms/diagnosis, date of service, and member's phone number.
- Of all admissions via the ER within **one business day**.
- Of all newborn deliveries within **one day of the delivery**; notification may occur by our Secure Provider Portal, fax, or by phone; and
- Adhere to the standards set in the Timeframes for Prior Authorization Requests and Notifications table in the Medical Management section of the provider manual.

HEALTH PLAN NOTIFICATIONS

Notification of Pregnancy

Providers should notify the health plans immediately of any member who is expecting.
This notification allows member to take advantage of the Start Smart for your Baby program.

Notification of Pregnancy Surrogacy

Providers should notify the health plan immediately of any member intending to come into a contractual agreement or is expecting because of surrogacy. All pregnancy related services provided to a surrogate mother are not covered, including but not limited to charges related to the baby's birth, hospitalization, or care because of surrogacy. Please see the Ambetter Evidence of Coverage for additional details.

Adding a Newborn or an Adopted Child

Coverage applicable for children will be provided for a newborn child or adopted child of an Ambetter member from the moment of birth or moment of placement for adoptions if the eligible child is enrolled timely as specified in the member's Evidence of Coverage.

APPOINTMENT AVAILABILITY

PRIMARY CARE & PEDIATRIC

Urgent Care: Within 24 hours of member's call

Non-Urgent/Sick Care: Within 48 hours of member's call

Routine: Within 15 business days of request

OBGYN

Urgent Care: Within 24 hours of member's call

Routine: Within 30 business days of request

SPECIALIST

Urgent Care: Within 24 hours of member's call

Routine: Within 30 business days

BEHAVIORAL HEALTH

Non-Life-Threatening Psychiatric Emergency: Within 6 hours of contact

Urgent: Within 48 hours of request

Routine (Initial Assessment or Follow Up): Within 10 business days

AFTER HOURS ACCESSIBILITY

Members must be able to access their providers 24-hours a day, 365 days a year

- Provider's office phones must be answered during normal business hours
- Messages left during normal business hours should be returned the same day

Members must be able to access their provider after normal business hours and on weekends by either

- Answering service or system that will page physician
- Answering system with option to page physician
- Advice nurse with access to physician
- Answering service that will page the physician after message is left

Unacceptable after-hours coverage include, but not limited to:

- A recording telling callers to leave a message
- A recording telling callers to go to an emergency department
- Calls not returned within 30 minutes

Sunflower will monitor providers' offices through scheduled and unscheduled visits and audits. It is recommended to record the message banner in English and Spanish. All pre-recorded messages must be high-quality, informative, and provide callers with certainty that they have reached the practice whose number they dialed. A member should, at minimum, have a means for leaving a message and should be told when to expect a return call.

PROVIDER SERVICES

The **Ambetter from Sunflower 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 or making changes to an existing group

By calling **Ambetter from Sunflower Health Plan** Provider Services at **1-844-518-9505**, providers can access real-time assistance for all their service needs.

PROVIDER NETWORK OPERATIONS

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

Please send the following items to sunflowerstatehealth@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**

PROVIDER ENGAGEMENT

- As an **Ambetter Health** provider, you will have a dedicated Network Performance Advisor available to assist you
- Our Provider Engagement Account Managers and Network Performance Advisors serve as the primary liaisons between Ambetter and the provider network
- Your Network Performance Advisor is here to help you operate your practice and address needs, such as:

- **Inquiries related to administrative policies, procedures, and operational issues**
- **Contract clarification**
- **Membership/provider roster questions**
- **Secure Portal registration, PaySpan enrollment, and Availity Essentials onboarding support**
- **Provider education**

Contact Us at Ambetter_KS_PR@sunflowerhealthplan.com

QUALITY PRACTICE CONSULTANT

- As an **Ambetter from Sunflower Health Plan** provider, you will have a team of Quality Practice Consultants available to assist you
- Our Quality Practice Consultants serve as the primary liaisons between our health plan and the provider network
- Your Quality Practice Consultants is here to help your practice and address needs, such as:

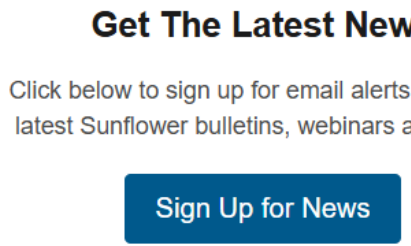
- **Performance pattern monitoring**
- **Provider education**
- **HEDIS/care gap reviews**
- **Financial analysis**
- **EHR utilization**

Contact Us at providerengagement@sunflowerhealthplan.com

TRAINING

- Annual Cultural Competency Training available On Demand.
- Project ECHO offers free continuing education credit quarterly
- Office Hours offers an opportunity for guidance on navigating the health plan. See our website for session dates.

Sign up for Email Alerts to be notified of policy changes, check run updates and upcoming training sessions.



