HealthSmart

Provider Manual

HealthSmart®

www.healthsmart.com

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Welcome

About HealthSmart

HealthSmart is the premier provider of customizable and scalable health plan solutions for self -funded employers. We deliver solutions that reduce costs and improve outcomes, all while treating eligible persons with dignity and respect. But that's just the beginning of our story.

We're a company of innovators.

Our **Network Solutions** known as the HealthSmart Preferred Care group offers national, comprehensive provider networks to provide three million eligible persons access to healthcare products and services.

HealthSmart Benefit Solutions delivers benefit plans and solutions to provide worry-free administration, quality coverage, and innovative care.

HealthSmart Care Management Solutions provides a full array of care management services that changes lives and helps employers and eligible persons take control of healthcare costs.

HealthSmartRx Solutions delivers extremely attractive full-service pharmacy benefit management, coupled with an Rx discount program.

HealthSmart **Casualty Claims Solutions** leverages technology, robust information and unmatched experience to deliver innovative claims management solutions with outstanding results.

We offer **business intelligence and web-based reporting** and a variety of health and wellness initiatives including onsite and remote employer-based clinics.

Vision and Mission

Our Vision. To be the premier administrator for self-funded plans that offers smart alternatives for smart consumers. We want our eligible persons to be educated on their choices for a healthy lifestyle and positive financial outcomes.

Our Mission. Our mission is to improve the health of our members while treating them with dignity and respect, and to reduce healthcare costs for our clients and members with innovative solutions and a flexible approach.

Our Values.

+ **Earned trust –** We use actions, not words, to earn the trust of our clients and members, and we deliver on what we say to keep that trust.
+ **Respect always –** In our daily jobs, we do things that demonstrate respect for the members we serve, our clients and each other.
+ **Do the right thing –** We don't take shortcuts, we don't let things fall through the cracks and when things don't go as planned, we make things right.
+ **Get better every day –** As good as our solutions, processes and workflows are today, we continually search for ways to improve.
+ **Innovation –** We think of new ways to solve problems, old and new, and deliver unique services that protect members and the client from unnecessary health care expense.
+ **Accountability –** We take responsibility for ourselves to own the quality of the jobs we perform, and hold each other to the same standards.
+ **Clients First –** We listen, clarify and confirm to understand our clients and respond with best-in-class service, support, and intelligence.
+ **Handle with Care –** We will treat every member with dignity and respect, whether assisting with claims, providing compassionate and effective care management, or answering questions.

II Quick Reference Guide

download file

Provider Quick Reference Guide

Submitting Demographic & Provider Changes

It is critical that you notify HealthSmart when you have any changes to your demographics and/or rosters.

Submit changes to your Regional Provider Relations team
(see Provider Relations Contacts below)

*Go to **Submission of Provider Updates section** for instructions & roster templates*

Joining Our Network

Providers must be registered with CAQH to apply with HealthSmart Preferred Network

Register with CAQH at https://proview.caqh.org/

Join our Network form Join Our Network

DENTAL PROVIDER APPLICATIONS – Email pr.west@healthsmart.com

+ **Subject Line:** Dental Provider Application – 'Provider Name'
+ Please include the following in email
  - Provider Name
  - Specialty
  - Address
  - Phone
  - Tax ID
  - NPI

*For complete overview of Credentialing process go to the **HealthSmart Provider Network Management section***

Eligibility

Refer to the member ID card on eligibility instructions as details vary by client

*For complete overview go to **Eligibility Determination section***

Prior Authorization

Refer to the member ID card for precertification instructions as details vary by client

*For complete overview go to **Prior Authorization section***

Submitting Claims

Refer to EDI instructions on member ID card

HealthSmart EDI Payor Routing Numbers:

+ 37283
+ HSPC
+ HSPC1
+ 75237 (Accel)
+ 87815 (C-8 Program)

*For complete overview go to **Claims***

Claim Status & Appeals

HealthSmart Online Claims Status Portal (OCS) provides 24/7 access on claim status, claim detail and repricing

Set up account at Sign up

OCS Login https://secure.healthsmart.com/ocs/ocslogin.aspx

*For complete overview go to the **Online Claim Status Portal (OCS) section***

Payments, Remittance Advice & Explanation of Benefits

We partner with Echo for payment processing

Electronic Funds Transfer Enrollment: providerpayments.com

For more information on Echo Payments:

+ Visit providerpayments.com
+ Email EDI@echohealthinc.com
+ Call 800-937-0896

*For complete overview go to **Billing & Payments section***

Provider Quick Reference Guide

Provider Lookup	**HealthSmart Provider Lookup tool** is available to everyone from HealthSmart.com **HealthSmart Provider Center:** https://healthsmart.com/Service-Centers/Provider-Center **HealthSmart Member Center:** https://healthsmart.com/Service-Centers/Member-Center **Direct Link:** https://providerlookup.healthsmart.com/searchproviders.aspx
Client List	**Request client list at** https://healthsmart.com/Contact-Us
C-8 Program Identifying Eligible Class Members	Participants must submit a C-8 Medical Monitoring Program packet by mail or fax to: C-8 (PFOA) Medical Monitoring Program c/o GCG PO BOX 10030 Dublin, OH 43107-6630 Fax: 614.553.1222 **Laboratory Corporation of America (LabCorp)** To find a Lab Corp in your area go to https://www.labcorp.com/
Customer Service	800.687.0500

Provider Relations Contacts

We have regional Provider Relations teams here to support you

Region	State in which provider practices	Provider Relations Team
Central	IA, IL, IN, KS, MO, MN, ND, NE, SD, WI	pr.central@healthsmart.com
East	CT, DE, KY, MA, MD, ME, MI, NH, NY, OH, PA, TN, VA, VT, WV, RI, NJ	pr.east@healthsmart.com
South	AL, AR, FL, GA, LA, MS, NC, NM, OK, SC, TX	pr.south@healthsmart.com
West	AZ, CA, CO, ID, MT, NV, OR, UT, WA, WY, HI, AK	pr.west@healthsmart.com

Provider Relations Mail

HealthSmart
Attn: Provider Relations
222 W. Las Colinas Blvd., Suite 500 N
Irving, TX 75039

Provider Relations Fax

214.574.2368
Attn: HealthSmart Provider Relations

III Healthsmart Products

Network Products

HealthSmart owns and manages several provider networks and products. These include but are not limited to HealthSmart Preferred Care, HealthSmart Preferred Physician & Ancillary network, Accel, HealthSmart Worker's Compensation Network, HealthSmart Payors Organization (or HPO). Our networks bring together nationwide healthcare coverage, credentialed providers, seamless administration, state-of-the-art healthcare management services, and a dedication to making a positive impact on our customers.

Your Participating Provider Agreement specifies the HealthSmart provider network(s)/product(s) in which you have agreed to participate. Depending on the applicable health plan, covered services may be covered under the eligible person's in-network benefit or may be considered out-of-network by the health plan. In addition, depending on the applicable health plan, and in accordance with any requirements of state or federal law, the HealthSmart network or HealthSmart affiliate logo may be included on the identification card as the applicable network, or such identification card may be included on the explanation of benefits or explanation of payment only. Whether a provider is eligible for payment under a particular product is contingent on the plan design, the terms of the Participating Provider Agreement and HealthSmart's applicable policies and procedures. The presence of the HealthSmart or a HealthSmart affiliate logo on an identification card is not a guarantee that a provider is enrolled in a particular product; that a particular payor has opted to access a particular product's rates with respect to a provider; or that a provider is entitled to payment for services at a particular product's rates.

HealthSmart makes available to its Participating Providers the list of the parties that have entered into Payor Agreements with HealthSmart, including which network(s)/product(s) said payors/plans participate. A current payor list is available upon request by Contacting Us.

The following are descriptions of the network products and examples of identification cards you may receive, which identify the network product. These are examples only and may not reflect all identification card types you may encounter. In addition, some HealthSmart networks may not require logos to be included on the identification card. Rather, identification of the network may be included on the explanation of payment or explanation of benefits. Please refer to your Participating Provider Agreement and this Provider Manual for more information.

HealthSmart Preferred Care II, LP and HealthSmart Preferred Network II, Inc.

Generally referred to as the HealthSmart Preferred Care Network, this is a nationwide Preferred Provider Organization (PPO) formed to meet the ever-changing and growing need for effective management of cost and quality in the healthcare delivery system. Eligible person(s) may receive medical care from any Participating Provider. Eligible person(s) will not be required to select Primary Care Physician (PCP) and referrals are not required. With a strong focus on customer service, HealthSmart Preferred Care creates a productive and effective business environment to meet the various needs of the health care delivery system for providers, employers, payors, and third-party administrators.

HealthSmart Accel Network

HealthSmart Accel is a superior managed care provider network designed to facilitate cost containment while offering excellent hospital and physician access. The Accel Network offers an unparalleled solution to meet the various needs of HealthSmart's clients in the areas of network management, pharmacy management and other managed care services. Accel is designed to deliver market leading discounts to HealthSmart's clients in exchange for accurate and timely payments to Participating Providers – joining together the provider's services with real cash flow.

Accel Highlights

Eligible person(s) may receive medical care from a participating licensed healthcare provider. The enrolled eligible person(s) will not be required to select Primary Care Physician (PCP) and referrals are not required.

Accel Participating Providers must make best efforts to refer within the Accel Network. Benefits may be limited on services rendered outside of the Accel Network. Services received outside of the network will be reimbursed at an RBRVS based fee schedule which will result in a higher eligible person financial responsibility. Precertification will be driven by the Eligible person(s) benefit design.

Accel Participation Guidelines

+ The Accel product will be identified on the eligible person's ID card.
+ Electronic claim processing, submission, remittance and fund transfer as well as online claim status and eligibility available.
+ Adjudication of all facility claims without requiring an invoice.
+ HealthSmart will reprice all claims submitted by Participating Providers.
+ Payment and audit guidelines are consistent with carrier guidelines.
+ HealthSmart will adhere to predefined payment and service terms as agreed to in the Accel Network Access Agreement.

HealthSmart Preferred Physician and Ancillary Provider Network

The HealthSmart Physician Ancillary Only PPO Network is a cost savings solution that provides eligible persons access to a HealthSmart Network of primary care physicians, specialists and ancillary provider types. HealthSmart uses the same rate structures the Participating Providers have for the HealthSmart Preferred Care product for the provider's convenience.

+ Hospitals and acute care facilities do not participate in this HealthSmart network product.
+ The eligible person's ID card has a unique logo which identifies the HealthSmart Physician Ancillary Only Network.
+ Please reference the ID card for the contact information to verify eligible person eligibility and benefits, request pre-certification, and submit claims.

HealthSmart Dental Network

HealthSmart's Dental Network specializes in providing access to dental health care providers for eligible persons, insurance companies, employer groups, third party administrators and other defined groups. HealthSmart is committed to delivering excellent service and customer satisfaction to HealthSmart clients, participating dentists and eligible persons.

HealthSmart Payors Organization: An Out-Of-Network Claims Solution

HealthSmart Payors Organization, or HPO, applies only to claims falling outside of a Payor's primary (direct) network. In other words, HPO applies only to claims that would be considered "out-of-network" or "non-par" by the applicable payor. HPO applies to those out-of-network providers that are selected by that payor. You may request a list of HPO clients (payors) that have elected to apply HPO rates to your claims by contacting HealthSmart Provider Relations at 800.687.0500.

HPO extends access to patients who wish to receive care from providers that are not in their primary network. Participation in HPO will assist in reducing the time and expense associated with out-of-network claims. HPO customers include national and regional health plans, TPAs, self-insured employers and more. The program focuses on partnering with our network providers by offering solutions which include competitive rates and contract terms. Benefits typically apply at a reduced or out-of-network benefit level, based on the patient benefit Plan.

In some cases, HPO may require a logo to be on the eligible person's identification card. However, in other cases, no logo may be required. In the event no logo is required to be included on the eligible person's identification card, identification of HPO or its affiliates will be included on the explanation of benefits or explanation of payment. Presence of the HPO logo on the identification card does not represent a guarantee of payment under the HPO product, or otherwise. You may request a list of payors that have elected to apply HPO rates to your claims by contacting HealthSmart Provider Relations.

HPO Highlights

As more financial responsibility shifts to the patients, providers are finding it increasingly difficult to collect the rising patient responsibility. Providers find that managing debt is costly and labor intensive. They may notice that they are not being paid consistent amounts, when a contractual reimbursement is not in place.

+ Participation can reduce bad debt because Payors pay directly to the provider instead of the patient.
+ Participation allows claims to be priced at a contractually negotiated rate resulting in fewer unpredictable reductions.
+ Payors recognize the importance of, and agree to, timely payment provisions.

In summary, you know what you will be paid and when you will be paid.

Workers' Compensation Network

When a worker is injured, nothing is more important than returning him or her to the workplace as quickly and cost effectively as possible. The strength of our contracts is what significantly differentiates HealthSmart from our competition.

The primary strength of HealthSmart's workers' compensation network is savings, which considerably impacts the cost of claims. HealthSmart's workers' compensation network is comprised of 130,000 directly contracted providers with a broad range of specialties who are committed and experienced in treating work-related injuries. Many of HealthSmart's providers are focused on working with payors and employers not only in addressing medical issues, but also returning the injured employee to the workplace quickly and with optimal outcomes.

Services/Providers Include:

- Primary care physicians
- Neurologists
- Occupational health and rehabilitation therapists
- Occupational Specialists
- Dental Providers
- Chiropractors
- Behavioral health care specialists
- Physical Therapy
- Ancillary providers
- Alternative Medicine practitioners
- Hospitals
- Pharmacy Networks
- Diagnostic Networks

Auto Medical Program

With a comprehensive Auto Medical provider network, HealthSmart understands successful outcomes should include timely access to experienced providers treating trauma-related injuries and special medical needs with maximum cost efficiency.

The primary strength of HealthSmart's Auto Medical network is savings, which considerably impacts the cost of claims. The HealthSmart Auto Medical network connects eligible persons to over 51,000 direct providers and offers a deep contract structure, broad coverage and a level of customer service that fosters professional and efficient working relationships between all entities. The Auto Medical Program is specifically defined as a product line under HealthSmart's Participating Provider Agreement.

MyDecision®

Elective procedures account for a substantial percentage of the dollars spent on healthcare today. Costs for these procedures vary immensely, which means higher medical claim spend for self-funded plans and high out-of-pocket costs for eligible persons. MyDecision® by HealthSmart is comprised of providers who have agreed to a single payment for an entire episode of care.

Types of Covered Services include orthopedic, general surgery, spinal and neurological, women's health, advanced imaging, endoscopic procedures and more.

How it works:

+ HealthSmart contracts directly the providers at aggressively priced bundled rates.
+ HealthSmart's clinical team provides integrated utilization management to determine medical necessity.
+ HealthSmart's real-time concierge outreach redirects eligible persons into a MyDecision provider environment.
+ The provider is paid the entire allowed amount within ten days of the service, resulting in savings to the eligible persons and the plan.

For more information, please visit HealthSmart Provider Center to view the MyDecision Provider Manual

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Ancillary Care Services (ACS)

HealthSmart's ACS Network is an ancillary network which positively impacts providers, eligible persons, and health plan savings. Utilization of ancillary services is growing at twenty-five percent (25%) annually due to an aging population and changing technologies that make many of these services an efficient and high-quality alternative to hospital-based settings. HealthSmart's ACS Network leverages HealthSmart's expertise to lower the administrative costs of ancillary services.

Ancillary Care Services (ACS) is a network manager of ancillary service providers. ACS has been the primary ancillary network solution for HealthSmart clients for the past nineteen years, with more than 4,200 ancillary service providers at over 45,000 treatment sites nationwide.

Because ACS brings additional savings of 8%-15% to HealthSmart's clients, HealthSmart automatically implements the ACS network on all eligible HealthSmart Benefit Solutions, Inc. TPA clients. It is a valuable addition to our robust suite of services. This grants the participating providers primary access to eligible persons.

ACS offers cost effective alternatives to physician and hospital-based services. It is positioned to lower ancillary healthcare costs and serve our Eligible persons with high quality, cost effective network of providers. The ACS network includes 30 specialties:

+ Acupuncture
+ Chiropractic Care
+ Durable Medical Equipment
+ Hospice
+ Lab
+ Massage Therapy
+ Pain Management
+ Rehab – Inpatient/ Outpatient
+ Specialty Pharmacy
+ Urgent Care Center
+ Ambulatory Surgery Center
+ Diagnostic Imaging
+ Hearing Aids
+ Implantable Devices
+ Lithotripsy
+ Occupational Therapy
+ Physical Therapy
+ Sleep Therapy
+ Speech Therapy
+ Vision
+ Cardiac Monitoring
+ Dialysis
+ Home Health
+ Infusion Services
+ Long-Term Acute Care
+ Orthotics and Prosthetics
+ Podiatry
+ Skilled Nursing Facility
+ Transportation
+ Walk-In Clinic

For more information, please visit HealthSmart Provider Center to view the ACS Provider Manual

C-8 (PFOA) Medical Monitoring Program

HealthSmart has been chosen as the independent contractor to provide health care provider network services for the C-8 (PFOA) Medical Monitoring Program ("the Program").

