Welcome To Ambetter of Tennessee

Your Partner In Better Healthcare

2024 Provider Orientation

Confidential and Proprietary Information

AGENDA

OVERVIEW

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

WHAT YOU NEED TO KNOW

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

QUESTIONS & ANSWERS

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OVERVIEW

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WE ARE AMBETTER

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

#1 carrier
on the health insurance marketplace

2014
Year that Ambetter began

3.3M+
members insured

29
states

LOCAL APPROACH TO CARE

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

- **Target a focused demographic**
- **Lower income, underinsured and uninsured**

WE ARE PROUD TO BE YOUR PARTNER

- The **Ambetter plan design philosophy** is to provide affordable care to individuals or families that need to purchase healthcare coverage on their own.

- **Our products** focus on various cost shares — many with low or no copay amounts — to meet the budgets and utilization needs of these consumers. This gives our members the peace of mind that they have full comprehensive medical coverage.

- Additionally, the **emphasis on reducing barriers and improving access to care** mitigates the risk of individuals showing up without insurance (uncompensated care). Ambetter’s generous cost-sharing initiatives lower patient financial responsibility while also reducing the amount that providers need to collect at time of service.

- Most importantly, Ambetter plans encourage members to establish relationships with their primary care providers to **achieve favorable health outcomes**.

AFFORDABLE CARE ACT

AFFORDABLE CARE ACT (ACA):
Key Objectives

- Increase access to quality health insurance
- Improve affordability

ADDITIONAL PARAMETERS:

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

**May be greater based on state requirements*

AFFORDABLE CARE ACT

REFORM THE COMMERCIAL INSURANCE MARKET – MARKETPLACE OR EXCHANGES

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

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

HEALTH INSURANCE MARKETPLACE

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

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

POTENTIAL MEMBERS CAN:

- Register for the exchange
- Determine eligibility for all health insurance programs (including Medicaid)
- Shop for plans
- Enroll in a plan
- Exchanges may be state-based, Federally facilitated, or a Federal-state hybrid — ***Tennessee is a Federally Facilitated Marketplace***

The Health Insurance Marketplace is the ONLY WAY to purchase insurance and receive subsidies.

HEALTH INSURANCE MARKETPLACE

FINANCIAL ASSISTANCE COMES IN THE FORM OF:

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

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

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

The Health Insurance Marketplace is the ONLY WAY to purchase insurance and receive subsidies.

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OUR NETWORKS

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NETWORKS BUILT TO OFFER MORE

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

OUR INNOVATIVE NETWORKS

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

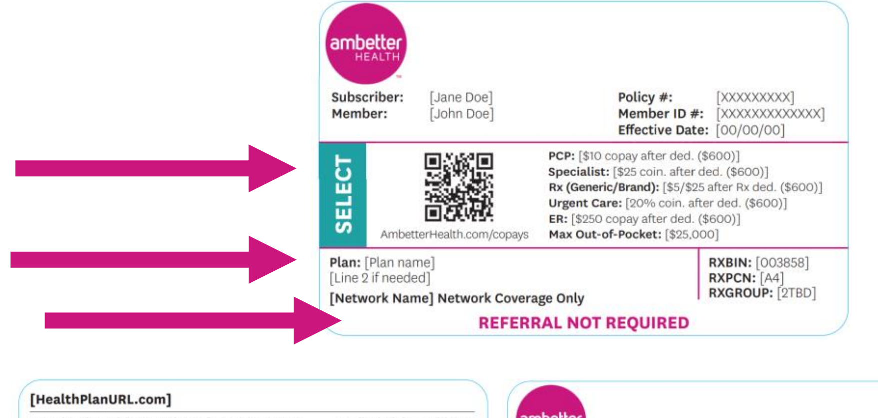
SELECT*: This tailored network is built around exclusive agreements with health systems and their providers and supports Ambetter's lower-premium products. Referrals aren't required. Prior authorizations are required for services not performed by a Select provider.