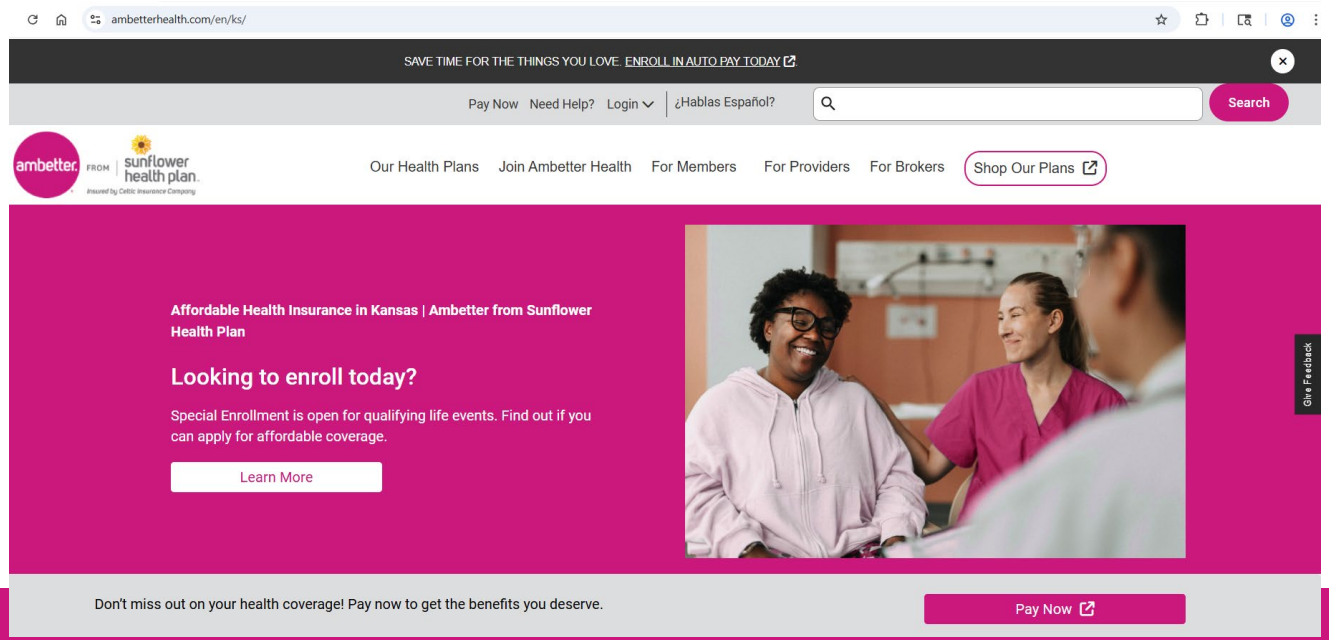
Provider Training Opportunities

2026 PROVIDER ORIENTATION

PUBLIC WEBSITE AND SECURE PORTAL

AMBETTER PUBLIC WEBSITE

ambetterhealth.com/en/ks/

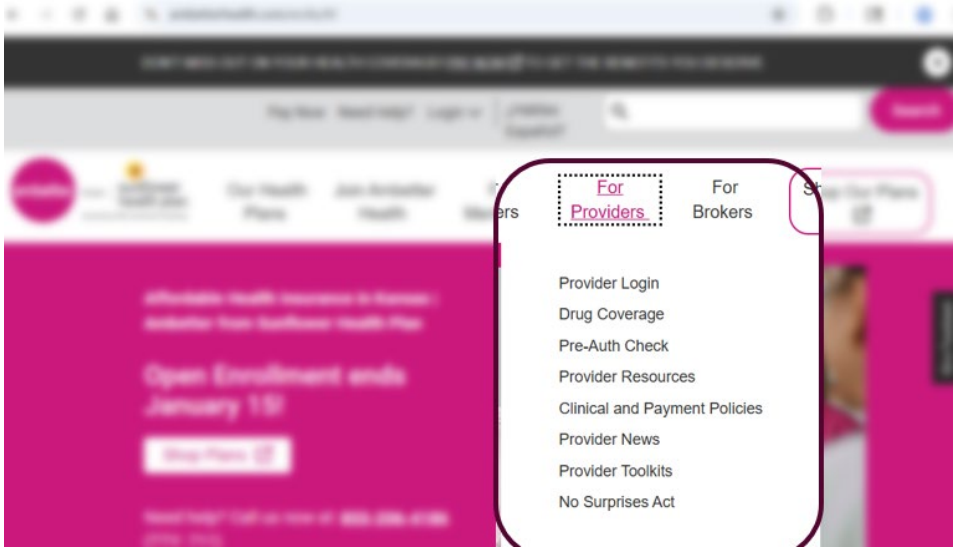


Ambetter Public Website

AMBETTER PUBLIC WEBSITE

WHAT'S ON THE PUBLIC WEBSITE?

- Provider Manual
- Provider Quick Reference Guides
- Important Forms such as Notification of Pregnancy, Prior Authorization Request Forms, and more.
- Pre-Authorization Lookup Tool
- Preferred Drug List (PDL)



Ambetter Public Website

CLINICAL & PAYMENT POLICIES

- Clinical policies are one set of guidelines used to assist in administering health plan benefits, either by prior authorization or payment rules.
- Claims payment policies are guidelines used to assist in administering payment rules based on generally accepted principles of correct coding.
  Ambetter Clinical & Payment Policies