In February 2005, The Wood County Circuit Court in West Virginia approved a class action settlement ("the Settlement") between the Plaintiffs and E.I. du Pont de Nemours and Co. ("DuPont"), the defendant, in a civil class action lawsuit styled Jack Leach, et al. v. E.I. du Pont de Nemours and Co., Civil Action No. 01-C-608 pending in the Circuit Court of Wood County, West Virginia ("the Litigation"). The Litigation involves claims arising from alleged contamination of human drinking water supplies with a chemical known as ammonium perfluorooctanoate (hereinafter "C-8") attributable to releases from DuPont's Washington Works Plant in Wood County, West Virginia.

As part of the Settlement, Class Counsel and DuPont selected an independent panel of three epidemiologists ("the Science Panel") to conduct and evaluate studies to answer the question whether a "Probable Link" exists between exposure to C-8 among Class Eligible persons and serious human disease ("Human Disease"). After lengthy studies, in which many class Eligible persons participated, the Science Panel found that there is a "Probable Link" between exposure to C-8 and the following Human Diseases: (1) pregnancy-induced hypertension (including preeclampsia), (2) kidney cancer, (3) testicular cancer, (4) thyroid disease, (5) ulcerative colitis, and (6) diagnosed high cholesterol (hypercholesterolemia). The Settlement Agreement defines a "Probable Link" to mean that, based upon the weight of the available scientific evidence; it is more likely than not that there is a link between exposure to C-8 and these Human Diseases. The Science Panel did not find that a Probable Link exists for any other Human Diseases.

As a Participating Provider in the HealthSmart network, you may be contacted by a HealthSmart program scheduler on behalf of an Eligible Class Eligible person to schedule an appointment for the screening tests recommended by the independent Medical Panel.

Each Eligible Class Eligible person is required to meet with a participating physician and have all the required screening documents completed and signed by a participating physician for the program. Eligible Class Eligible persons will not present the standard Eligible person identification card. Instead, they will have an Eligible Class Eligible person packet with four forms that include a unique Eligible person identification number and HealthSmart network logos: 1) a Class Eligible person Screening and Questionnaire Form; 2) Instructions for Physicians; 3) Diagnosis Form and 4) a HIPAA Form. Covered medical services provided for C-8 monitoring are paid by the Program in accordance with your HealthSmart Participating Provider Agreement.

The highest concentration of potential Class Eligible persons reside in West Virginia and Ohio, however, potential Class Eligible persons are located across the United States. It is critical that you and your office staff review and familiarize yourself with this program so that you are prepared to perform the screening should you receive calls from Eligible Class Eligible persons. When Covered Services are provided to an Eligible Class Eligible person, **you must sign and return Program documents to the Program Administrator** as notated in the Instructions for Physicians and the Participating Provider C-8 Program Guide. This information is also documented within the Provider Quick Reference Guide.

Below are Program resources specifically for HealthSmart providers and office staff that offer more details about the C-8 Program. The resources prepared for your office are listed below:

Participating Provider C-8 (PFOA) Program Guide

+ Quick Reference Guide for Provider
+ Provider Frequently Asked Questions
+ Information on the C-8 (PFOA) Program
+ Prepared by the Medical Panel for the C-8 Class Eligible persons
+ Lab Requisition Form for C-8 (PFOA) Testing
+ Lab Requisition Form for Other recommended testing
+ Screening and Follow Up Testing Form
+ Diagnosis Form
+ C-8 (PFOA) Medical Monitoring Program Coding

You may obtain these resources and other Program related documents and information by visiting www.healthsmart.com. Information regarding upcoming dates for webinars designed to offer program details will also be published on our website. If you have questions regarding the program, you may contact Customer Service at **800.222.1368**.

All Eligible Class Eligible persons of the C-8 Medical Monitoring Program ("the Program") will be sent a letter from the Program informing them the Medical Panel has recommended the Program pay for follow up appointments, and the covered diagnostic tests, due to symptoms listed below for thyroid disease, ulcerative colitis, testicular cancer, or kidney cancer that your patients are experiencing that were not present at the time of their initial screening appointment with you. The Medical Panel has recommended that patients call their screening physicians for an appointment if the following symptoms occur. Accordingly, you may be receiving phone calls from Class Eligible persons to schedule a follow-up appointment to their initial screening appointment.

1 Thyroid Disease

a. Clinical hypothyroidism (thyroid hormone too low): develop several symptoms that include severe fatigue, cold intolerance, unintentional weight gain, constipation, dry skin, muscle pain or weakness, and menstrual irregularities.

b. Clinical hyperthyroidism (thyroid hormone too high): develop several symptoms that include anxiety, tremor (shakes), heart palpitations, heat intolerance, increased perspiration, and weight loss despite a normal or increased appetite.

2 Ulcerative Colitis

a. Diarrhea (with or without blood) that lasts more than 10 days.

b. Waking up at night to move your bowels.

c. Feeling you have to get to the bathroom urgently to have a bowel movement and that you might not make it in time for more than half of your stools over a six-week period.

3 Testicular Cancer

a. Testicular abnormality such as pain, fullness, mass, stone or change in size.

b. Gynecomastia (male breast enlargement)

4 Kidney Cancer

a. Blood in your urine.

b. Pain in your abdomen on most days in the last two months.

c. A fever on most days for the past two weeks.

d. Recent loss of weight without trying

5 High Cholesterol

There are no specific symptoms associated with this condition.

6 Pregnancy Induced Hypertension and Preeclampsia

There are no specific symptoms associated with these conditions. All pregnant women should be screened for these conditions as part of regular health care for these conditions during each pregnancy.

If a Class Eligible person has been previously diagnosed with a particular disease, they would not be eligible for coverage for further testing of that particular disease under the Program. Those services should be billed to the patient's primary insurance policy. For more information, please call the C-8 Customer Service line at **800.222.1368.**

IV Healthsmart Provider Network Management

HealthSmart Provider Network Management

Join Our Network

Providers can join the Network as an:

+ Individual Provider
+ Group of Providers
+ Hospital Based Group
+ Ancillary / Facility

To join the HealthSmart Network providers need to:

1. Be registered with CAQH (Council for Affordable Quality Healthcare Inc.).
   a. If not registered with CAQH, please go to https://proview.caqh.org/
      i. The CAQH application can be faxed to CAQH at 866.293.0414
   b. If registered with CAQH, verify that information is accurate and up to date with CAQH Proview Login
   c. For more information on CAQH Proview, refer to User Guide
2. Complete the online Join Our Network form

Upon completion of the form, the HealthSmart Provider Relations team will start the Credentialing process.

Provider Nominations

Members can nominate a provider by completing the online Nominate a Provider form.

Upon completion of the form, the HealthSmart Provider Relations team will review the nomination to ensure the provider satisfies our business needs and requirements, including, but not limited to the HealthSmart credentialing and contracting requirements.

Credentialing

HealthSmart is committed to build and maintain the highest quality provider network(s). This commitment involves the rigorous credentialing and re-credentialing of certain provider types before accepting them into our networks. Providers are required to participate in and pass our Credentialing process. The HealthSmart Medical Advisory has the responsibility to establish and adopt necessary criteria for participation, termination, and direction of the credentialing procedures, including participation, denial, and termination. HealthSmart conducts a Medical Advisory Committee meeting each month.

The Credentialing process begins once the provider has completed and executed a Participating Provider Agreement. Failure of an applicant to adequately respond to a request for missing or expired information may result in termination of the application process and denial for participation in the network(s). Upon receipt and verification of all required documentation and information, providers will be submitted to the HealthSmart Medical Advisory Committee to review for approval or denial of the providers' network participation.

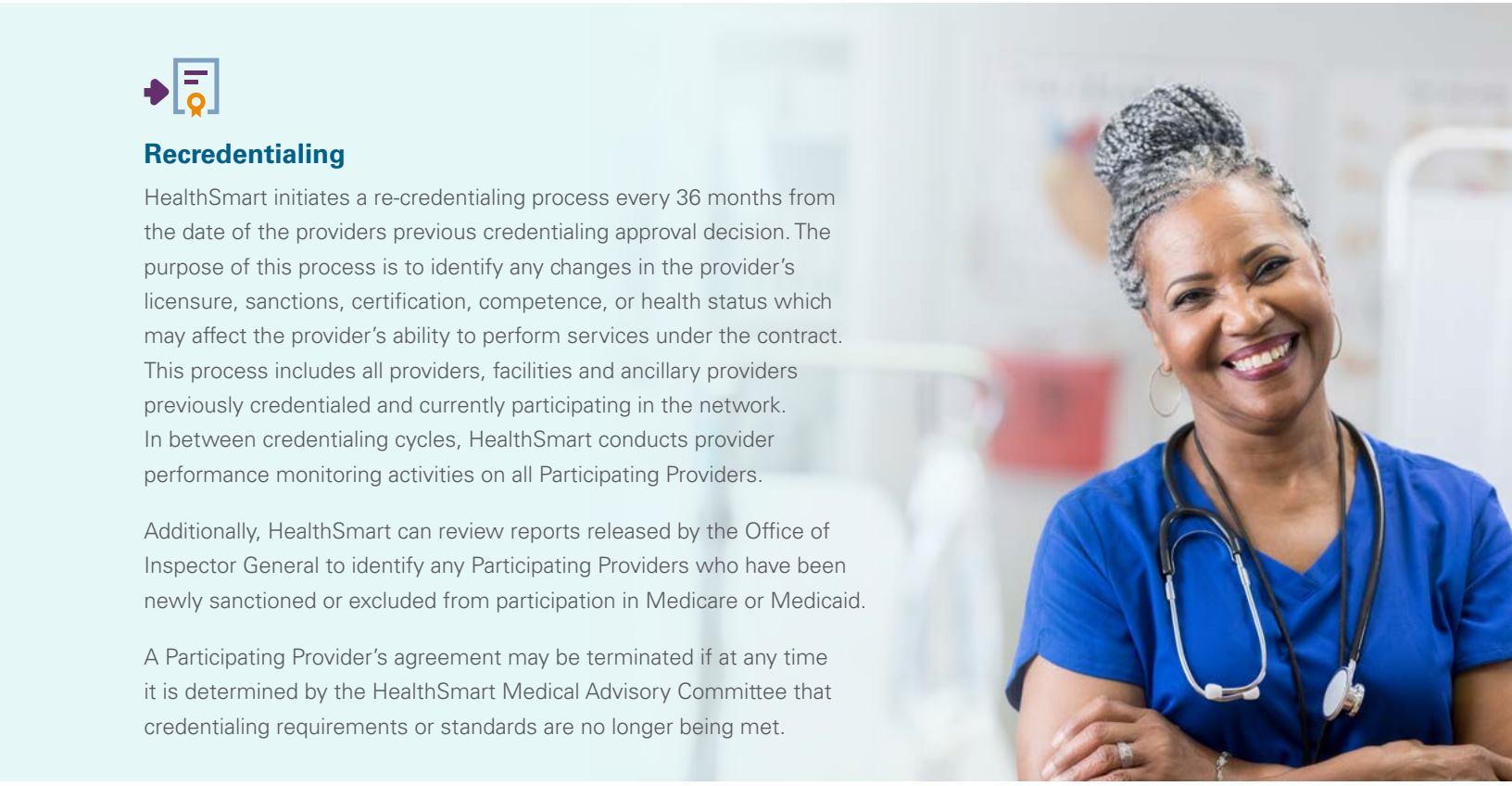
The following information and supporting documentation on the next page may be required to complete HealthSmart's credentialing process:

Individual Physicians, Physician Groups:

+ Provide HealthSmart access to view provider's CAQH profile by completing the HealthSmart CAQH Access Form
+ Signed attestation as to correctness and completeness on history of license, clinical privileges, disciplinary actions, felony convictions, current illegal substance use and alcohol abuse, mental and physical competence and ability to perform essential functions with or without accommodation
+ Active State License
+ Highest level of Education including residency (including a recent CV)
+ Board Certifications (if applicable)
+ Education/Training required (if provider is not board certified)
+ Current malpractice insurance policy face sheet which includes insured dates and the amounts of coverage
+ Current Drug Enforcement Administration (DEA) registration certificate (if applicable)
+ Complete and signed W-9 form
+ Documentation on any and all state sanctions, restrictions on Licensure and or limitation on scope of practice
+ Listing of malpractice claims and license agency actions
+ Documentation of hospital privileges in good standing or alternate admitting arrangements (where applicable)
+ Documentation of Federal sanction activity including Medicare/Medicaid services (OIG-Office of Inspector General)

Hospital, Facility, Ancillary Providers:

+ State License
+ Accreditation
+ Medicare and/or Medicaid Certification
+ Medicare/Medicaid (Office of Inspector General (OIG)
+ Site Visit (if non accredited)



Recredentialing

HealthSmart initiates a re-credentialing process every 36 months from the date of the providers previous credentialing approval decision. The purpose of this process is to identify any changes in the provider's licensure, sanctions, certification, competence, or health status which may affect the provider's ability to perform services under the contract. This process includes all providers, facilities and ancillary providers previously credentialed and currently participating in the network. In between credentialing cycles, HealthSmart conducts provider performance monitoring activities on all Participating Providers.

Additionally, HealthSmart can review reports released by the Office of Inspector General to identify any Participating Providers who have been newly sanctioned or excluded from participation in Medicare or Medicaid.

A Participating Provider's agreement may be terminated if at any time it is determined by the HealthSmart Medical Advisory Committee that credentialing requirements or standards are no longer being met.

Delegated Credentialing

HealthSmart offers delegated credentialing for provider groups and entities that meet HealthSmart's guidelines for initial and re-credentialing of its providers. A pre-delegation audit will be performed prior to granting delegated status. HealthSmart will review the group's policy and procedures for compliance with NCQA standards and may review random sample of the group's credentialing files.

Delegated groups must sign a Delegated Credentialing Agreement upon approval by the HealthSmart Medical Advisory Committee which outlines the standards and obligations to be maintained throughout the term of the delegation arrangement.

Delegated Monthly Reporting Requirements

On a regular basis, no less than monthly, the Delegated group shall submit a report and roster capturing any actions taken related to providers changes including:

+ Licensing Status
+ Hospital privilege changes
+ Additions to the group
+ Demographic changes
+ Termination from the group
+ Any other changes to the provider roster

Delegated Program Change Notification

The delegated group is required to provide 15 days advance notice to HealthSmart of any material changes to the organization or to its performance of any of the delegated functions.

Hospital Status Notification

The delegated group will notify HealthSmart within 10 days if a hospital revokes or suspends the clinical privileges of a physician except in the case of non-compliance with medical record requirements.

Audit

HealthSmart reserves the right to continually monitor and audit delegated entities performance of credentialing and re-credentialing by examining their policies and procedures and credentialing/re-credentialing files. Audits can be conducted electronically, or onsite with advance written notice in accordance with our Policy and Procedure or the Delegated Provider Agreement. Delegated groups will receive a written notice of their annual audit results within 45 business days of the Medical Advisory Committee approval.

Corrective Action (Corrective Action Plans)

If a deficiency in service or delegation responsibility are identified by HealthSmart, the delegated group will provide a written response within 15 days that either:

+ Disputes the deficiency and provides supporting evidence or;
+ Submits a corrective action plan, including procedures and timelines.

If the parties fail to reach an agreement on the existence of a deficiency, or the appropriate corrective action and timeframe, HealthSmart reserves the right to terminate the Delegated Credentialing agreement with a 15-day notice.

Monthly Reporting Requirements

On a monthly basis, the delegated group is required to submit a monthly report and updated roster that captures any actions taken related to providers changes including:

+ Licensing Status
+ Additions
+ Demographic changes
+ Terminations
+ Any other changes significant to individuals credentialing or recredentialing

Delegated groups must include an updated roster of practitioners with changes from the previous roster highlighted and readily identifiable. The updated roster will serve as notice of change in name, address, phone number, fax number, specialty and termination status.

Program Change Notification

The delegated group will provide 15 days advance notice to HealthSmart of any material changes to the organization or to its performance of any of the delegated functions

Hospital Based Physician Status Notification

The delegated group will notify HealthSmart within 10 days if a hospital revokes or suspends the clinical privileges of a physician except in the case of non-compliance with medical record requirements

Audit

HealthSmart reserves the right to annually monitor and audit delegated entities performance of credentialing and recredentialing by examining their policies and procedures and credentialing/ recredentialing files.