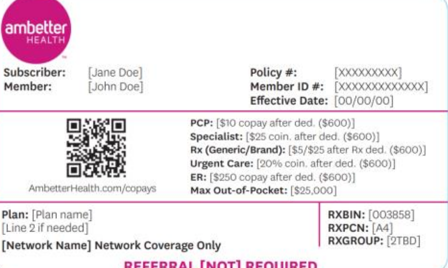
**Network availability varies by state.*

HOW TO IDENTIFY A MEMBER'S NETWORK

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

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





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

OUR NETWORKS:
AMBETTER SELECT

- The SELECT Network is built around **Ascension St. Thomas Health System** that serves **Middle Tennessee Counites: Cheatham, Davidson, Rutherford, Trousdale, Williamson, Wilson.**

- **Ascension St. Thomas Health System** provides the majority of our in-network providers. To ensure adequate access to services for our members, additional Ambetter Providers are invited to join the network.

- For members, this network design offers easy care navigation and a streamlined continuum of care, as well as budget-friendly premiums.

- For providers, SELECT provides exclusive access to new patient populations in their region.

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WHAT YOU NEED TO KNOW

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KEY CONTACT INFORMATION

Ambetter of Tennessee

WEB

www. AmbetterofTennessee.com

PORTAL

Ambetter Secure Provider Portal

PHONE

1-833-709-4735 (TTY 711)

AMBETTER PROVIDER MANUAL

THE PROVIDER MANUAL IS YOUR COMPREHENSIVE GUIDE TO DOING BUSINESS WITH AMBETTER OF TENNESSEE.

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

Key information includes:

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

The Provider Manual can be found in the Provider Resources section of the Ambetter of Tennessee website.

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PROVIDER ENGAGEMENT

The **Ambetter of Tennessee** Provider Engagement team includes trained staff available to respond quickly and efficiently to all provider inquiries, or requests, including:

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

By calling Ambetter of Tennessee Provider Services at **1-833-709-4735 (TTY 711)**, providers can access real time assistance for all their service needs.

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PROVIDER ENGAGEMENT

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

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

PROVIDER NETWORK OPERATIONS

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

Please send the following items to AmbetterTNOps@CENTENE.com

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

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PUBLIC WEBSITE & SECURE PORTAL

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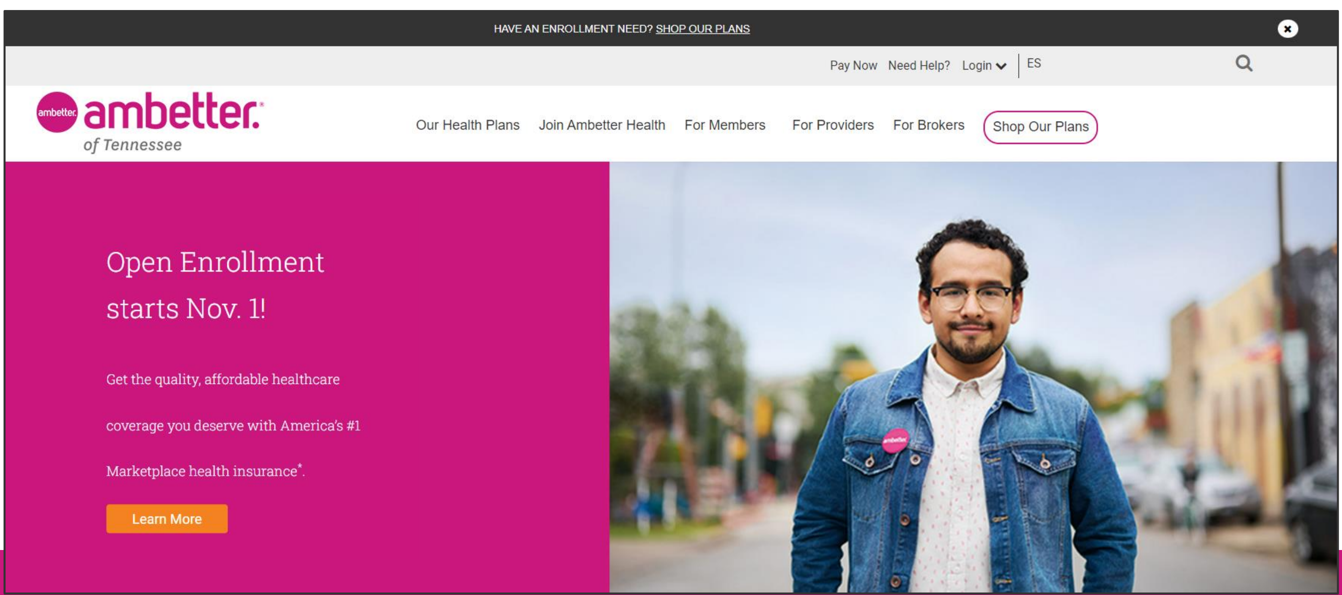
AMBETTER PUBLIC WEBSITE