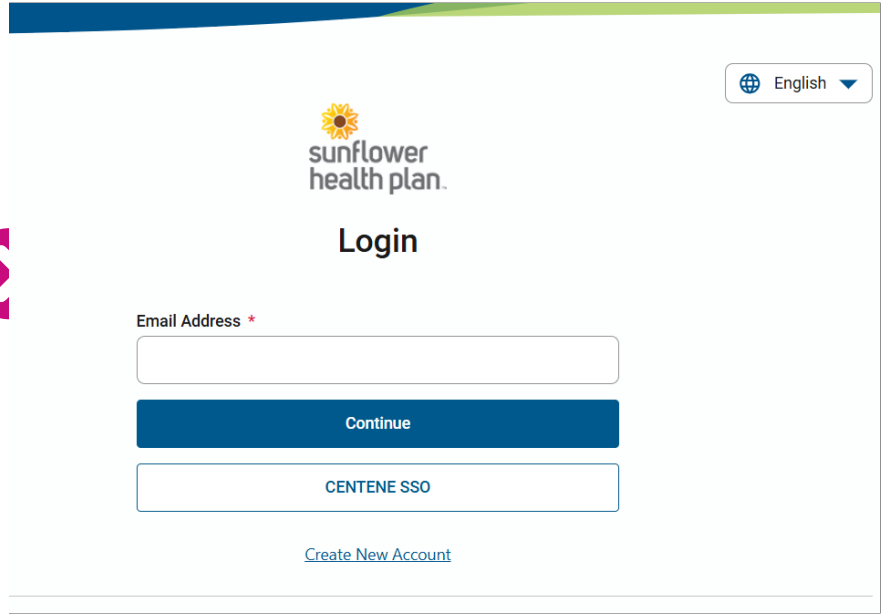
AMBETTER PAYMENT POLICIES

POLICY #	TITLE
CC.PP.007	Maximum Units (PDF)
CC.PP.008	Cerumen Removal (PDF)
CC.PP.009	Unlisted Procedure Codes (PDF)
CC.PP.010	EM Bundling Edits (PDF)
CC.PP.011	Coding Overview (PDF)
CC.PP.012	IV Hydration (PDF)
CC.PP.013	Modifier -25 clinical validation (PDF)
CC.PP.014	Modifier -59 clinical validation (PDF)

Health Plan Policies

SECURE PROVIDER PORTAL

- Registration is free and easy!
- Contact the Account Manager within your office, or your Ambetter Network Performance Advisor or Provider Engagement Account Manager to begin registration.



Secure Provider Portal

SECURE PROVIDER PORTAL

WHAT'S ON THE SECURE PROVIDER PORTAL?

- Member eligibility verification and patient panel listings
- Care gap reports and quality measure tracking
- Submit and track prior authorizations
- Submit claims and check claim status
- Submit corrected claims and request adjustments
- Payment history
- Monthly PCP performance and cost reports
- Provider performance and utilization analytics
- Referral submission for Value network plans

SECURE PROVIDER PORTAL

INSIGHTFUL REPORTS

PCP reports available on **Ambetter** 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

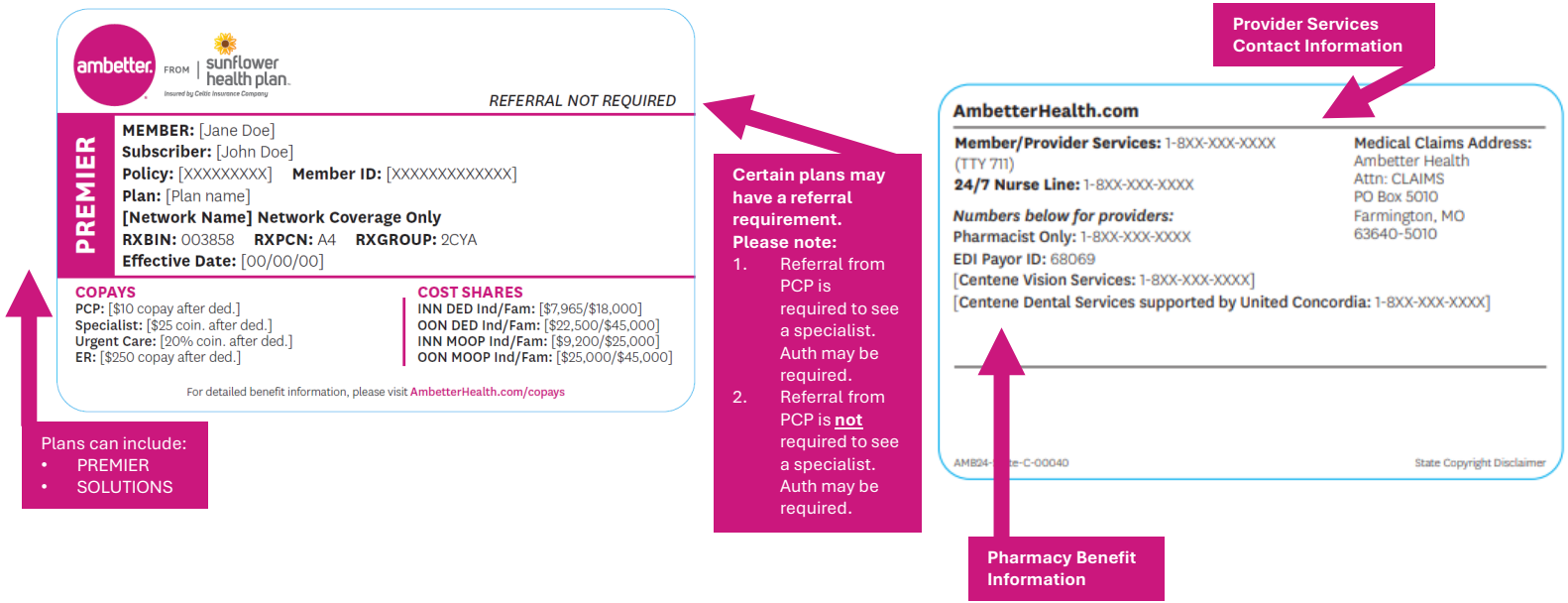
Ambetter Health has transitioned to Availity Essentials as its secure provider portal for eligibility, claims, authorizations, and payer resources.