Audits will be conducted electronically or onsite with a 30 day advance written notice. HealthSmart access to files will not include information related to peer review committees, or any other confidential information unrelated to credentialing.

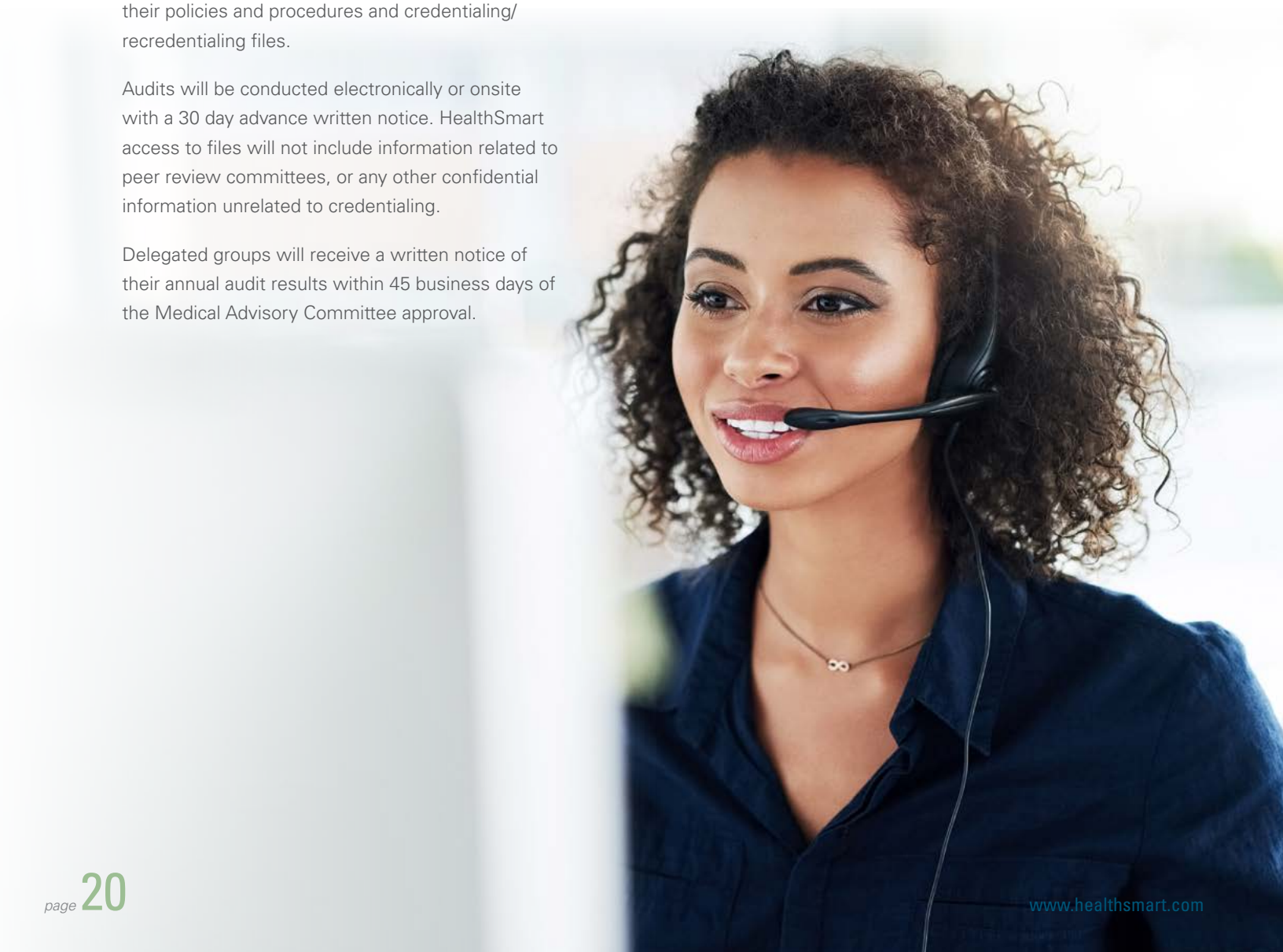
Delegated groups will receive a written notice of their annual audit results within 45 business days of the Medical Advisory Committee approval.

Corrective Action

If a deficiency in service is identified by HealthSmart, the delegated group will provide a written response within 15 days that either:

+ Disputes the deficiency and provides supporting evidence or;
+ Submits a corrective action plan, including procedures and timelines.

If the parties fail to reach an agreement on the existence of a deficiency, or the appropriate corrective action and timeframe, HealthSmart reserves the right to terminate the Delegated Credentialing agreement with a 15-day notice.



Submission of Provider Updates

For HealthSmart to maintain accurate provider profiles, provider directories, and for reimbursement purposes, Participating Providers are contractually obligated to notify HealthSmart of any relevant changes to credentialing information within 10 days of the effective date of the change.

Non-Delegated updates must be submitted using the ***HealthSmart Non-Delegated Roster***

Delegated updates must be submitted using the ***HealthSmart Delegated Roster***

Changes that require notice to HealthSmart may include, but are not limited to, the following:

Provider demographic changes:

+ Must include provider name, TIN, NPI for identification purposes
+ Include old information, new information and effective date of change
+ Medicare numbers
+ Hospital privileges
+ National Provider Indicator (NPI) change
+ Address change
+ Office hours change
+ Phone number change
+ Practice name change

Provider joining existing practice/group:

+ New provider must first be credentialed before rendering treatment to any plan member
+ Information must include provider name, Specialty, Practice Location, Practice Phone, Practice Email, TIN, CAQH for credentialing

Provider deletions / terminations (provider no longer participating with the practice/group)

+ Must include provider name, Specialty, Practice Location, Remit Address, Practice Phone, TIN, NPI for identification purposes (if available). Include effective date of termination

Billing Changes

+ Updates pertaining to billing information such as Tax Identification number and billing address must be submitted with an updated W-9

Tax identification number change

+ Changes in practice name, legal entity or tax ID numbers may require an amendment, assignment or new agreement, depending on the reason for the change

HealthSmart requires that changes such as those outlined above be submitted at least 30 days prior to the effective date of the change to facilitate accurate directory information and claims payment.

Please submit updated rosters via email to your Regional Provider Relations Team:

Region	State in which provider practices	Provider Relations Team
Central	IA, IL, IN, KS, MO, MN, ND, NE, SD, WI	pr.central@healthsmart.com
East	CT, DE, KY, MA, MD, ME, MI, NH, NY, OH, PA, TN, VA, VT, WV, RI, NJ	pr.east@healthsmart.com
South	AL, AR, FL, GA, LA, MS, NC, NM, OK, SC, TX	pr.south@healthsmart.com
West	AZ, CA, CO, ID, MT, NV, OR, UT, WA, WY, HI, AK	pr.west@healthsmart.com

Provider Termination

Obligations of Participating Provider following Termination:

Participating Providers are responsible for all contractual obligations for all services and transactions that occurred prior to the termination date.

After termination, Participating Providers remain responsible for maintaining confidentiality of and access to medical records, proprietary information, continuation of services, and indemnification, and any other provisions explicitly stated in the Provider Agreement that survive the termination.

Coordination of Care Following Termination of HealthSmart Participation

If the network participation ends, HealthSmart eligible persons must be transitioned timely and for appropriate care. If an eligible person is receiving ongoing care, continued services may be required for a reasonable time at the in-network contracted rate. Customer Service is available to assist you and our members with this transition.

Provider Lookup Tool

Participating Providers will be added to the HealthSmart Provider Lookup. Members can access the HealthSmart Provider Lookup from the www.healthsmart.com Member Center at https://healthsmart.com/Service-Centers/Member-Center.

The HealthSmart Provider Lookup allows members to search by:

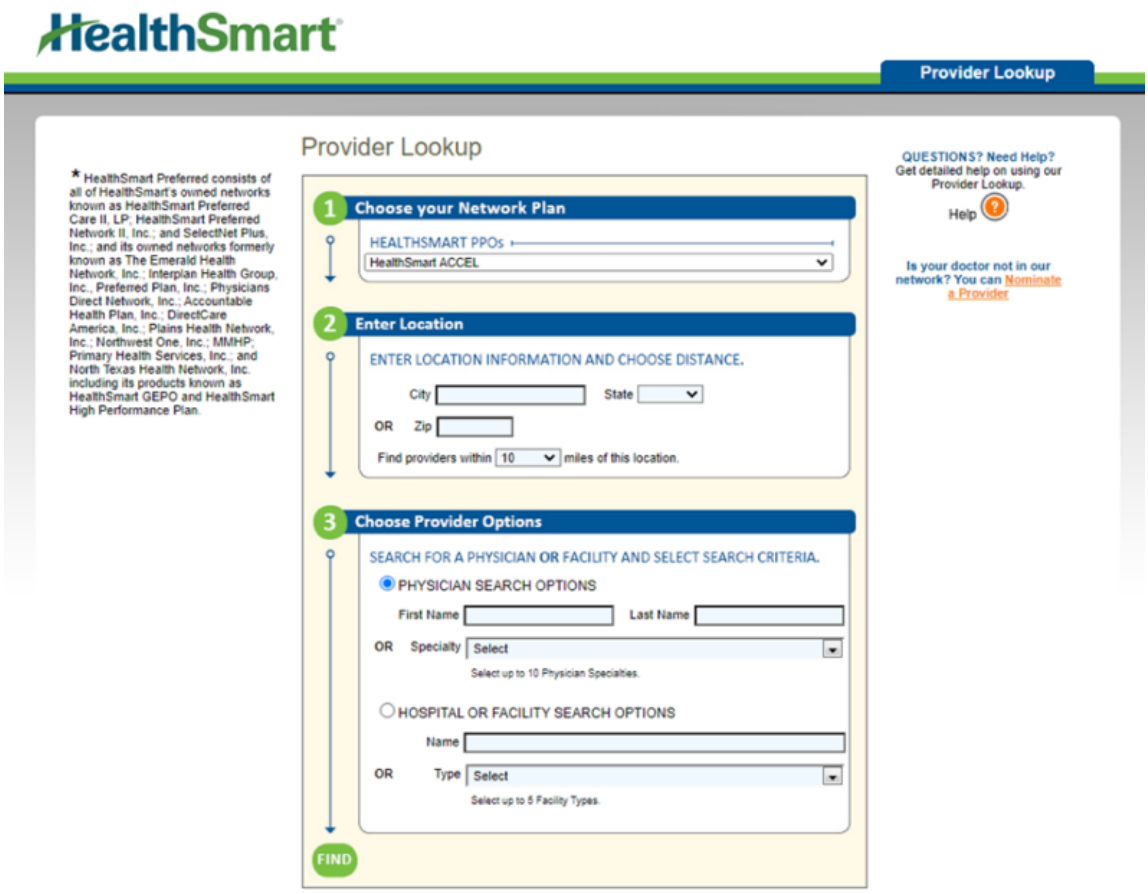
1. Network
2. Location
3. Specialty Type, Facility Type and/or Provider Name

Provider Lookup search results will provide a listing of all Participating Providers that meet the search criteria. From the search results, members can click on any provider name to see details.

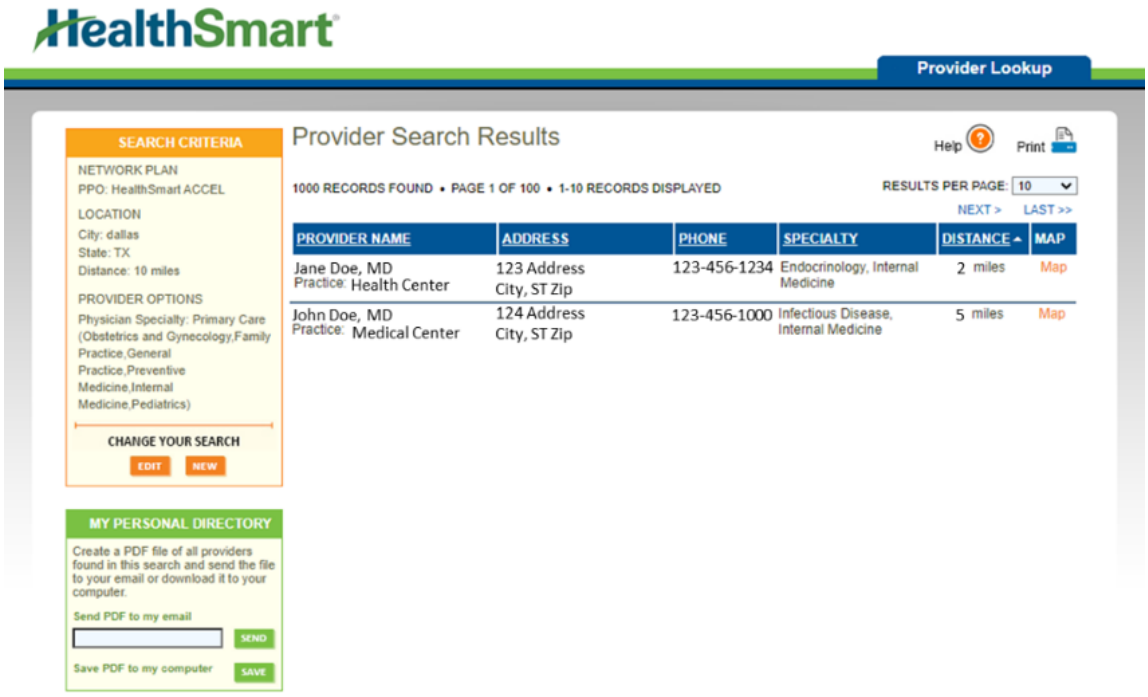
The Provider Lookup also has the following features:

+ My Personal Directory Email results – Create PDF file of all providers found in the search and send the file to email or download to the computer.
+ Electronic Business Card (vCard) - Create an Electronic Business Card of a specific provider in vCard format for use in email programs and send the file to email or download to the computer.
+ Print results
+ Google Map of location
+ Driving directions