www. AmbetterofTennessee.com



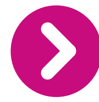
AMBETTER PUBLIC WEBSITE

WHAT'S ON THE PUBLIC WEBSITE?

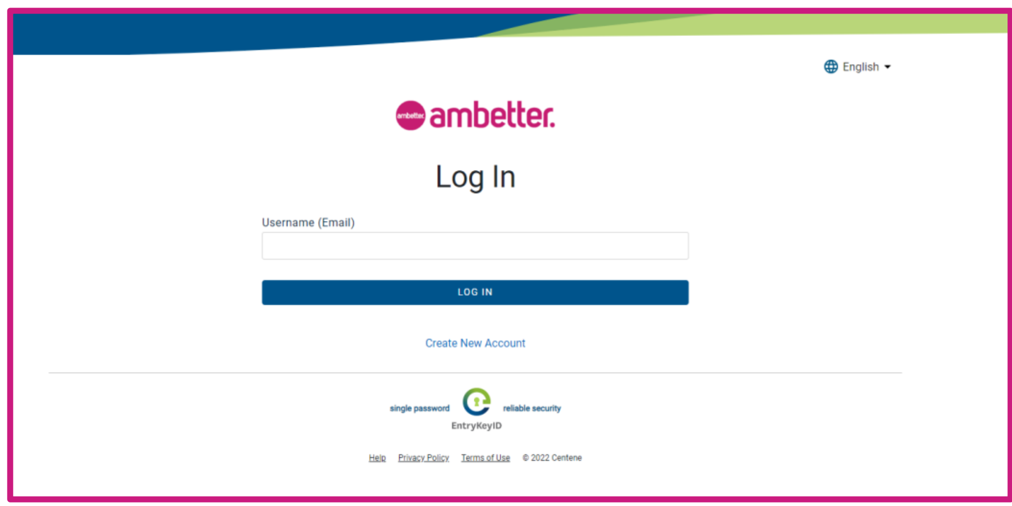
- Provider Manual
- Quick Reference Guides
- Important Forms (Notification of Pregnancy, Prior Authorization Fax forms, etc.)
- The Pre-Auth Needed Tool
- The Pharmacy Preferred Drug Listing

SECURE PROVIDER PORTAL

REGISTRATION IS FREE AND EASY!



Contact your Provider Engagement Administrator to get started!



SECURE PROVIDER PORTAL

WHAT'S ON THE SECURE PROVIDER PORTAL?

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

SECURE PROVIDER PORTAL

INSIGHTFUL REPORTS

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

PCP REPORTS INCLUDE:

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

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VERIFICATION OF ELIGIBILITY, BENEFITS & COST SHARES

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NAVIGATING THE MEMBER ID CARD

ambetter HEALTH

Subscriber: [Jane Doe]
Member: [John Doe]

Policy #: [XXXXXXXXX]
Member ID #: [XXXXXXXXXXXXX]
Effective Date: [00/00/00]

SELECT

AmbetterHealth.com/copays

PCP: [$10 copay after ded. ($600)]
Specialist: [$25 coin. after ded. ($600)]
Rx (Generic/Brand): [$5/$25 after Rx ded. ($600)]
Urgent Care: [20% coin. after ded. ($600)]
ER: [$250 copay after ded. ($600)]
Max Out-of-Pocket: [$25,000]

Plan: [Plan name]
[Line 2 if needed]
[Network Name] Network Coverage Only

RXBIN: [003858]
RXPCN: [A4]
RXGROUP: [2TBD]