- The legacy Ambetter Secure Provider Portal remains available for select functions during the phased transition.
- An Availity administrator at your office is the person responsible for registering their practice in Essentials, managing user accounts, and should have legal authority to sign agreements for their organization.
- Practice administrators can register for Availity Essentials at:
  - **www.Availity.com/documents/learning/LP_AP_GetStarted**
  - 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.

2026 PROVIDER ORIENTATION

VERIFICATION OF ELIGIBILITY, BENEFITS AND COST SHARES

MEMBER ID CARD



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 using Secure Provider Portal. The patient list includes member name, ID number, date of birth, care gaps, disease management enrollment, and product enrollment.
- PCPs may administer services even if the member is not currently assigned to their panel, and request reassignment for future care.

Verification of Eligibility, Benefits and Cost Share

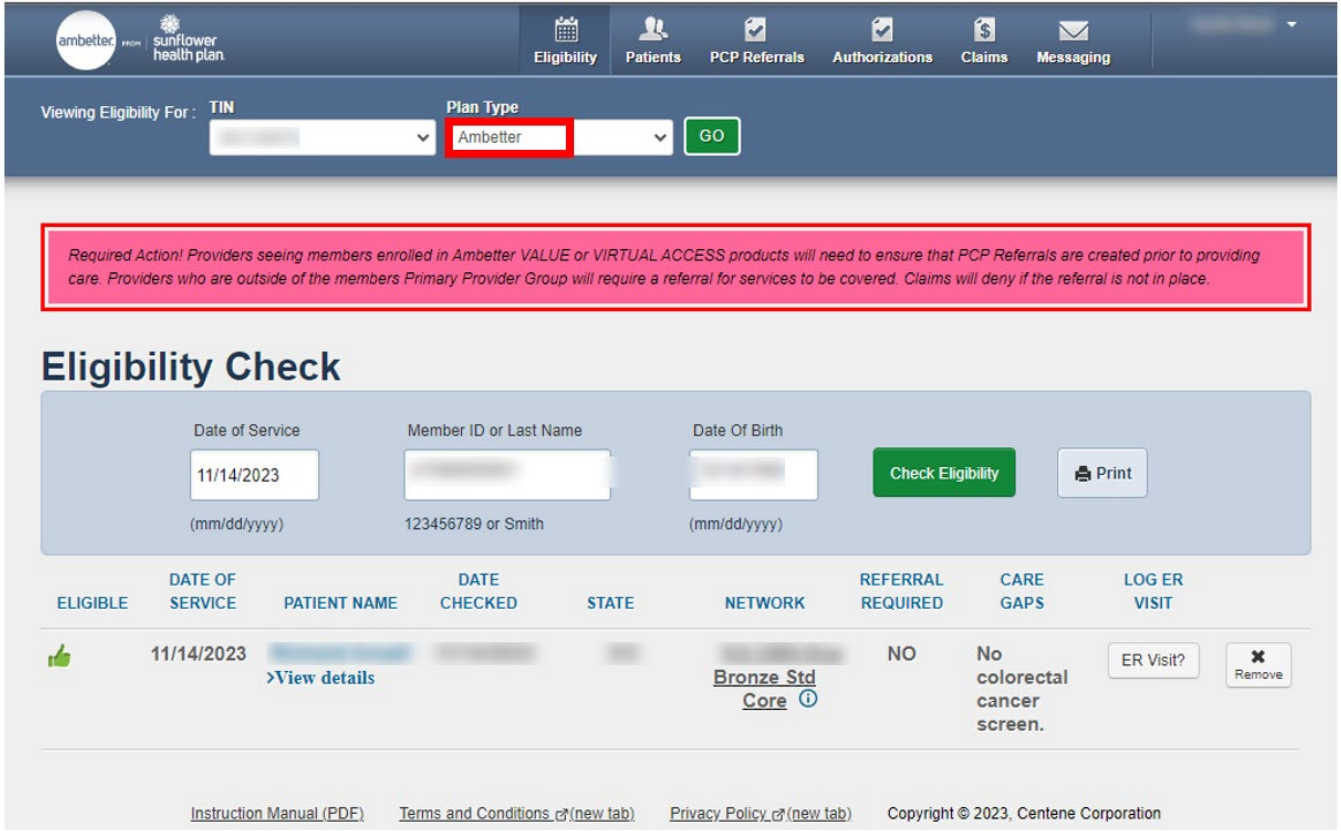
ELIGIBILITY, BENEFITS AND COST SHARE

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

- **The Ambetter Secure Portal.** If you are already a registered user of the Sunflower 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:** 1-844-518-9505