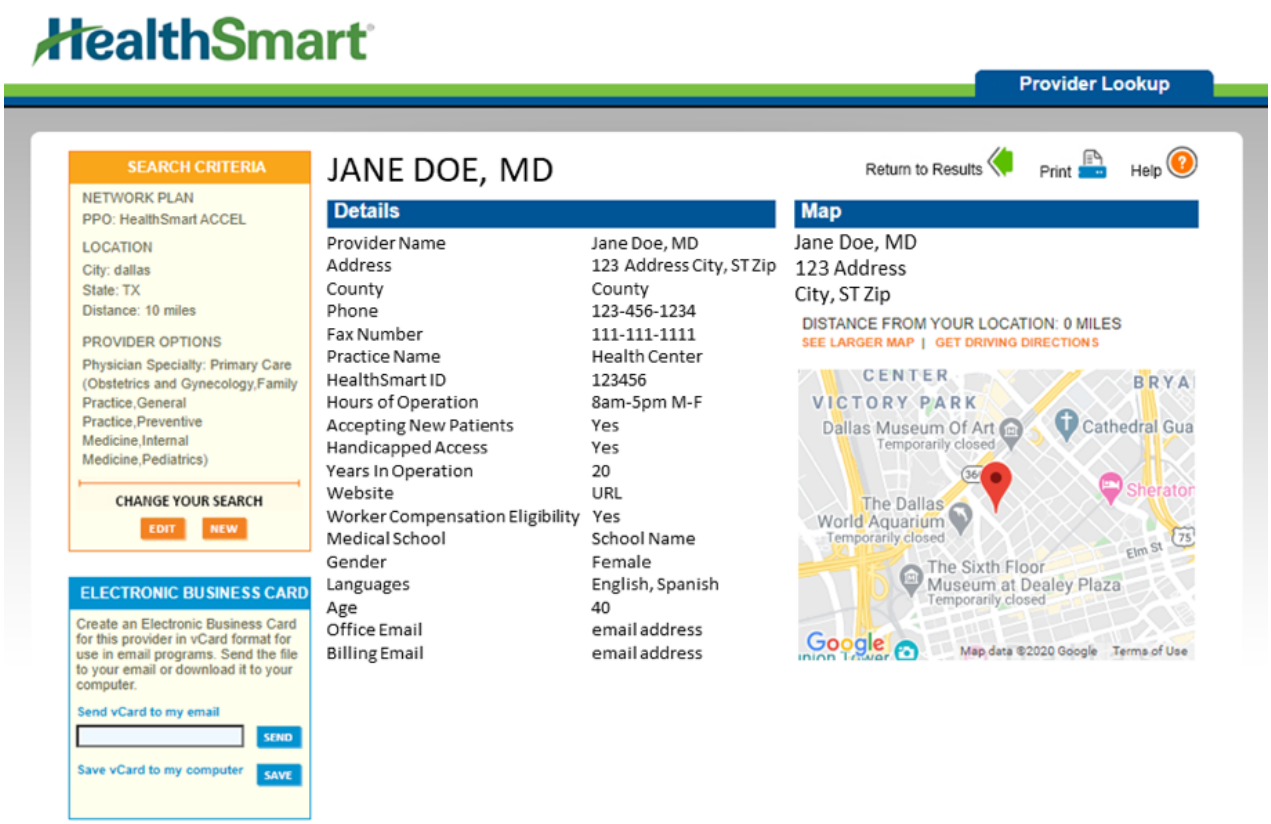
Healthsmart Provider Lookup



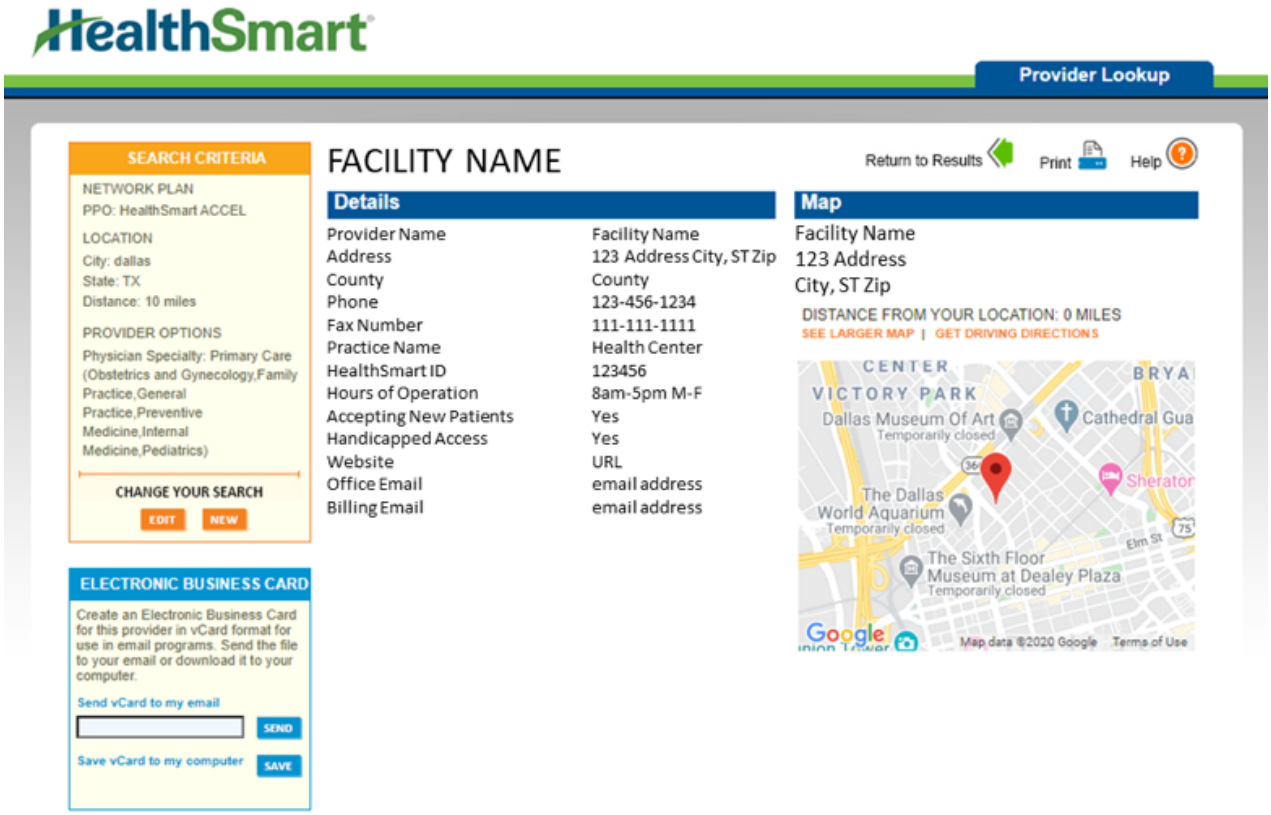
Healthsmart Provider Lookup – Search Results List



Healthsmart Provider Lookup – Provider Detail Page



Healthsmart Provider Lookup – Hospital/Facility Detail Page



Utilization Management

Participating Providers are required to participate in and observe the protocols of the Utilization Management, Case Management and Quality Improvement Programs adopted by the payor to ensure that the covered services rendered by a Participating Provider meet the requirements of care, treatment and medical necessity consistent with industry standards. Failure to comply with the applicable Utilization Management Program may result in reduction of benefits to the eligible person as well as payment adjustments or denials.

Participating Providers should call the applicable phone number on the eligible person's identification card to request a prior authorization or seek guidance on the plan requirements. For procedures on how to request Prior Authorization, please refer to ***Prior Authorization section*** of manual.

If you or an eligible person do not agree with a determination to not approve or certify a health care service made under the Utilization Management program, you or the eligible person have the right to appeal the determination in accordance with Utilization Management program's appeal process. The appeals process may vary by the health plan's or payor's Utilization Management program and/or as mandated by state or federal law. Contact the number on the eligible person's identification card to request an appeal. For more information go to the ***Disputes, Appeals & Grievances section*** of the manual.

Concurrent Review

After the admission, the Utilization Management Department will monitor services on a concurrent basis. If the eligible person is not discharged within the number of days initially approved, the Utilization Review personnel will contact the attending physician for additional medical information. Both care and services for each case are monitored. Further certification will depend upon the establishment of medical necessity.

Discharge Planning

Discharge Planning is the process which assesses an eligible person's need for treatment after hospitalization to help arrange for the necessary services and resources to effect an appropriate and timely discharge from the hospital. Discharge planning is also designed to identify those eligible persons who will need care after discharge from the hospital. This care may include home health services, extended care facilities or home I.V. therapy. Early identification will ensure timely discharge thus providing less expensive yet quality care.

Emergency Admissions

Notification of Emergency Admission must take place within 48 hours of the admission by contacting the number on the eligible person's identification card.

Maternity Admissions

The eligible person should contact HealthSmart Care Management Solutions or the company providing Utilization Management Services on behalf of the plan early in the pregnancy with the expected date of delivery. The Utilization Review personnel will work closely with the physician to monitor the pregnancy for potential high risk. If the pregnancy is determined to be high risk, the case should be referred to a Case Management Nurse for potential intervention. The Utilization Management Department should be notified when the eligible person is admitted for labor and delivery. Any other admissions prior to delivery, such as complications of pregnancy, require separate notification. The Utilization Management Department should also be notified if the baby is not going to be discharged with the mother.

Medical Criteria

A system used by Utilization Management Department personnel that utilizes clearly established, nationally recognized criteria for determining the appropriateness of medical services provided or to be provided. The criteria are reviewed at least annually and revised as indicated. The criteria may contain length of stay parameters based upon expected outcomes of care as specified in Milliman Care Guidelines.

Case Management

Case Management identifies eligible persons that can benefit from close review and management due to length, severity, complexity and/or cost of healthcare. Case Managers locate and assess medically appropriate settings for the eligible person, arrange for ancillary care and coordinate care of complex health care services so the eligible person's health care benefits can be managed as efficiently as possible.

Utilization Management *Continued*

Preventable Errors

In rendering covered services, Participating Provider shall not be entitled to compensation from payor or eligible person(s) if such services or treatment were medically necessary as a result of Participating Provider's preventable error(s), including but not limited to, error(s) arising from surgery, use of medical devices or products, inadequate patient protection, inadequate care management, or unclean or unsafe environmental conditions.

Retrospective Review

The company providing Utilization Management recognizes that there will be eligible persons who will not have precertification and concurrent review performed. These cases will be reviewed retrospectively focusing on day of admission and continued hospital stay. The Utilization Management Department personnel will contact the hospital or attending physician to obtain all necessary information. Using established medical criteria, the Utilization Management Department personnel will determine the medical necessity of the hospitalization. If the criteria are met, the hospital admission will be certified. If the medical criteria are not met, the denial and appeal procedures for precertification and concurrent review will be followed.

Review Guidelines

Review Guidelines will be conducted in accordance with the following National Database: Healthcare Screening Criteria for Utilization Management, Geographic Annualized Volume - Milliman Care Guidelines.

V Provider Requirements

Participating Provider Requirements

Participating Provider Rights & Responsibilities

Provider Rights:

+ To be treated by HealthSmart, its Eligible persons and Payor clients with dignity and respect.
+ To have HealthSmart Eligible person furnish their ID cards and requested medical information as requested.
+ To expect other HealthSmart Participating Providers to act as partners in Eligible persons' treatment plans.
+ To expect Eligible person to follow their health care instructions and directions.
+ To make a complaint or file an appeal against HealthSmart, Payor and/or an Eligible person.
+ To file a grievance on behalf of a member, with the Eligible person's consent.
+ To contact HealthSmart Provider Services and or Customer Service with any questions, comments, or problems.
+ To collaborate with other health care professionals who are involved in the care of Eligible person.
+ To collect member copays, coinsurance, and deductibles at the time of service.

Provider Responsibilities:

+ Participating Provider shall provide health care services to patients within the scope of its licensure or accreditation.
+ Participating Provider acknowledges and agrees to participate in the products and plans for which they are contracted and render covered services to eligible person(s).
+ Participating Provider shall make available and provide medically necessary covered services within the scope of Participating Provider's license in accordance with generally accepted medical practices and standards prevailing in the medical community.
+ Participating Provider shall comply with all applicable laws, including but not limited to, the Americans with Disabilities Act.
+ Participating Provider shall provide covered services to eligible person(s) in the same time and manner as customarily and regularly provided by Participating Provider to other patients who are not eligible person(s) and shall not discriminate against, any eligible person on basis of race, color age, religion, sex, national origin, ancestry, marital status, source of payment, disability, health status, utilization of medical or mental health services or supplies, sexual preference or orientation, veteran's status, or any other unlawful basis including, without limitation, the filing of a complaint, grievance or legal action against Participating Provider.
+ Participating Provider shall verify the eligibility of eligible person(s) to receive covered services and obtain preauthorization from payor prior to rendering covered services, as may be required and in accordance with payor's policies and procedures and/or the plan.
+ Participating Provider shall cooperate with, participate in, and observe the protocols of the Utilization Management Program Guidelines, Quality Management Programs, and Provider Manual, and shall provide Covered Services to Eligible person in accordance with the applicable Utilization Management Program, as well as any other policies, procedures, standards, rules or guidelines adopted by Payor.
+ Participating Providers that are a hospital, clinic, outpatient center, laboratory or other health care facility, are accredited, and have and maintain all licenses, permits and certifications required by law for operation of its facility, parts thereof and/or equipment.
+ Participating Providers that are a physician, doctor of osteopathy, or allied health professional, are duly licensed to practice medicine, osteopathy or its applicable specialty and to provide covered services under the terms of this Agreement and shall maintain such licensure at all times it provides services to Eligible person.
+ Participating Provider is in compliance with all applicable local, state, and federal laws relating to the provision of services, and renders services in accordance with all applicable licensing requirements as well as all area standards of professional ethics and practice.
+ Participating Provider abides and will abide by recognized standards of coding and not engage in any unbundling, upcoding or other similar activities.
+ Participating Provider currently complies with and shall continue to meet and remain in compliance with, the HealthSmart participation and credentialing criteria.
+ Participating Provider shall submit provider rosters, demographic, and tax identification changes to HealthSmart on a monthly basis, or thirty (30) days prior to the effective date of such change, as applicable.

+ Participating Provider agrees that, when medically appropriate, Participating Provider shall refer eligible persons to HealthSmart Network Participating Providers for covered services which are not available from Participating Provider.
+ Participating Provider will not bill balance bill eligible person(s) for any amounts over and above the contractual or imposed reimbursement amounts.
+ Participating Provider shall bill or collect from Eligible person(s)) deductibles, coinsurance or copayments required by the plan; and/or fees or charges for services that are not covered services; fees which exceed a specific benefit limitation.
+ Participating Provider shall submit clean claims electronically or on paper on a UB-04, CMS-1500 or successor form(s) with an itemized bill when applicable or requested in accordance with applicable law and within the time constraints outlined in their provider agreement.
+ Participating Provider shall maintain medical records in accordance with good professional standards, to the extent necessary for continuity of care, for all other necessary purposes, and in compliance with all applicable laws.
+ Participating Provider shall provide any accounting, administrative, and medical records maintained and pertaining to eligible person and/or to Participating Provider's performance to the Center for Medicare and Medicaid Services (CMS), any Peer Review Organization (PRO) with which HealthSmart and/or Payor contracts as required by CMS, the US Comptroller General, their designees and any other governmental officials entitled to such access by law (collectively, "Governmental Officials") as required by law and as may be necessary for compliance by HealthSmart and/or Payor with the provisions of all state and federal laws.
+ Participating Provider will transfer the medical records of the eligible person(s) to such other Participating Provider acquiring applicable disclosure and following confidentiality laws.
+ Participating Provider shall cooperate with accreditation and credentialing surveys, and compliance monitoring.
+ Participating Provider will maintain policies of comprehensive general and professional liability insurance in amounts reasonably satisfactory to HealthSmart and in accordance with standard industry practice.
+ Participating Provider shall give prompt written notice to HealthSmart whenever they become aware of any claims, suits or disciplinary actions have been taken against them.

Non-Discrimination

HealthSmart requires Participating Providers to provide covered health care services to all eligible person(s) in the same time and manner as customarily and regularly provided without regard to race, ethnicity, age, religion, sex, national origin, ancestry, marital status, source of payment, disability, health status, utilization of medical or mental health services or supplies, sexual preference or orientation, veteran's status or any other unlawful basis deemed unlawful under federal, state or local law.

Facility Management

When providing services to HealthSmart eligible persons:

+ Verify the eligible person's eligibility and benefits before rendering services which can be done by contacting the number on the eligible person's ID card.
+ Prior authorize services when required. Contact the number on the eligible person's ID card.
+ Failure to verify eligibility and obtain prior authorization may result in claim denial or reduction of benefits.

Office Hours

Participating Providers are expected to provide the same office hours of operation to HealthSmart eligible persons as those offered to PPO and commercial eligible persons. There are a range of primary, specialty, facility and ancillary services available and accessible to HealthSmart eligible persons in their service area.

After Hours Care

Life-threatening situations require the immediate services of an emergency department. Urgent care can provide quick after-hours treatment and is appropriate for infections, fever, and symptoms of cold or flu. Participating Providers that cannot provide services after hours should refer eligible persons to an urgent care center when appropriate. Physicians or an appropriately licensed professional must be available for after-hours calls.

Wait Times for Eligible persons

The following expected wait times for HealthSmart eligible persons to schedule an appointment with a HealthSmart Participating Provider should not exceed the following:

+ Twenty-four (24) to forty-eight (48) hours for urgent appointments
+ Four (4) weeks for specialty care appointments
+ Six (6) weeks for routine appointments

Timeliness Standards for Notifying Eligible person of Test Results

After receiving results, notify eligible persons within:

+ Urgent: 24 hours
+ Non-urgent: 10 business days

Data Management

Medical Records

Participating Providers shall maintain complete and professionally adequate medical records for all patients, in accordance with good professional standards, to the extent necessary for continuity of care, for all other necessary purposes, and in compliance with all applicable laws.

HealthSmart may request and has the right to inspect any accounting, administrative, and medical records maintained by Participating Provider pertaining to eligible persons and/or to Participating Provider's performance.

Participating Provider shall provide such information to the Center for Medicare and Medicaid Services (CMS), any Peer Review Organization (PRO) with which HealthSmart and/or Payor contracts as required by CMS, the US Comptroller General, their designees and any other governmental officials entitled to such access by law (collectively, "Governmental Officials") as required by law and for compliance by HealthSmart and/or Payor with the provisions of all state and federal laws.

HealthSmart, Payor, and Government Officials shall have access to, and copies of, the medical records, books, charts, and papers relating to Participating Provider's provision of health care services to eligible persons, and payment received by Participating Provider from eligible persons (or from others on their behalf).

These records are required to be maintained for least six (6) years after the end of each contract year, or longer period if required by law. Participating Provider shall make readily available to HealthSmart, Payor and/or governmental agencies with regulatory authority, all medical and related administrative and financial records of eligible person(s) who receive Covered Services. Payor (or its designee) may request, and Participating Provider shall not unreasonably withhold or delay, additional records as may be requested in order to verify that Participating Provider's charges are reasonable and in line with prevailing community standards, to the extent not prohibited by applicable law.

Participating Provider shall, upon request of eligible person(s) or other Participating Provider, and subject to applicable disclosure and confidentiality laws, transfer the medical records of the eligible person(s) to such other Participating Provider at no charge to the eligible person(s). This obligation shall survive any termination or expiration of Participating Provider's agreement with HealthSmart.