REFERRAL NOT REQUIRED

Plans can include:

- Ambetter Gold / Silver / Bronze
- SELECT

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

Pharmacy Benefit Information

Provider Services Contact Information

AmbetterofTennessee.com

Member/Provider Services: 1-833-709-4735 (Relay 711)
24/7 Nurse Line: 1-833-709-4735

Numbers below for providers:
Pharmacist Only: 1-833-750-4246
EDI Payor ID: 68069

Medical Claims Address:
Ambetter of Tennessee
ATTN Claims
PO Box 5010
Farmington, MO
63640-5010

Additional information can be found in your Evidence of Coverage. If you have an Emergency, call 911 or go to the nearest Emergency Room (ER). Emergency services given by a provider not in the plan's network will be covered without prior authorization. Receiving non-emergent care through the ER or with a non-participating provider may result in a change to member responsibility. For updated coverage information, visit AmbetterofTennessee.com.

AMB23-TN-C-00048

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ELIGIBILITY, BENEFITS & COST SHARE

PROVIDER MUST VERIFY MEMBER ELIGIBILITY

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

PANEL STATUS

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

ELIGIBILITY, BENEFITS & COST SHARE

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

- ✓ **Ambetter Secure Portal**
  If you are already a registered user of the Ambetter of Tennessee secure portal, you do NOT need a separate registration!

- ✓ **24/7 Interactive Voice Response System**
  Enter the Member ID Number and the month of service to check eligibility

- ✓ **Contact Provider Services**
  1-833-709-4735 (TTY 711)

VERIFICATION OF ELIGIBILITY ON THE PORTAL

Manage Practice | Eligibility | Patients | PCP Referrals | Authorizations | Claims | Messaging

Viewing Eligibility For : TIN | Plan Type: Ambetter | GO

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

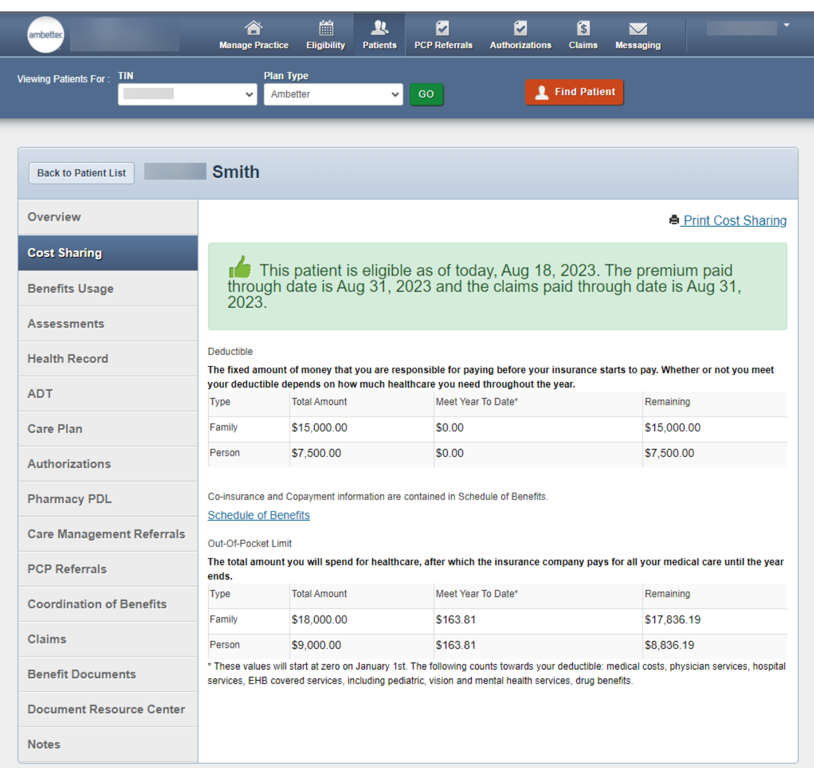
Required Action! Providers seeing members enrolled in Ambetter VALUE or VIRTUAL ACCESS products will need to ensure that PCP Referrals are created prior to providing care. Providers who are outside of the members Primary Provider Group will require a referral for services to be covered. Claims will deny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