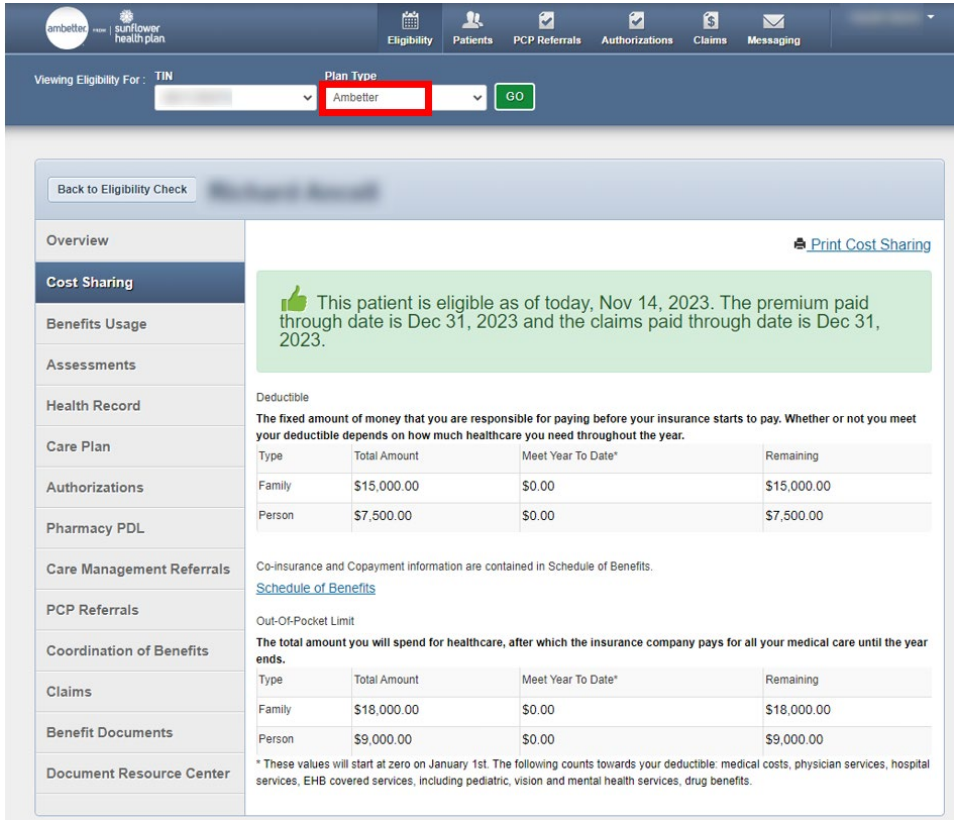
Verification of Eligibility, Benefits and Cost Share

VERIFICATION OF ELIGIBILITY ON THE PORTAL



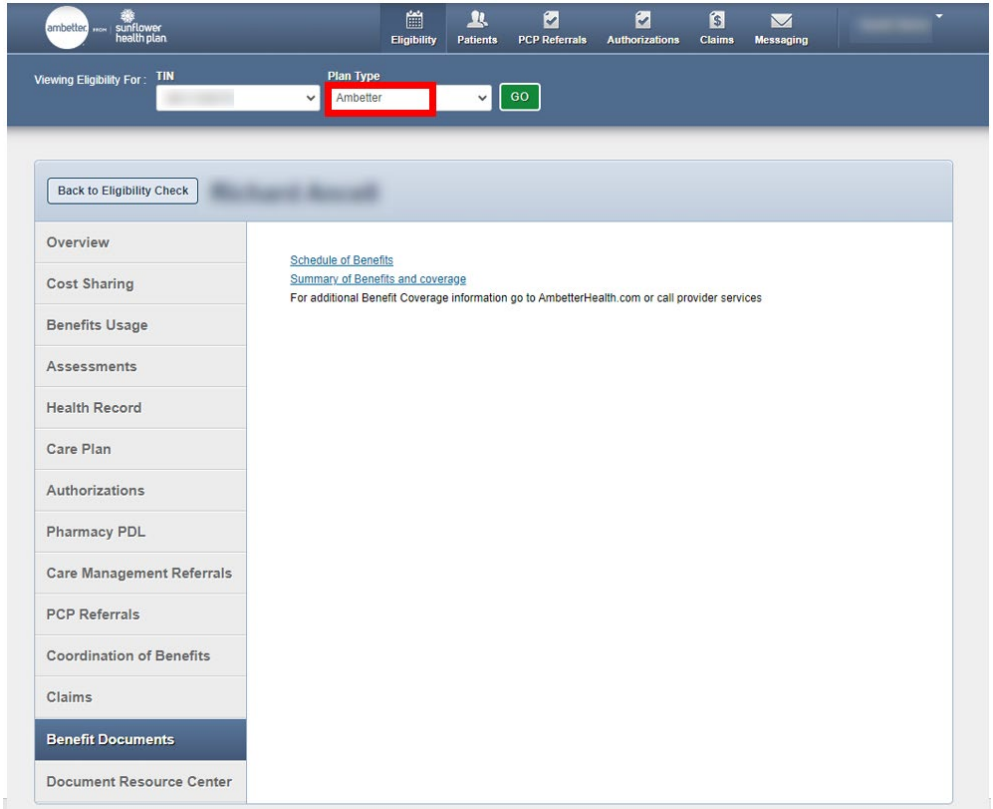
*Be sure the Plan Type is set to Ambetter.