Confidentiality –HIPAA/ PHI

HealthSmart Participating Providers agree that all Protected Health Information, including that related to patient conditions, medical utilization and pharmacy utilization, available by any means, will be used exclusively for patient care, medical records, claims submissions, and all other related purposes as permitted by the HIPAA Privacy Rule.

Confidential or Proprietary Information

Participating Provider may, from time to time, receive confidential or proprietary information from HealthSmart, including business plans, customers, customer lists, operations, programs, relationships, targets, compensation terms and arrangements described within the HealthSmart Provider Agreement. Participating Provider agrees that such information shall be kept confidential and, unless otherwise required by law (in which case Participating Provider will provide prompt written notice to HealthSmart prior to such required disclosure) shall not be disclosed to any person except as authorized in writing by HealthSmart.

Regulatory Requirements

Incorporation of Other Legal Requirements

Any provisions now or hereafter required to be included in this manual by applicable federal and/or state laws and regulations or by CMS shall be binding upon and enforceable against Participating Providers and be deemed incorporated herein, irrespective of whether or not such provisions are expressly set forth in this manual or elsewhere in Participating Provider's agreement.

Administrative, Medical and Reimbursement Policy Changes

From time to time, HealthSmart may amend its policies to comply with applicable federal, state or local laws and regulations. HealthSmart will communicate changes to the Provider Manual as technology, procedures, policies and programs change. These may be communicated through a variety of methods including but not limited to:

+ Periodic Provider Manual updates
+ Letter
+ Facsimile
+ Email
+ Website updates

Providers are responsible for periodically checking HealthSmart's website for policy updates in the Provider Manual and complying with these changes upon receipt of these notices or otherwise becoming aware or informed of such changes.

Eligible Persons Rights And Responsibilities

Participating Providers must comply with the rights of Eligible person as set forth below. Eligible persons have the right:

1. To receive accurate information about HealthSmart services, HealthSmart Participating Providers, the rights of eligible persons and Participating Providers, and how to contact HealthSmart with any questions or concerns.
2. To be treated with respect and dignity.
3. To privacy of their personal health information, consistent with state and federal laws, and HealthSmart policies.
4. To communicate with their providers about the medically necessary care and treatments for their condition, regardless of cost or benefit coverage. Eligible persons have a right to know about and understand any costs they will need to pay.
5. To register complaints about HealthSmart services or the care provided by a HealthSmart Participating Provider. This includes the right to have their complaints addressed in a timely and appropriate manner.
6. To choose the healthcare provider in the HealthSmart network consistent with the terms of their benefit plan and applicable state and federal law.
7. To adequate access to qualified medical practitioners and treatment or services regardless of age, race, creed, sex, sexual orientation, national origin, or religion. Sex discrimination includes, but is not limited to, discrimination on the basis of pregnancy, gender identity and sex stereotyping.
8. To access medically necessary urgent and emergency services 24 hours a day and seven days a week.

Eligible person Responsibilities

1. To read and understand, to the best of their ability, all materials concerning their health benefits or to ask for assistance if they need it.
2. To treat all health care professionals and staff with courtesy and respect.
3. To give accurate and complete information about present conditions, past illnesses, hospitalizations, medications, and other matters about their health. Eligible persons should make it known whether they clearly understand their care and what is expected of them. The member needs to ask questions of their provider, so they understand the care they are receiving
4. To show their I.D. card and keep scheduled appointments with their provider and call the provider's office during office hours whenever possible if the member has a delay or cancellation.
5. To follow all health benefit plan guidelines, provisions, policies, and procedures.
6. To give all information about any other medical coverage they have at the time service.
7. To pay all deductible amounts, copayment amounts, or cost-sharing percentages at the time of service.

VI Eligibility Determination

Verification of Eligibility

Eligibility

Participating Provider shall verify the eligibility of eligible person(s) to receive Covered Services and obtain preauthorization from Payor prior to rendering Covered Services. It is within the sole discretion of Payor to determine the eligibility of any eligible person(s) and whether a service is a Covered Service under the Plan.

HealthSmart recommends you contact the HealthSmart payor located on the eligible person's ID card and if possible, prior to rendering services. Plan design may vary, and restrictions may apply specific to a payor and/ or plan. At the time of service, obtain an estimate of patient's coinsurance, deductible, plan design and copay information to determine eligible person's payment responsibility.

To achieve maximum reimbursement for an eligible person, proposed medical care must be certified by the payor's Utilization Management (UM) service. This UM process can be a combination of telephone, written, or online communication. Depending on the urgency of the medical care, notification requirements will vary. Contact the UM vendor number on the eligible person's ID card.

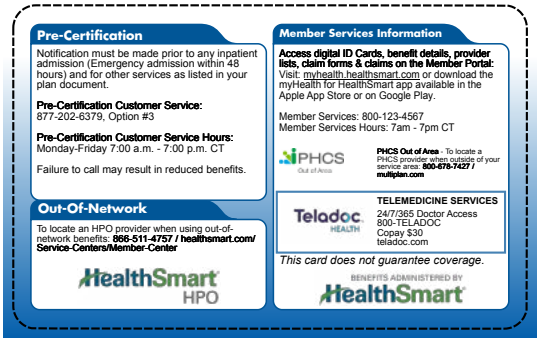
Certifying treatment does not guarantee payment for services rendered to any eligible person. When a determination is made not to approve or certify a health care service, written notification is sent to the attending physician, hospital, eligible person and payor and an appeal may be initiated by the provider and/or the eligible person.

ID Cards

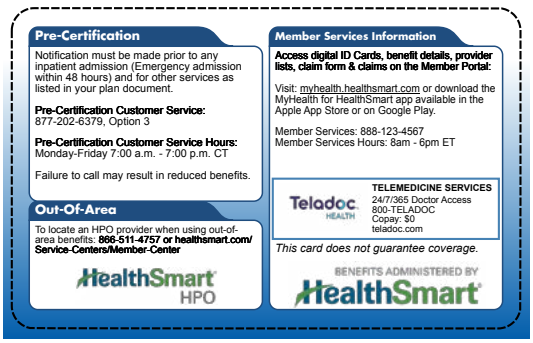
HealthSmart eligible persons are issued an identification card by the payor. Although each card will differ depending on the HealthSmart payor, in most cases, the HealthSmart logo or name should be visible. As indicated in the Participating Provider Agreement and this Provider Manual, certain networks/products may not require a logo on the patient identification card. Please note that presentation of an eligible person ID card is not a guarantee of eligibility.

Below are examples of the HealthSmart eligible person ID card. ID cards may vary based upon the product, plan and payor.

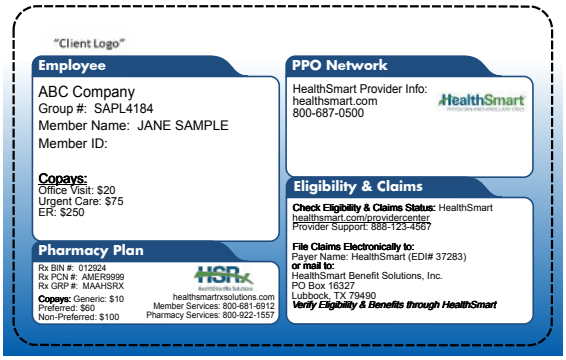
HealthSmart Accel ID Card

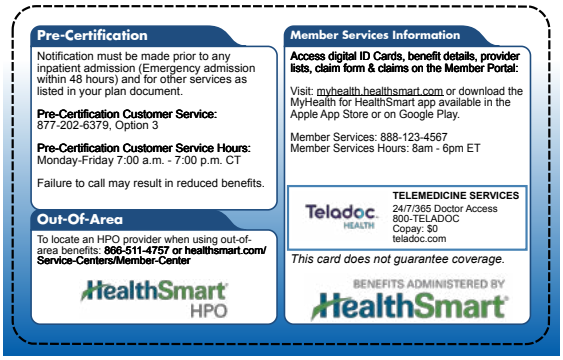


HealthSmart Preferred Care ID Card

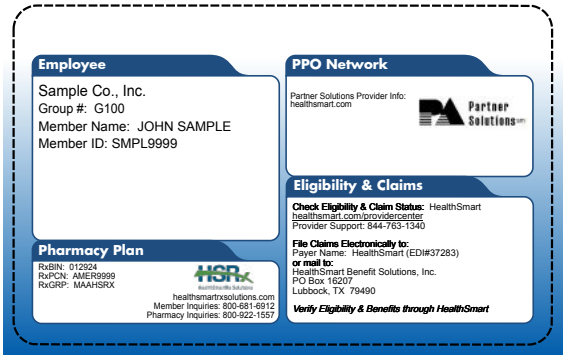


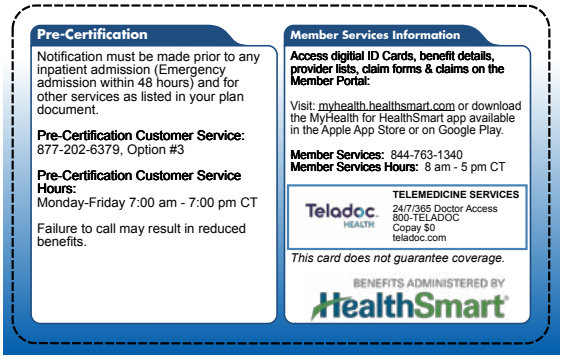
HealthSmart Physician & Ancillary Only ID Card





HealthSmart Partners Solution ID Card





Services that Require Prior Authorization

To verify if a service requires prior authorization, please contact the number on the eligible person's identification card.

It is the responsibility of the facility in coordination with the rendering provider to ensure that an authorization has been obtained for all inpatient and selected outpatient services. All inpatient admissions require prior authorization.

Anesthesiology, pathology, radiology, or hospitalist services related to a procedure or hospital stay requiring a prior authorization will be considered downstream and will not require a separate prior authorization.

Services related to an authorization denial will result in a denial of all associated claims. It is the responsibility of the facility in coordination with the rendering provider to ensure that an authorization has been obtained for all inpatient and selected outpatient services. All inpatient admissions require prior authorization.

Procedure for Requesting Prior Authorizations from HealthSmart Care Management

Please note, the contact information below is specific to HealthSmart's owned Care Management Department. Clients may utilize different vendors and it is important to contact the number on the eligible person's ID card to avoid any misdirected requests that could result in a delay.

Prior authorizations through HealthSmart Care Management can be requested by phone, secure email for fax.

Phone: The HealthSmart Care Management Department is available Monday through Friday from 7:00 AM to 6:00 PM Central Standard Time (CST) at 877.202.6379

Fax: Fax prior authorization requests utilizing a completed HealthSmart Prior Authorization Request Form along with supplemental clinical information to 214.574.2355. The form can be found in the Provider Manual Appendix.
Please note: *Faxes will not be monitored after hours and will be responded to the next business day.*

Email: Prior authorization requests can be sent by secure email utilizing a completed HealthSmart Prior Authorization Request Form along with supplemental clinical information to hsprecert@healthsmart.com. The form can be found in the Provider Manual Appendix.

Please note: *Emails will not be monitored after hours and will be responded to the next business day.*

Referrals

To prevent a potential reduction in health benefits, please make best efforts to refer eligible persons to HealthSmart Participating Providers. In addition, Participating Providers shall admit eligible persons to participating facilities within the HealthSmart Network except in the case of an emergency. For assistance in finding other HealthSmart Participating Providers for referral purposes, contact HealthSmart Provider Customer Service at 800.687.0500 or through the Provider Lookup online at www.healthsmart.com.

In the event the Participating Provider does not have hospital privileges with a participating network facility and an eligible person requires hospitalization, Participating Provider must make best efforts to refer the eligible person to another Participating Provider with hospital privileges at a facility within the same network. Inform the eligible person whenever a referral is made to an out-of-network provider.

Coordination of Benefits

Eligible persons are sometimes covered by more than one insurance policy. Always obtain complete benefit information from each payor when verifying an eligible person's health plan benefit and precertification requirements.

VII Billing & Payments

Billing & Payments

Reimbursement

Participating Provider should bill for services for an eligible person at their normal retail rate. Participating Provider shall accept the applicable reimbursement amount from the payor as specified in their contract with HealthSmart as payment in full for services rendered. Payments are less applicable copayments, deductibles or coinsurance amounts payable by the eligible person. Payor's plan may exclude or reduce benefits for some types of medical care. Therefore, Participating Provider should verify an eligible person's plan coverage requirements by calling for eligibility and benefits using the toll-free number on the eligible person's identification card.

Participating Provider may not charge an eligible person for covered services beyond copayments, coinsurance or deductibles, as described in the applicable benefit plan.

Eligible persons should be billed directly for services which are not covered by the eligible person's health benefits plan.

If applicable, Participating Provider shall be reimbursed by the payor upon application of benefits. Prompt claim processing by the payor is contingent upon Participating Provider submitting a clean claim (as defined by the provider agreement), including completing each claim form accurately and completely. HealthSmart must also have all the necessary patient and insured information in order to reprice the claim timely.

Electronic Fund Transfer (EFT)

Electronic payment and remittance options helps save time and simplify reconciliation. Details and options for setup with Echo below.

1. Virtual Card Services

A Virtual Credit Card payment (VCP) is a form of EFT payment where the provider is given a virtual credit card number to process the payment. There is a fee associated with each transaction based on the contract between the provider and their merchant acquirer. Cards not processed within 30 days of issuance will automatically be resent by ECHO and those not processed after 60 days will be issued as the next available payment method for the provider.

You can manage any issued virtual card payments and/or select a different payment method at https://echovcards.com.

2. EFT Payments

Payer Direct ACH: Providers enroll with ECHO Health online using a payer specific URL to receive ACH payments. Enrollments by payer are done separately. To enroll in payer direct ACH for ACS, complete the enrollment process at https://enrollments.echohealthinc.com/EFTERADirect/HealthSmart

All Payer ACH: Providers contract with ECHO Health to receive ACH payments from all payers. Enrollment occurs online at https://enrollments.echohealthinc.com/EFTERAInvitation.aspx, or by paper submission, and is only required once. The provider is automatically enrolled with existing and future payers for EFT and ERA delivery. This option ensures the quality of the 835 is balanced and formatted in the way the provider has instructed.

Elavon is a processor of credit card transactions, (a.k.a. Merchant Acquirer) which offers a payment solution program (Transend Pay) that pushes through a payment delivery system to deliver funds to the providers' bank account. Unlike a virtual card, the provider (merchant) does not need to key in the credit card number. Providers contract directly with Elavon for this service.

3. Medical Payments Exchange (MPX)

Medical Payments Exchange (MPX) is an online paper check replacement option that allows providers who receive paper checks the option to print and deposit the check, convert the payment to Virtual Card on demand, or enroll in ACH for future payments.

If you are not enrolled with us to receive payments via electronic funds transfer (EFT) and have enrolled for MPX you will receive your payments in your MPX portal account. Otherwise, you may receive a MPX payment by Choice Card notification or Paper Check notification, with information on how you can enroll for free printable paper checks delivered with your Explanation of Payment (EOP) 7-10 days faster than normal paper checks. The notification includes instructions for selecting your preferred payment option via our website https://echochecks.com.

Instructions to get setup:

If you are currently enrolled with ECHO in their All Payer ACH program, there is no additional action required. If you are not enrolled and wish to receive payments via ACH, please complete the steps below.

To sign-up to receive EFT for HealthSmart only, visit https://enrollments.echohealthinc.com/EFTERADirect/HealthSmart No Fees apply.

To sign-up to receive EFT from all payers processing payments on the ECHO platform, visit https://enrollments.echohealthinc.com/EFTERAInvitation.aspx. A fee for this service may be required.

From the landing page review the instructions, then select the ***"Click Here"*** button to begin the enrollment process. When presented with the sign in screen, select ***"Enroll using TIN"*** to begin.

You will be asked to provide your Tax Identification Number (TIN), an ECHO payment draft number and amount as part of the enrollment authentication process. You can enter any valid ECHO draft number and amount from a payment issued to you from ECHO in the last six months, regardless of the payer.

If you do not have a valid ECHO draft number, you will not be able to complete the authentication process. When you receive your first payment from ECHO, you can use the draft number and amount to complete the authentication and EFT/ERA enrollment process.

Provider Payments Portal

The Provider Payment Portal is dedicated to expanding the benefits of the ECHO system to your providers. The portal offers many benefits to providers, including but not limited to the ability to:

+ Centralized location for viewing documents from all payers under the ECHO umbrella
+ View PDF images of EPP documents (non-payments and payments)
+ View or download 835 files produced by ECHO for their Tax ID
+ View settlement status of payments issued to their Tax ID; for paper checks, this will show the front and back of the cleared check image
+ View PDF image of 1099 form, and manage their account, including edit notification settings and complete ACH deposit ping testing.