Eligibility Check

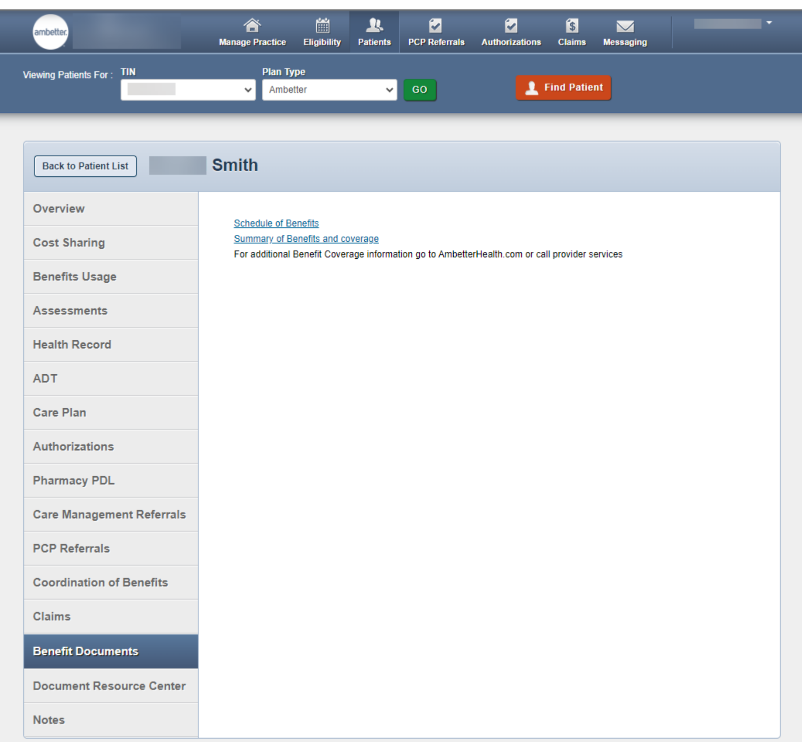
Date of Service (mm/dd/yyyy) 08/18/2023 | Member ID or Last Name 123456789 or Smith | DOB mm/dd/yyyy | Check Eligibility | Print

ELIGIBLE	DATE OF SERVICE	PATIENT NAME	DATE CHECKED	STATE	NETWORK	REFERRAL REQUIRED	RECENT ADT	CARE GAPS	LOG ER VISIT	
	08/18/2023	Smith ›View details	08/18/2023	FL	CMS Exp Bronze Std Core ⓘ	NO	NO	Non-compliant for annual well visit.	ER Visit?	✖ Remove

VERIFICATION OF COST SHARES ON THE PORTAL



VERIFICATION OF BENEFITS ON THE PORTAL



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PRIOR AUTHORIZATION

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HOW TO SECURE A PRIOR AUTHORIZATION

NEED PRIOR AUTHORIZATION?
It can be requested in the following ways:

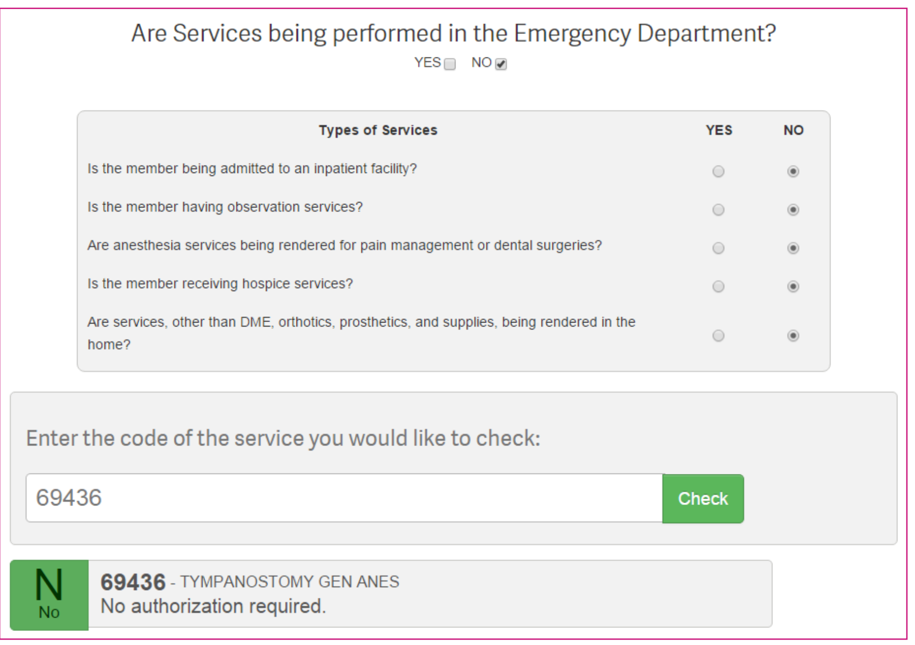
- ✓ Secure Web Portal (This is the preferred and fastest method.)
- ✓ Phone **1-833-709-4735 (TTY 711)**
- ✓ Fax **1-844-811-8467**