VERIFICATION OF COST SHARES ON THE PORTAL



*Be sure the Plan Type is set to Ambetter.

VERIFICATION OF BENEFITS ON THE PORTAL



*Be sure the Plan Type is set to Ambetter.

2026 PROVIDER ORIENTATION

PRIOR AUTHORIZATION

HOW TO SECURE A PRIOR AUTHORIZATION

NEED PRIOR AUTHORIZATION?

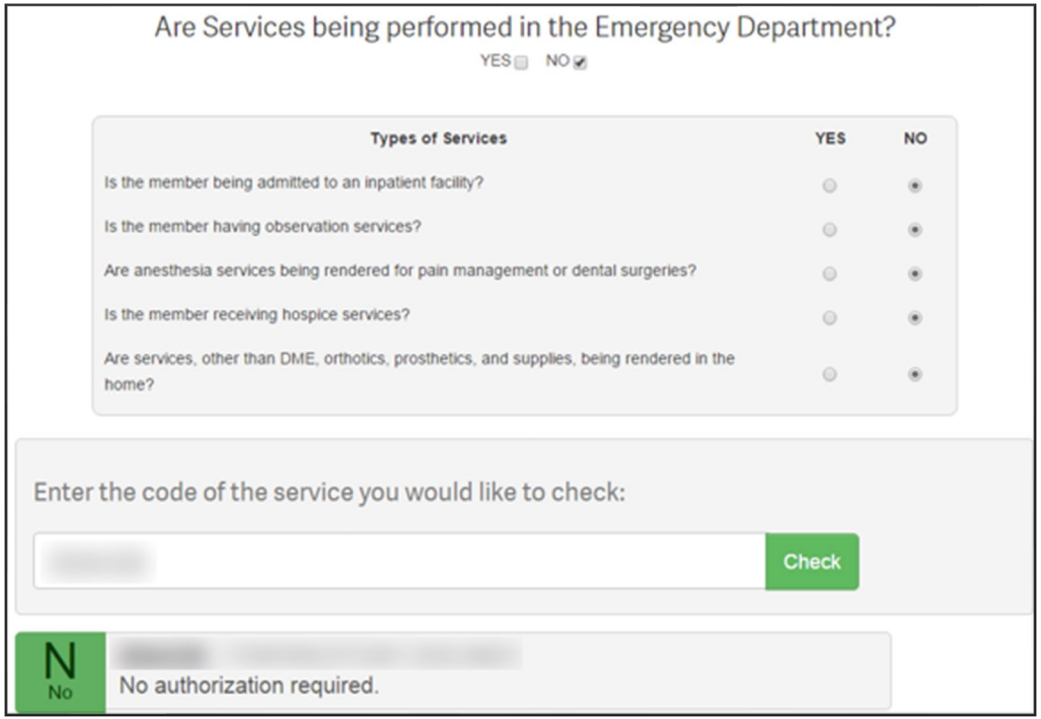
Submit requests using one of the following methods:

- Secure Provider Portal (This is the preferred and fastest method.)
- Phone: Contact the Utilization Management Department using the number listed on the member's ID card. **1-844-518-9505**
- Fax: Use the Prior Authorization Fax Forms available on the Ambetter website. Fax submissions are reviewed during business hours only.**1-844-474-7115**

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 Sunflower Health Plan website at ambetterhealth.com/en/ks/



REQUIREMENTS

Services that require prior authorization include*:

- All inpatient admissions
- Selected outpatient services
- Experimental or investigational treatments
- High-tech imaging (e.g., CT, MRI, PET)
- Infertility services
- Pain Management procedures
- Organ transplant evaluations
- Clinical trial services
- Out-of-network services (excluding emergency care)

**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/substance use
  - Hospice care
  - Rehabilitation facilities
  - Transplants, including evaluation
- Observation stays more than 23 hours require Inpatient Authorization
- Urgent/Emergent Admissions
- Partial Inpatient, PRTF and/or Intensive Outpatient Programs (IOP)

**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 REQUIRING PRIOR AUTHORIZATION INCLUDE*:

- Non-emergent air ambulance transport (fixed-wing)
- Durable Medical Equipment (DME)
- Home health care services:
  - Home infusion therapy
  - Skilled nursing care
  - Physical, occupational, and speech therapy
  - Private duty nursing
  - Adult medical day care
  - Hospice care
  - Medical supplies and equipment furnished in the home

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

Prior Authorization Timeframes

TIMEFRAMES

Type	Timeframe
Prospective/Urgent	Three calendar days
Prospective/Non-Urgent	15 calendar days
Emergency services	60 minutes (1 hour)
Concurrent/Urgent	24 hours (1 calendar day)
Retrospective	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 does **not** retro-authorize services.
  - Claims submitted without updated authorization will be denied.
  - Providers may appeal if extenuating circumstances prevented timely authorization.

Correct Coding for Prior Authorization

2026 PROVIDER ORIENTATION

CLAIMS, BILLING AND PAYMENTS

CLAIMS

WHAT IS A CLEAN CLAIM?

- A clean claim is one submitted in a nationally accepted format using current CPT, ICD-10 and HCPCS codes, without defects or missing documentation, and that meets all billing requirements for 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

The timely filing deadline for initial claims is 180 days* from the date of service, or date of primary payment, when Ambetter is secondary.