Echo Contract Information

URL: www.providerpayments.com
Call: 800.937.0896
Email: EDI@ECHOHealthInc.com

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+ View settlement status of payments issued to their Tax ID; for paper checks, this will show the front and back of the cleared check image
+ View PDF image of 1099 form, and manage their account, including edit notification settings and complete ACH deposit ping testing.

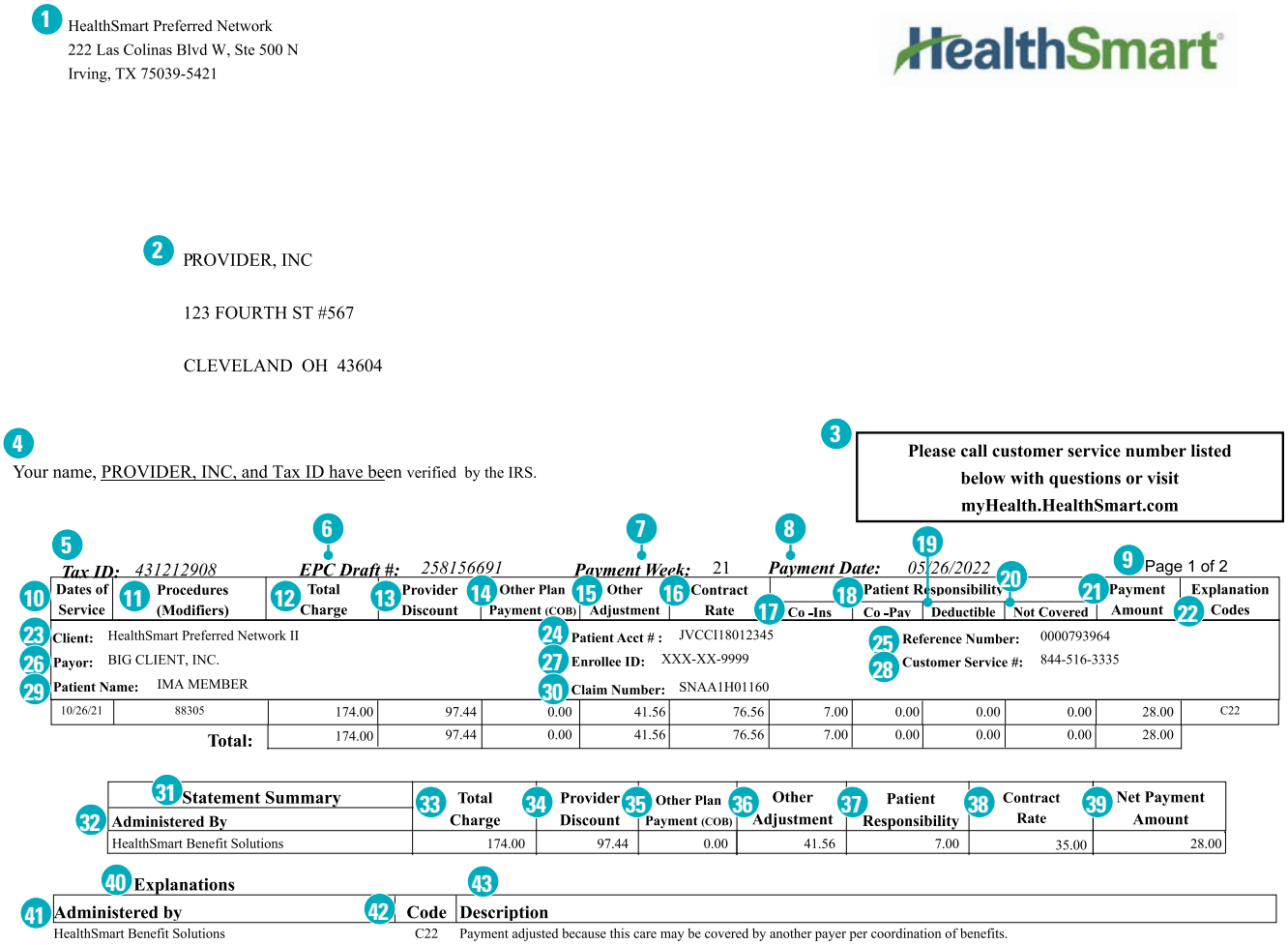
Echo Contract Information

URL: www.providerpayments.com
Call: 800.937.0896
Email: EDI@ECHOHealthInc.com

Explanation of Payment

All payments and EOBs for your claims are sent to ACS first. These payments and denials are posted to our claim record and go through a variety of edits to determine if it was paid accurately and according to the terms of its contract with the payor. ACS will send you an Explanation of Payment (EOP) that details each payment or denial, reflecting all patient responsibility and non-covered services EXACTLY as determined by the Payor.

If any claims are improperly paid or require appeal, ACS will begin the appeals process on behalf of the Provider. For appeal instruction go to Disputes, Appeals & Grievances



1 HealthSmart Preferred Network
222 Las Colinas Blvd W, Ste 500 N
Irving, TX 75039-5421

2 PROVIDER, INC

123 FOURTH ST #567

CLEVELAND OH 43604

4 Your name, PROVIDER, INC, and Tax ID have been verified by the IRS.

3 **Please call customer service number listed below with questions or visit myHealth.HealthSmart.com**

5 *Tax ID:* 431212908 6 *EPC Draft #:* 258156691 7 *Payment Week:* 21 8 *Payment Date:* 05/26/2022 9 Page 1 of 2

10 Dates of Service	11 Procedures (Modifiers)	12 Total Charge	13 Provider Discount	14 Other Plan Payment (COB)	15 Other Adjustment	16 Contract Rate	17 Co -Ins	18 Patient Responsibility Co -Pay	19 Deductible	20 Not Covered	21 Payment Amount	22 Explanation Codes
10/26/21	88305	174.00	97.44	0.00	41.56	76.56	7.00	0.00	0.00	0.00	28.00	C22
Total:		174.00	97.44	0.00	41.56	76.56	7.00	0.00	0.00	0.00	28.00	

23 **Client:** HealthSmart Preferred Network II
24 **Patient Acct # :** JVCCI18012345
25 **Reference Number:** 0000793964
26 **Payor:** BIG CLIENT, INC.
27 **Enrollee ID:** XXX-XX-9999
28 **Customer Service #:** 844-516-3335
29 **Patient Name:** IMA MEMBER
30 **Claim Number:** SNAA1H01160

31 Statement Summary 32 Administered By	33 Total Charge	34 Provider Discount	35 Other Plan Payment (COB)	36 Other Adjustment	37 Patient Responsibility	38 Contract Rate	39 Net Payment Amount
HealthSmart Benefit Solutions	174.00	97.44	0.00	41.56	7.00	35.00	28.00

40 **Explanations**

41 Administered by	42 Code	43 Description
HealthSmart Benefit Solutions	C22	Payment adjusted because this care may be covered by another payer per coordination of benefits.

44 **Important Information**

This Explanation of Payment reflects payments and benefit determinations received by HealthSmart Preferred Network as a result of your membership in the HealthSmart Network. All patient responsibility and other benefit determinations have been made by the members' plan administrator and are reflected here exactly as they are on the member's original EOB. Payment is based on your contract fee schedule with HealthSmart, less non-covered services,

How to Read an Explanation of Payments to Providers

Below is a description of your Explanation of Provider Payment (EPP). The numbers correspond with the numbers on the sample copy of the EPP (see the last page for an example of an EPP).

1. **Claim Processing Address:** address to send claim correspondence.
2. **Address:** the name and address where the EPP is being mailed.
3. **Contact:** contact information for questions regarding the claim payment.
4. **IRS Verification:** please follow all direction in this section if there are issues on the service provider's name or Tax Identification Number not matching the IRS.
5. **Tax ID:** the IRS Tax Identification number for the service provider being paid.
6. **EPC Draft #:** the payment ID assigned to the transaction (check number, eCheck Number, Trace Number (ACH), or Virtual Card Token ID).
7. **Payment Week:** the week of the year for the provider payment by individual payer.
8. **Payment Date:** the date of the provider payment being sent.
9. **Pages:** the number of EPP pages being sent with the payment.
10. **Date of Service:** the date(s) on which services were rendered.
11. **Procedures (Modifiers):** the Current Procedural Terminology (CPT) codes listed on the service provider's bill.
12. **Total Charge:** the charge for each claim processed.
13. **Provider Discount:** savings received from a Preferred Organization (PPO), if applicable.
14. **Other Plan Payment (COB):** adjustment based upon the benefits of other health plans or insurance carriers, including Medicare.
15. **Other Adjustment:** adjustment amount that is not a COB adjustment, contract rate or Patient Responsibility.
16. **Contract Rate:** the agreed upon rate between the service provider and the plan benefit administrator.
17. **Patient Responsibility Co-Ins:** the direct Out of Pocket cost related to the percent of plan contribution.
18. **Patient Responsibility Co-Pay:** the allowed charge amount, specified by the member's plan, that the member must pay before benefits are paid.
19. **Patient Responsibility Deductible:** the allowed charge amount that applies to the member's plan deductible and must be paid by the member before benefits are paid.
20. **Patient Responsibility Not Covered:** charge that is not eligible for benefits under the plan.
21. **Payment Amount:** benefits payable for services provided.
22. **Explanation Codes:** the individual code used to request additional information or provide further explanations of the claim payment.
23. **Client:** the payor, TPA, or PPO network that we work with to process your claims..
24. **Patient Acct #:** the number assigned by the service provider.
25. **Reference Number:** the number assigned by the HealthSmart claim system.
26. **Payor:** the name of the member's Group (in most cases, this is the member's employer).

27 **Enrollee ID:** employee's social security number (last 4 digits only) or identification number. Refer to this ID number if you call or write about this claim.

28 **Customer Service #:** number to call with questions regarding the claim payment.

29 **Patient Name:** the name of the individual for whom services were rendered or supplies were furnished.

30 **Claim Number:** the unique identification number assigned to this claim. Please refer to this number if you call or write about this claim.

31 **Statement Summary:** the summary section of total amount of claims processed for payment provided.

32 **Administered by:** the plan benefit administrator

33 **Total Charge:** the sum of the total charge for each claim processed.

34 **Provider Discount:** the sum of the total savings received from a Preferred Organization (PPO) for each claim process, if applicable.

35 **Other Plan Payment (COB):** the sum of the total adjustments for each claim processed. Based upon the benefits of other health plans or insurance carriers, including Medicare.

36 **Other Adjustment:** the sum of the total adjustments for each claim processed that is not a COB adjustment, contract rate or Patient Responsibility amount.

37 **Patient Responsibility:** the sum of the total members' responsibilities after all benefits have been calculated.

38 **Contract Rate:** the agreed upon rate between the service provider and the plan benefit administrator.

39 **Net Payment Amount:** total benefits payable for services provided.

40 **Explanations:** section for additional explanation on Codes or Notes from claims.

41 **Administered By:** the plan benefit administrator.

42 **Code(s) or Note(s):** the Explanation Code identifier(s) from the above claim(s).

43 **Description:** additional explanation of the Explanation Codes or Notes.

44 **Important Information:** statement explaining your entitlement to a review of the benefit determination on the Explanation of Provider Payment (EPP). This information varies according to each benefit plan.

VII Claims

Claims

Claim Submission

Claims should be sent by following the instructions on the eligible person's identification card. As a Participating Provider, you agree to submit claims for payment timely as defined in your Participating Provider Agreement (or as otherwise required by state or federal law). Incomplete claims or claims received late may be denied for payment by client or payor. Participating Providers shall not bill client, payor, HealthSmart or eligible person(s) for such denied claims. All claims should be submitted using Participating Providers normal billed charges and the appropriate procedure code per American Medical Association (AMA) and Center for Medicare and Medicaid Services (CMS) standards.

Participating Providers are required to:

+ Submit clean claims in a timely manner, for services rendered to eligible persons.
+ Submit claims using normal billed charges and the appropriate procedure codes per American Medical Association (AMA) and Center for Medicare and Medicaid Services (CMS) standards.
+ Submit HealthSmart clean claims electronically or on a UB-04, CMS-1500 or successor form(s).
+ Submit all claims in accordance with applicable law, and at Participating Provider's normal rate.
+ Submit claims for payment within ninety-five (95) days of the date healthcare services were provided (or as otherwise required by state or federal law, your Participating Provider Agreement or within the eligible person(s) plan). Claims received after this time period may be denied for payment, and Participating Providers shall not bill the eligible person(s).

Prompt repricing and routing of your claims is contingent upon a Participating Provider completing each claim form accurately and completely.

Submitting Claims Electronically

Submission of claims electronically is the recommended method for Participating Providers as it is faster and more accurate than paper claims submission. CMS-1500 and UB-04's may be submitted electronically through transaction networks and clearinghouses in a process known as Electronic Data Interchange (EDI). The EDI payor routing number on the Eligible persons ID card should be used for claim submission.

HealthSmart EDI payor routing numbers:

+ 37283 (Change Healthcare)
+ HSPC
+ HSPC1
+ 75237 (Accel)

Submitting Claims by Mail

If, despite best efforts, Participating Provider cannot submit claims electronically, Participating Provider shall submit paper claims using a UB-04, CMS-1500 or successor form(s).

Claims must be submitted to the physical address on the Eligible persons ID card.

Reason for Returned or Rejected Claims

In order to process the claim, the information filed must be complete and accurate. Some examples for returned or rejected claims are listed below:

+ Unable to identify employer group listed on the claim
+ Employer group is not effective for the date of service
+ Employer group terminated prior to this date of service
+ Patient no longer has access to the HealthSmart network
+ Patient/ insured not valid for this date of service for this group
+ Payor has requested that claims be submitted directly to them
+ Missing claim elements

HealthSmart Repricing & Coding Guidelines

Anesthesia Payment Guidelines - All anesthesia services shall be repriced using ASA Guidelines, units, and modifiers inclusive of A, P and Q modifiers. In the event an appropriate ASA code is not available, Participating Provider shall use appropriate CPT-4 coding and/or modifiers.

AWP - All drugs and biological (HCPCS) codes shall have rates set utilizing Red Book AWP pricing. This pricing shall be maintained with updates no more than quarterly (Jan., April, July, and Oct) or as per effective dates indicated by the state of Texas for state supplied vaccines as appropriate.

Coding Guidelines – HealthSmart shall recognize standard DRG, APC, ADA, NCCI, CPT-4, ASA, ICD-9, ICD-10 Medicare guidelines to re-price claims.

CPT Modifiers - HealthSmart shall recognize standard insurance HCPCS, CPT-4, ADA, and ASA modifiers in accordance with Medicare standards.

Coding Methodologies - HealthSmart shall recognize the following coding methodologies in accordance with published coding manuals and guidelines described in the Participating Provider's Agreement. HealthSmart recognizes these publications will change from time to time. Therefore, HealthSmart shall utilize current year at the time of service as a guide for re-pricing claims. Additional information on such coding methodology may be found at the following website locations:

+ CPT-4 www.ama-assn.org/practice-management/cpt
+ ASA www.asahq.org
+ HCPCS www.cms.hhs.gov/medicare/hcpcs
+ ICD-9 www.cms.hhs.gov/medlearn/icd9code.asp
+ ICD-10 www.cms.hhs.gov/ICD10IC
+ DRG www.cms.gov
+ Revenue Codes www.cms.gov

Down Coding and Rebundling - HealthSmart does not currently apply down coding or rebundling methodologies in its re-pricing of claims. These guidelines are in no way intended to represent subsequent payor claims processing procedures, guarantee of payment or imply covered benefits. For payor claims processing procedures and covered benefit information please contact the payor directly.

Multiple Surgeries - If more than one surgical procedure is performed during a single surgical episode, the claim will be priced in accordance with the Provider Agreement and claims logic applied by the payor.

Repricing Guidelines - The above represented claims re-pricing procedures reflect those of HealthSmart only and are subject to change from time to time. Such procedures shall remain consistent with and in accordance with the Agreement, and applicable State and Federal law. These guidelines are in no way intended to represent subsequent payor claims processing procedures, guarantee of payment or imply Covered Services. For payor claims processing procedures and Covered Benefit information please contact the payor directly. For a complete list of HealthSmart Payors, please visit www.healthsmart.com.

HealthSmart Repricing Sheet can be viewed at HealthSmart's Online Claim Status Portal (OCS).