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

IS PRIOR AUTHORIZATION NEEDED?

- Use the **Pre-Auth Needed Tool** to quickly determine if a service or procedure requires prior authorization.

- Available on the provider section of the Ambetter of Tennessee **Website**.



PRIOR AUTHORIZATION REQUIREMENTS

PROCEDURES / SERVICES THAT NEED PRIOR AUTHORIZATION INCLUDE*:

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

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

PRIOR AUTHORIZATION REQUIREMENTS

INPATIENT AUTHORIZATION IS NEEDED FOR THE FOLLOWING*:

- All elective/scheduled admission notifications requested at least 5 days prior to the scheduled date of admit including:
  - All services performed in out-of-network facilities
  - Behavioral health/substance use
  - Hospice care
  - Rehabilitation facilities
  - Transplants, including evaluation
- Observation stays more than 23 hours require Inpatient Authorization
- Urgent/Emergent Admissions
- Within 1 day following the date of admission
- Newborn deliveries must include birth outcomes
- Partial Inpatient, PRTF and/or Intensive Outpatient Programs (IOP)

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

PRIOR AUTHORIZATION REQUIREMENTS

ANCILLARY SERVICES THAT NEED PRIOR AUTHORIZATION INCLUDE*:

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

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

PRIOR AUTHRIZATION TIMEFRAMES

Service Type	Timeframe
Scheduled admissions	Prior Authorization required (5) days prior to the scheduled admission date
Elective outpatient services	Prior Authorization required (5) days prior to the elective outpatient service date
Emergent inpatient admissions	Notification (1) business day
Observation – 48hours or less	Notification within 1 day for non-participating providers
Observation – greater than 48 hours	Requires inpatient prior authorization within 1 business day
Maternity admissions	Notification within (1) day
Newborn admissions	Notification within (1) day
Neonatal Intensive Care Unit (NICU) admissions	Notification within (1) day
Outpatient Dialysis	Notification within (1) day
Organ transplant initial evaluation	Prior Authorization required at least 30 days prior to the initial evaluation for organ transplant services.
Clinical trials services	Prior Authorization required at least 30 days prior to receiving clinical trial services.

UTILIZATION DETERMINATION TIMEFRAMES

Type	Timeframe
Prospective/Urgent	Within (2) business days of receipt of all information needed to complete the review, no to exceed 3 calendar days from receipt of request. If all information is not received by the end of the 3rd calendar day, a determination will be made based on available information.
Prospective/Non-Urgent	Within (2) business days of receipt of all information needed to complete the review, no to exceed 15 calendar days from receipt of the request. If all information is not received by the 15th calendar day, of the request a determination will be made based on available information.
Concurrent/Urgent	Within one (1) calendar day from receipt of the request. Extension: A onetime extension may be granted of up to 3 calendar days if additional information is needed. If all information is not received by the end of the 3rd calendar day, a determination will be made based on available information.
Concurrent/Non-Urgent	Two (2) business days from receipt of all information necessary. Extension: A onetime extension may be granted up to 3 days. If all information is not received by the end of the 3rd day a determination will be made based on available information.
Retrospective	Thirty (30) calendar days from receipt of the request.