CLAIMS MAY BE SUBMITTED IN THE FOLLOWING WAYS:

- **The Secure Provider Portal**
- **Electronic Clearinghouse**
  - Payor ID 68069
  - Sunflower Health Plan uses Availity Clearinghouse
- **Mail**
  Ambetter
  P.O. Box 5010
  Farmington, MO 64640-5010

* PAR providers have 180 days, non-PAR provider have 90 days

LEVEL I DISPUTES / CLAIM RECONSIDERATION

CLAIM RECONSIDERATIONS

- For reconsideration requests, providers can use the **Dispute – Option 2** 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. Use the ***Provider Request for Reconsideration and Claim Dispute Form***
- Must be submitted within 180 days of the Explanation of Payment.
- Mail claim reconsiderations to:
  Ambetter from Sunflower Health Plan
  Attn: Level I - Request for Reconsideration
  PO 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 at Ambetter Provider Resources
- Mail completed Claim Dispute form to:

  Ambetter from Sunflower Health Plan Attn: Level II – Claim Dispute
  PO Box 5000
  Farmington, MO 63640-5000

CLAIM SUBMISSION SUSPENDED STATUS

WHAT IF A MEMBER IS IN SUSPENDED STATUS?

- After the first month of non-payment, the member enters a suspended status. The Explanation of Payment will indicate LZ Pend: Non-Payment of Premium.
- Under the ACA, members receiving Advanced Premium Tax Credits (APTCs) are granted a three-month grace period to pay outstanding premiums before coverage is terminated.
- During suspended status (months 2 and 3 of the grace period), claims may be pended or denied depending on payment status.
- When the premium is paid by the member, the claims will be released and adjudicated.
- If the member does not pay the premium by the end of the grace period, coverage is terminated retroactively, and providers may bill the member directly for services rendered during suspended status.

CLAIM SUBMISSION SUSPENDED STATUS

EXAMPLE TIMELINE OF A MEMBER IN SUSPENDED STATUS

- **January 1 -** Member pays premium
- **February 1 -** Premium due; member does not pay
- **March 1 -** Member enters suspended status (Month 2 of grace period)
- **April 1 -** Member remains in suspended status (Month 3 of grace period)
- **May 1 -** If premium remains unpaid, coverage is terminated retroactively. Provider may bill member directly for services rendered during suspended status.

Claims for members in suspended status may be pended or denied depending on payment status and are not considered "clean claims."

HELPFUL INFORMATION ABOUT CLAIMS

MAKE SURE TO INCLUDE THE RENDERING TAXONOMY CODE!

- Claims **must** include the rendering provider's taxonomy code and corresponding ID qualifier.
- Claims submitted without a valid taxonomy code will be rejected upfront and will not enter the adjudication system.
- For paper claims, include the taxonomy code in in Box 24J and 33b.
- For electronic claims, include it in loop 2310B/2420A and 2010AA.

REMINDER: DO NOT FORGET THE CLIA NUMBER!

- For CLIA-certified or CLIA-waived services, the CLIA number **must** be entered in **Box 23** of the CMS 1500 paper claim form.
- For electronic claims, report the CLIA number in loop 2300 or 2400 (REF02 with REF01 = X4).
- Claims missing CLIA numbers will be rejected upfront.

BILLING THE MEMBER

COPAYS, CO-INSURANCE AND DEDUCTIBLES

- Copays, coinsurance, and any unpaid portion of the deductible may be collected at the time of service. Providers must verify the member's benefit design and cost share responsibility prior to rendering services.
- Deductible information, including the amount paid toward the deductible, can be accessed via the Secure Provider Portal.
- If the amount collected from the member exceeds the actual liability after claim adjudication, the provider must reimburse the member within 45 days.

ELECTRONIC FUNDS TRANSFER – 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).
  - See the Guide for How to Register for PaySpan® Health on our website.

ELECTRONIC FUNDS TRANSFER

2026 PROVIDER ORIENTATION

COMPLAINTS, GRIEVANCES AND APPEALS

COMPLAINTS, GRIEVANCES AND APPEALS

CLAIMS

- If the Complaint/Grievance is related to claim(s) payment, the provider must follow the process for claim reconsideration and claim dispute.

COMPLAINT/GRIEVANCE

- Must be filed within 30 days from the date of the incident.
- Upon receipt of complete information to evaluate the request, Ambetter will provide a written response within 5 days acknowledging the request.
- Ambetter will resolve the grievance within 30 days and provide a written resolution notice.

COMPLAINTS, GRIEVANCES AND APPEALS

PROVIDER CLAIM APPEAL PROCESS

- Claim Appeal (Dispute) requests must follow the **claim reconsideration and claim dispute process.** A claim dispute should be used only when a provider has received an unsatisfactory response to a request for reconsideration.

MEMBER APPEALS PROCESS

- Must be filed within 180 days from the Notice of Action.
- Ambetter shall acknowledge receipt within 5 business 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 calendar days for post-service appeals and 15 business days for pre-service appeals.
- 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 Ambetter website.

2025 PROVIDER ORIENTATION

QUALITY IMPROVEMENT

QUALITY IMPROVEMENT PROGRAM

Goal of Quality Program

- Is to improve members' health status through a variety of meaningful quality improvement activities implemented across all care settings and aimed at improving quality of care and services delivered.
- Patient safety is integrated throughout many activities across the plan, but primarily through identification of potential and/or actual quality of care events.