*For more information or to access OCS, go to the **Online Claim Status Portal (OCS) section** of manual.*

HealthSmart Repricing Sheet

HealthSmart

14215

PPO Claims Transmittal : HCFA

36898126

Mail To :

HEALTHSMART BENEFIT SOLUTIONS
PO BOX 93670
LUBBOCK, TX 79493-3670

Patient Name :	LAST NAME, FIRST NAME	**Receive Date :**	06/29/2020
Insured Name :	LAST NAME, FIRST NAME	**Process Date :**	06/29/2020
Insured ID :	123-45-6789	**Claim ID :**	36898126
		Processor :	HSNGNE
		Printed By :	**HSNGNE**
Provider Name :	TEST PROVIDER	**Claim Form :**	HCFA
Provider Specialty :	LAB	**Print Type :**	NEW
Federal Tax ID :	38-2084239	**Service Start Date :**	06/01/2020
Client Name :	HEALTHSMART HOLDINGS INC	**Service End Date :**	06/01/2020
Parent Company :	HEALTHSMART BENEFIT SOLUTIONS		

Dates Of Service Begin	End	CPT Code	Modifier(s)	Description	Days or Units	Billed Charges	PPO Discount	Adjusted Charges
06/01/2020	06/01/2020	99213		OFFICE/OUTPATIENT VISIT EST	1	175.00	87.50	87.50
					Total :	**$175.00**	**$87.50**	**$87.50**

Discount from : HEALTHSMART ACCEL

External Claim ID :

Message(s) :
Repriced Claim.

Pay to Provider

HEALTHSMART PREFERRED NETWORK II INC
PO BOX 207656
DALLAS, TX 75320

TIN : 061621470

This form represents a claim that has been processed by a HealthSmart PPO network. The adjusted charges reflect the rate applied from the provider's contract with the network shown above. This form does not guarantee benefits or eligibility.

HealthSmart Network Solutions PO Box 53010 Lubbock, TX 79453-3010 1-800-346-3141

PUser: HSNGNE@HSNT-DEFAULT
TDate: 6/29/2020 3:12:27PM (6/29/2020 3:12:36PM)

Page 1 of 1

DALTX13-WEBIMPRINT5.9.4-V5.3.10
BNo: 574610.33-543806 QNo: 38501189

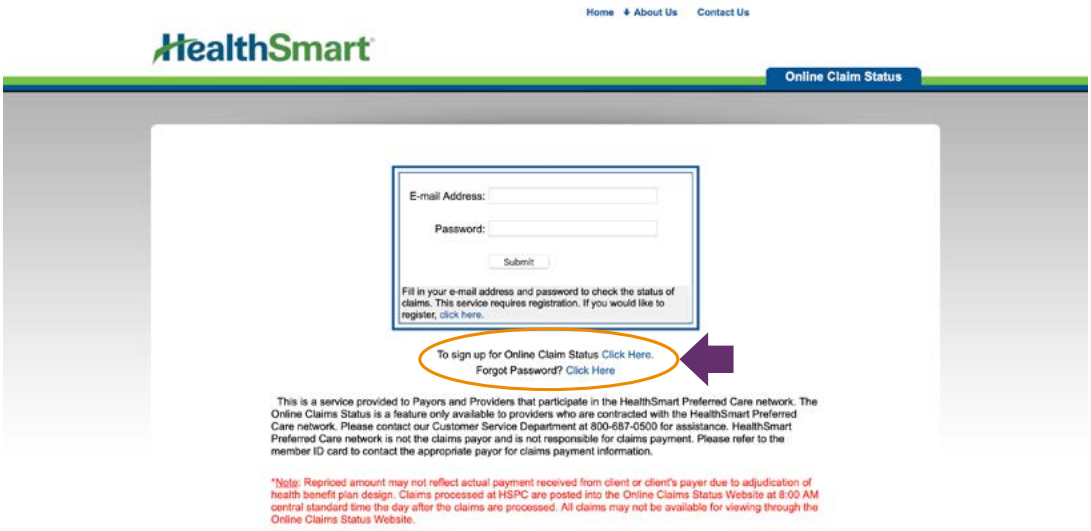
Online Claim Status Portal (OCS)

HealthSmart Online Claims Status Portal provides 24/7 access on claim status, claim detail and repricing to our Network Providers.

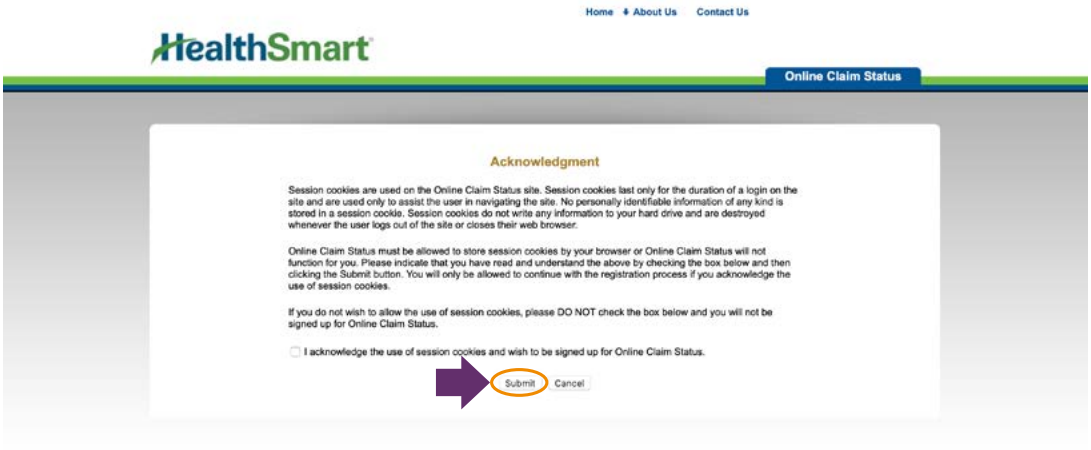
Online Claim Status Portal (OCS) - Sign Up

1 To sign up for HealthSmart Online Claim Status (OCS) go to: **Sign up**

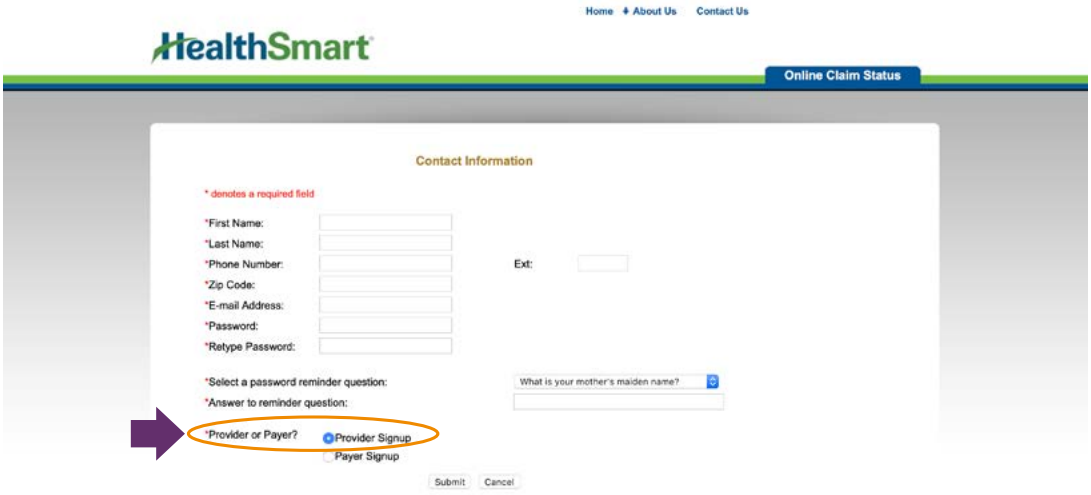
2 Click to sign up for Online Claim Status **"Click Here"** option



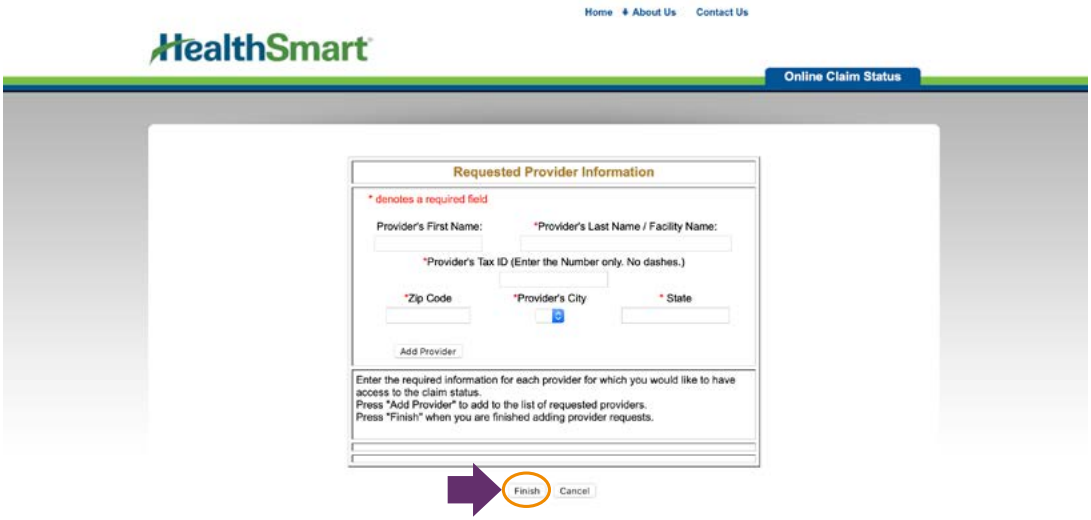
3 Read Acknowledgment page, Check Box and Submit



4 Complete the required contact information. Select **Provider Signup** and **Submit**.



5 Complete the requested provider information and select **Finish**



6 Registration Confirmation

7 Upon receipt of request HealthSmart will review your request. Provider will be notified via e-mail of approval or denial. Please allow 24-48 hours for a response.

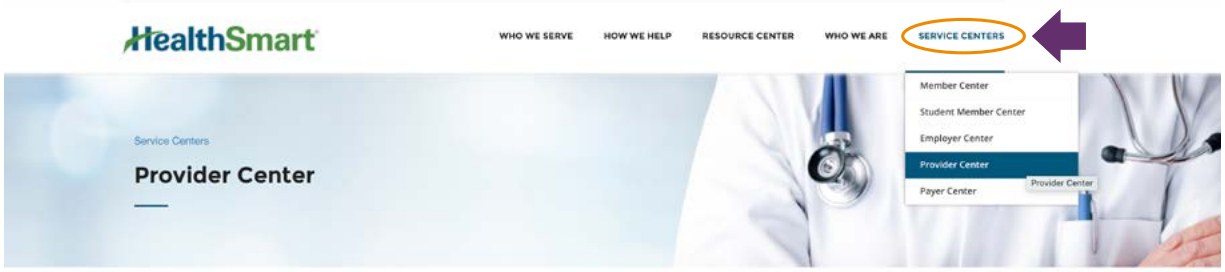
Online Claim Status Portal (OCS) - Login

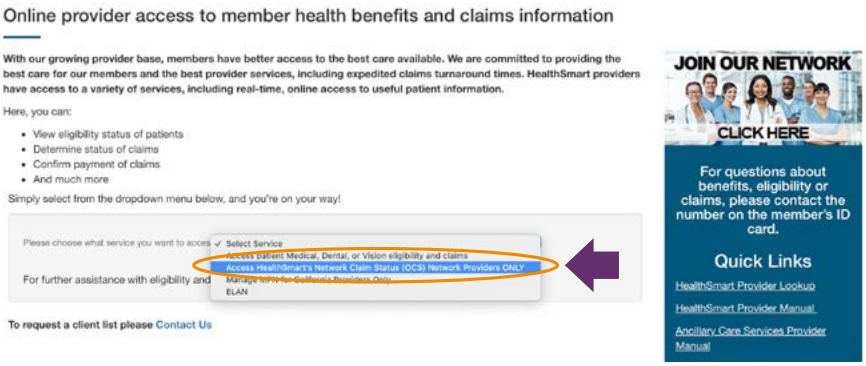
Providers can access the OCS Portal by going directly to the login page or going through www.healthsmart.com.

Go directly to login page: https://secure.healthsmart.com/ocs/ocslogin.aspx

Go to healthsmart.com: https://healthsmart.com/Service-Centers/Provider-Center

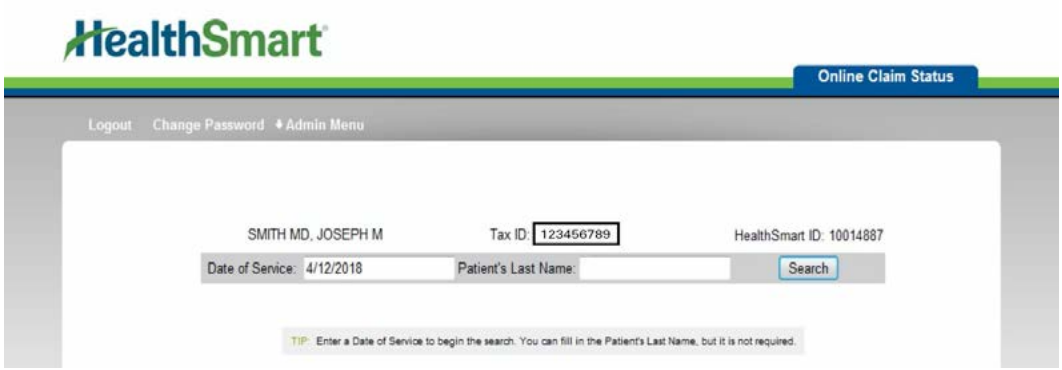
+ Click on **Select Service** dropdown
+ Click on **Access HealthSmart's Network Claim Status (OCS) Network Providers ONLY**





Online Claim Status Portal (OCS) – Claim Search

1. Once logged in, click on the appropriate provider's name
2. Enter **'Date of Service'**
3. **'Patient's Last Name'** not required but recommended for a quicker search
4. **'Search'**



Online Claim Status Portal (OCS) - Viewing Claim Details

The claim detail screen provides the following information:

+ Patient's Name
+ Patient Date of Birth
+ Submitted Charge – Charge submitted by provider
+ Date Received – Date HealthSmart received claim
+ Date Processed – Date HealthSmart processed claim
+ Status – Current status of the claim with HealthSmart

  A Adjusted – Claim has been adjusted and processed

  D Duplicate – Indicated claim is a duplicate and will not be processed

  R Repriced – Claim has been repriced (Click on the 'R' to see Repricing Sheet)

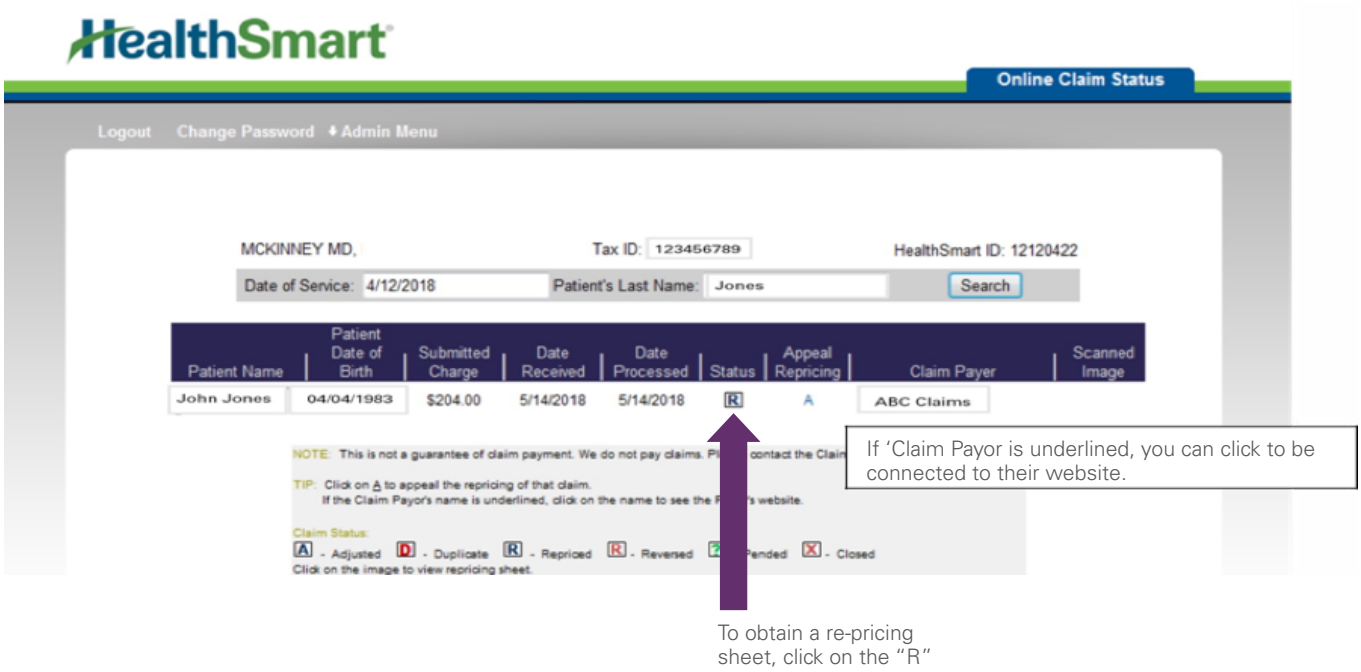
  R Reversed – Repricing has been reversed