Quality of Care Issues

- Require investigation of the factors surrounding the event to make a determination of their severity and need for corrective action, up to and including review by the Peer Review Committee as indicated.
- Received in the QI department are tracked and monitored for trends in occurrence, regardless of their outcome or severity level.

Quality Improvement

HEALTHCARE EFFECTIVE DATA INFORMATION SET (HEDIS)

- **HEDIS** is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) that allows comparison across health plans. It gives purchasers and consumers the ability to distinguish between health plans based on comparative quality instead of simply cost differences.
- **HEDIS** Scores – Physician-specific scores are used to measure PCP practice's preventive care efforts.
- How Can Providers Improve Their **HEDIS** Scores?

Knowledge & Understanding of HEDIS Measures	**Submit Claims Including CPT II & Encounter Claims**	**Chart Documentation Reflects Services Provided**	**Provide Medical Records When Requested**

Quality Improvement

2026 AMBETTER HEDIS MEASURES

- AAB - Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis
- AAF-E - Follow-Up After Acute and Urgent Care Visits for Asthma
- AAP - Adults' Access to Preventive/Ambulatory Health Services
- ADD-E - Follow-Up Care for Children Prescribed ADHD Medication
- AHU - Acute Hospital Utilization
- AIS-E - Adult Immunization Status
- APM-E - Metabolic Monitoring for Children and Adolescents on Antipsychotics
- APP - Use of First-Line Psychosocial Care for Children on Antipsychotics
- ASF-E - Unhealthy Alcohol Use Screening and Follow-Up
- AXR - Antibiotic Utilization for Respiratory Conditions
- BCS-E - Breast Cancer Screening
- BPC-E - Blood Pressure Control for Patients With Hypertension
- BPD - Blood Pressure Control for Patients With Diabetes
- CBP - Controlling High Blood Pressure
- CCS-E - Cervical Cancer Screening
- CHL - Chlamydia Screening
- CIS-E - Childhood Immunization Status
- COL-E - Colorectal Cancer Screening
- COU - Risk of Continued Opioid Use
- CRE - Cardiac Rehabilitation
- CWP - Appropriate Testing for Pharyngitis
- DBM-E - Documented Assessment After Mammogram
- DBO - Deprescribing of Benzodiazepines in Older Adults
- DMH - Diagnosed Mental Health Disorders
- DMS-E - Utilization of the PHQ-9 to Monitor Depression Symptoms
- DRR-E - Depression Remission or Response for Adolescents and Adults
- DSF-E - Depression Screening and Follow-Up for Adolescents and Adults
- DSU - Diagnosed Substance Use Disorders
- EDU - Emergency Department Utilization
- EED - Eye Exam for Patients With Diabetes
- FMA-E - Follow-Up After Abnormal Mammogram Assessment
- FUA - Follow-Up After Emergency Department Visit for Substance Use
- FUH - Follow-Up After Hospitalization for Mental Illness
- FUI - Follow-Up After High-Intensity Care for Substance Use Disorder
- FUM - Follow-Up After Emergency Department Visit for Mental Illness
- GSD - Glycemic Status Assessment for Patients With Diabetes
- HDO - Use of Opioids at High Dosage
- IET - Initiation and Engagement of Substance Use Disorder Treatment
- IMA-E - Immunizations for Adolescents
- KED - Kidney Health Evaluation for Patients With Diabetes
- LBP - Use of Imaging Studies for Low Back Pain
- LSC-E - Lead Screening in Children
- PBH - Persistence of Beta-Blocker Treatment After a Heart Attack
- PCE - Pharmacotherapy Management of COPD Exacerbation
- PCR - Plan All-Cause Readmissions
- PND-E - Prenatal Depression Screening and Follow-Up
- PNS-E - Postpartum Depression Screening and Follow-Up
- POD - Pharmacotherapy for Opioid Use Disorder
- PPC - Prenatal and Postpartum Care
- PRS-E - Prenatal Immunization Status
- SAA - Adherence to Antipsychotic Medications for Individuals With Schizophrenia
- SNS-E - Social Need Screening and Intervention
- SPC-E - Statin Therapy for Patients With Cardiovascular Disease
- SPD-E - Statin Therapy for Patients With Diabetes
- TSC-E - Tobacco Use Screening and Cessation Intervention
- UOP - Use of Opioids From Multiple Providers
- URI - Appropriate Treatment for Upper Respiratory Infection
- W30 - Well-Child Visits in the First 30 Months of Life
- WCC - Weight Assessment and Counseling for Nutrition and Physical Activity
- WCV - Child and Adolescent Well-Care Visits

MEDICAL RECORD REQUESTS

You may receive a request from Sunflower's Medical Management, Quality, Auditing department, etc. We would like to remind you that Medical Records are required by contract for:

- All covered members (including those dual eligible where Sunflower was not payer of service provided)
- Contractual reasons for record requests
- To conduct utilization or quality review of member care
- Regulatory audits, monitoring, or reviews by the state, federal government or MCO
- To meet document requests required by accrediting organizations
- Public official requests

Chasing the Chart Reference Guide

Quality Improvement

2026 PROVIDER ORIENTATION

QUESTIONS & ANSWERS

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