  ? Pended – More information is required to process the claim

  X Closed – Claim not processed

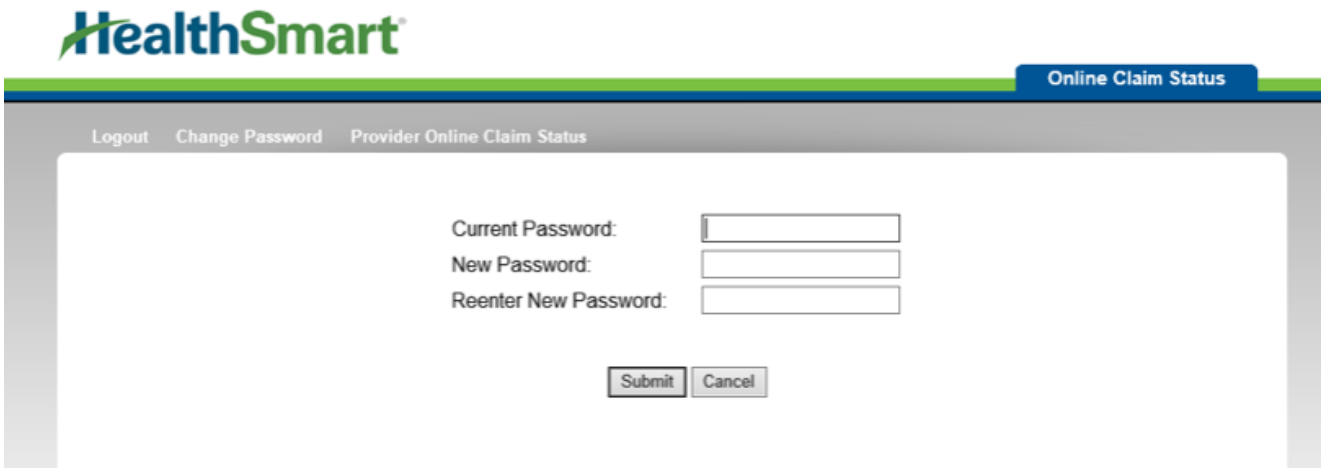
+ Appeal Repricing – Click on the 'A' to submit a request to appeal
+ Claim Payor – Claim Administrator. If underlined, you can click to be connected to their website

  Scanned Image – Click on the scanned Image to see copy of claim (UB/HCFA) and any attachments received



Online Claim Status Portal (OCS) – Change Password

You can change password on the site. If you are unable to login and need to reset your password, contact us at 800.687.0500.



HealthSmart's Network Clients

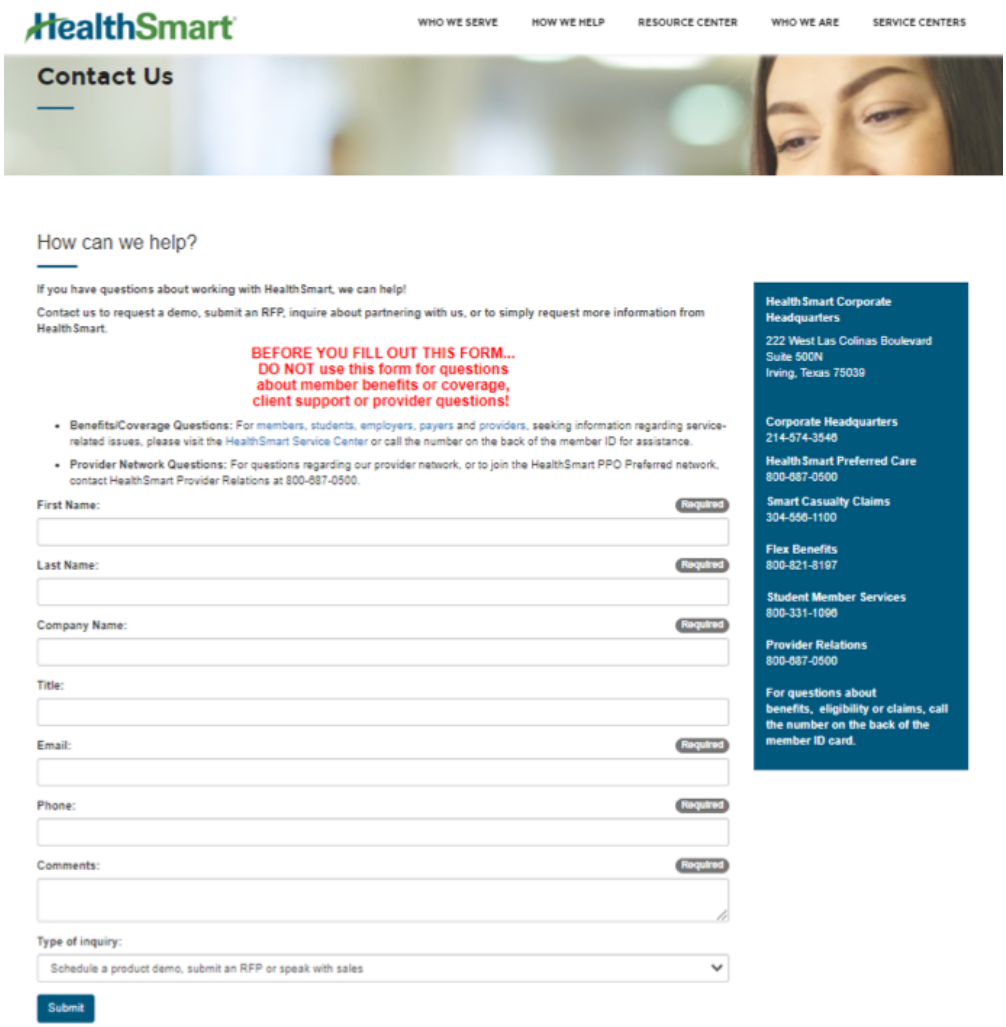
HealthSmart Network Solutions has many and variety of customer types. We work directly with our clients to customize a plan that meets their needs and the needs of their customers. Our goal is to be as flexible and affordable as possible while providing a high-quality product. HealthSmart expects its clients to consider and observe the terms and conditions of our Participating Provider Agreements.

The customers who access our network products include but are not limited to:

+ Third Party Administrators (TPA)
+ Health Plans
+ Network Aggregators
+ Self-funded Unions
+ Bill Review Vendors

Client/Payor List

To obtain a current client list, please go to healthsmart.com/contact-us. When completing the form choose "Request Client List" in the "Type of Inquiry" drop down box.



IX Disputes, Appeals & Grievances

Disputes, Appeals & Grievances

Claim Appeals

The claim appeal and resolution process is available to any Participating Provider that wishes to initiate the process. The appeals process may vary by the client, so it is best practice for you to contact the payor on the patient's ID card. Providers can also submit an appeal through the HealthSmart Online Claim Status Portal (OCS).

Submitting an Appeal through Online Claim Status Portal (OCS)

1. Login
2. Search for claim to appeal
3. Claim must have a 'Status' of 'R' Repriced in order submit an appeal
4. Click on the 'A' under 'Appeal Repricing'
5. Complete the Appeal request and hit submit
6. To register for access to the Online Claim Status Portal (OCS), please see full instruction in the Online Claims Status Portal (OCS) section of the manual.

The appeal will be reviewed by HealthSmart and/or the appropriate party. Once a disposition and finding is reached, a HealthSmart or payor representative will notify the requestor. If a secondary review is required, the initial appeal and review findings may be submitted for next level review. When a final disposition has been reached, notification is sent to the requestor of the appeal/complaint. If the review resulted in a change to the reimbursement of the claim(s), notification of the resolution is submitted to the payor to reprocess the claim in accordance with the findings of the appeal.

Credentialing Disputes

HealthSmart may deny participation or terminate participation during the credentialing or re-credentialing process for the following:

+ Failure to meet the standards and criteria set forth in HealthSmart's Credentialing Policies and Procedures.
+ Failure of an applicant to adequately respond to a request for missing or expired information.
+ Providers accepted or treated a patient prior to being fully credentialed.
+ Failure to meet credentialing standards conducted every 36 months.
+ Failure to meet annual audit process standards (Delegated groups).
+ Failure to meet monthly reporting standards (Delegated groups).
+ Failure to provide notice to HealthSmart of any material changes to their organization.
+ Failure to provide demographics or roster changes.

Corrective Action Notifications indicate a deficiency in a providers credentialing documentation, application or delegated responsibilities. Notified providers are required to submit a written response within 15 days of receipt of a Corrective Action Notice, outlining:

+ A disposition and response to the deficiencies stated in the Notification.
+ Dispute of the deficiency with valid supporting evidence.
+ A corrective action plan to address the deficiencies, including procedures and timelines.

If the parties fail to reach an agreement on the existence or resolution of a deficiency, HealthSmart reserves the right to terminate the credentialing process, the Participating Providers status or the Agreement in question with Notice.

For questions regarding a provider credentialing status, termination or correction action notification please contact the issuing party on the Notice or our Provider Relations Team.

Region	State in which provider practices	Provider Relations Team
Central	IA, IL, IN, KS, MO, MN, ND, NE, SD, WI	pr.central@healthsmart.com
East	CT, DE, KY, MA, MD, ME, MI, NH, NY, OH, PA, TN, VA, VT, WV, RI, NJ	pr.east@healthsmart.com
South	AL, AR, FL, GA, LA, MS, NC, NM, OK, SC, TX	pr.south@healthsmart.com
West	AZ, CA, CO, ID, MT, NV, OR, UT, WA, WY, HI, AK	pr.west@healthsmart.com

Clinical Or Medical Necessity Appeals

An appeal is a request to the health insurer or plan by either an Eligible person or Participating Provider to review an adverse benefit determination.

The appeal process is available to any provider that wishes to initiate the process. The appeals process may vary by the client or payor's Utilization Management program and/or as mandated by state or federal law. If you or an eligible person do not agree with a determination to not approve or certify a health care service made under the Utilization Management program, you or the eligible person have the right to appeal the determination in accordance with Utilization Management program's appeal process. Please contact the appropriate Utilization Management vendor on the member's ID card. Failure to observe the protocols of the Utilization Management program may result in a reduction of benefits to the Eligible person.

Disputes, Appeals & Grievances of any nature can be mailed to:

HealthSmart | Attn: Client Service – Provider Appeals | 222 W. Las Colinas Blvd., Suite 500 N | Irving, TX 75039

Please provide the following information when submitting an appeal/complaint:

+ Contact information (name, phone number, fax number and email address of the submitter)
+ Description of the issue and appeal/complaint with relevant and supporting documentation
+ An EOB and/or a copy of the claim(s) in question

X Appendix

CAQH Access Form

download file

To ensure that HealthSmart can access your CAQH application, please complete this form and return to the appropriate email address based on your practice location indicated below.

Contracted Group Name: _____

State Practice Location: _____

Provider Last Name: _____ **Provider First Name:** _____

Degree: _____ **Specialty (as it relates to the practice):** _____

CAQH Number: _____ **Date of Birth:** _____

Individual NPI: _____ **Practice TIN:** _____

If provider is a mid-level provider (NP, PA, CRNA, CNS), please provide the name of his/her supervising physician as required by state.

Attestation and the following are current:

- License #
- NPI #
- SSN #
- Tax ID #
- Explanation of gaps in work history
- Explanation of gaps in education
- Certificate of Insurance (COI)
- Copy of Board certification
- References
- Curriculum vitae (CV)
- W9

☐ Yes ☐ No

Access granted to HealthSmart to access CAQH application ☐ Yes ☐ No

Do you practice exclusively within the inpatient setting? (e.g. Pathology, ER, Anesthesiology, Radiology, Nurse Practitioner, Physician Assistant, etc ☐ Yes ☐ No

Completed by (print): _____ **Date:** _____

Signature: _____

Email Address: _____

For additional information on CAQH, please see below.

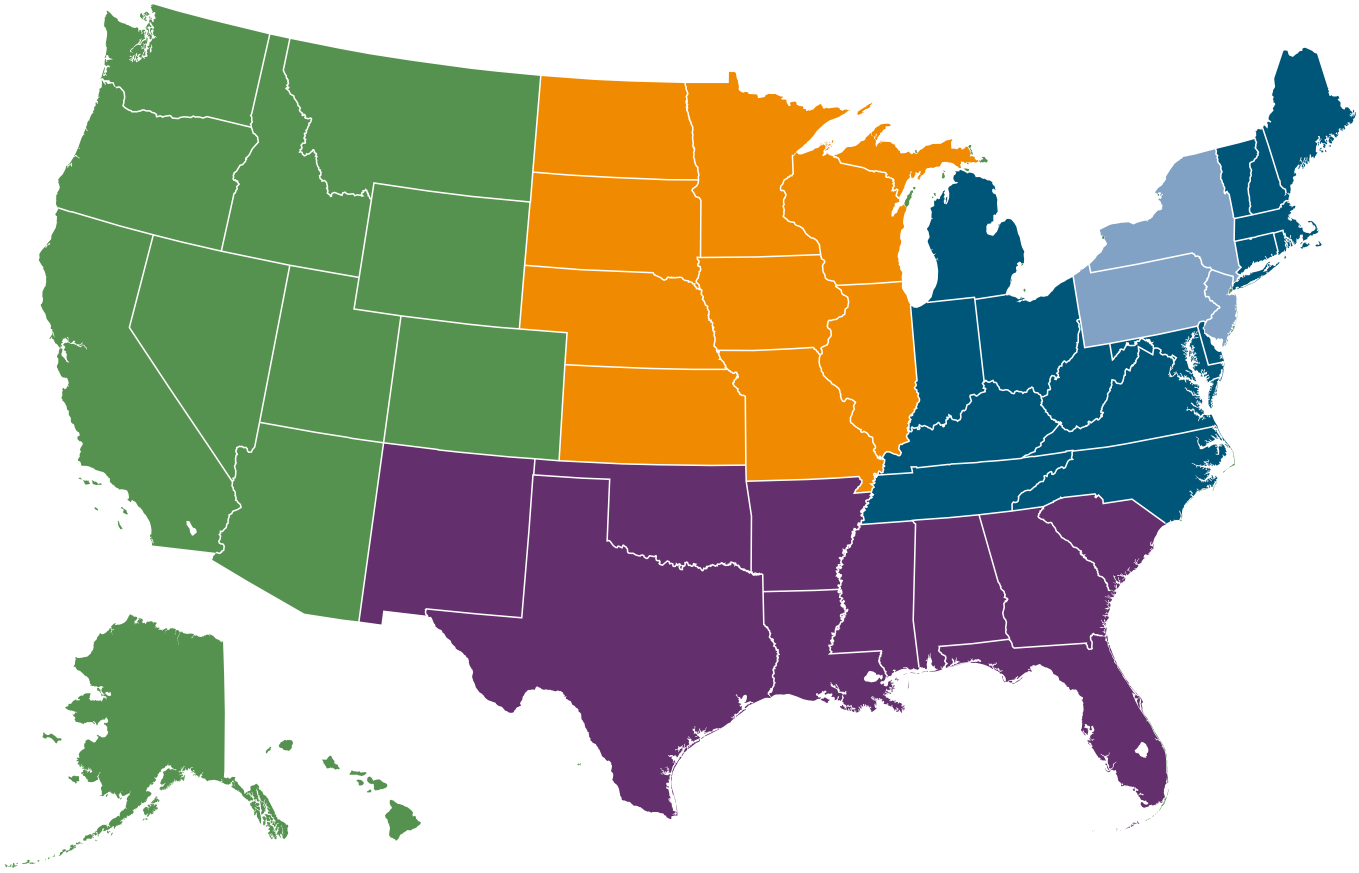
CAQH Website:https://upd.caqh.org/oas/

CAQH Provider Help Desk
Phone Number: 888.599.1771
Email address: caqh.updhelp@acsgs.com

CAQH Provider Help Desk Hours
7am-9pm EST – Monday – Thursday
7am-7pm EST – Friday

Provider Relations Territory Map

Territory Assignment by Region



West Region
Email: pr.west@healthsmart.com
Fax: 214.574.2368

South Region
Email: pr.south@healthsmart.com
Fax: 214.574.2368

Central Region
Email: pr.central@healthsmart.com
Fax: 214.574.2368

East Region **WTC**
Email: pr.eastl@healthsmart.com
Fax: 214.574.2368

Roster Templates

download file

Roster - DELEGATED Group or Facility

download file

Roster - DELEGATED Individual Provider

download file

Roster - NONDELEGATED Group or Facility

download file

Roster - NONDELEGATED Individual Provider

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