PRIOR AUTHORIZATION: CORRECT CODING

PRIOR AUTHORIZATION WILL BE GRANTED AT THE CPT CODE LEVEL

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

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CLAIMS, BILLING & PAYMENTS

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CLAIMS

WHAT IS A CLEAN CLAIM?

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

ARE THERE ANY EXCEPTIONS?

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

HOW TO SUBMIT A CLAIM

The timely filing deadline for initial claims is 90 calendar days from the date of service, or date of primary payment, when Ambetter is secondary.

CLAIMS MAY BE SUBMITTED IN THREE WAYS:

1. **Secure Ambetter Provider Portal**

2. **Electronic Clearinghouse**

- Payor ID 68069
- Clearinghouses currently utilized by Ambetter will continue to be utilized
- For a listing of our clearinghouses, visit our website at **www.AmbetterofTennessee.com**

1. **Mail**

   Ambetter
   P.O. Box 5010
   Farmington, MO 64640-5010

CLAIM RECONSIDERATIONS & DISPUTES

CLAIM RECONSIDERATIONS

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

CLAIM DISPUTES

- Must be submitted within **180 days** of the Explanation of Payment.
- A Claim Dispute form can be found on our website **Provider Resource page**.
- Mail completed Claim Dispute form to:
  Attn: Claims Department
  P.O. Box 5010
  Farmington, MO 63640-5010

CLAIM SUBMISSION: SUSPENDED STATUS

WHAT IF A MEMBER IS IN SUSPENDED STATUS?

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

CLAIM SUBMISSION: SUSPENDED STATUS

EXAMPLE TIMELINE OF A MEMBER IN SUSPENDED STATUS

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

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

HELPFUL INFORMATION ABOUT CLAIMS

MAKE SURE TO INCLUDE THE RENDERING TAXONOMY CODE!

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

REMINDER: DO NOT FORGET THE CLIA NUMBER!

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

BILLING THE MEMBER

COPAYS, CO-INSURANCE AND DEDUCTIBLES

- Copays, co-insurance and any unpaid portion of the deductible may be collected at the time of service.
- Deductible information, including the amount that has been paid toward the deductible so far, can be accessed via the Ambetter Secure Provider Portal.
- If the amount collected from the member is higher than the actual amount owed upon claim adjudication, the provider must reimburse the member within **45 days**.

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CLAIMS PAYMENTS

ELECTRONIC FUNDS TRANSFER

PAYSPAN®: A FASTER, EASIER WAY TO GET PAID

- Ambetter offers PaySpan® Health, a free solution that helps providers transition into electronic payments and automatic reconciliation.
- If you currently utilize PaySpan®, you will need to register specifically for Ambetter.

SET UP YOUR PAYSPAN® ACCOUNT:

- Visit www.PAYSPANHealth.com and click Register.
- You may need your National Provider Identifier (NPI) **and** Provider Tax ID Number (TIN) or Employer Identification Number (EIN).

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COMPLAINTS, GRIEVANCES & APPEALS

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COMPLAINTS, GRIEVANCES & APPEALS

CLAIMS

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

COMPLAINT/GRIEVANCE

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

COMPLAINTS, GRIEVANCES & APPEALS

APPEALS

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

MEDICAL NECESSITY

- Must be filed within **30 days** from the Notice of Action.
- Ambetter shall acknowledge receipt within **10 days** of receiving the appeal.
- Ambetter shall resolve each appeal and provide written notice as expeditiously as the member's health condition requires but not to exceed **20 days**.
- Expedited appeals may be filed if the time expended in a standard appeal could seriously jeopardize the member's life or health. The timeframe for a decision for an expedited appeal will not exceed **72 hours**.

COMPLAINTS, GRIEVANCES & APPEALS

MEMBER REPRESENTATIVES

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

NEED MORE INFORMATION?

- Full details of the claim reconsideration, claim dispute, complaints/grievances and appeals processes can be found in our Provider Manual, located on our website at **AmbetterofTennessee.com**.

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SPECIALTY SERVICES & VENDORS

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SPECIALTY COMPANIES & VENDORS

Service	Specialty Company/Vendor	Contact Information
High Tech Imaging Services	National Imaging Associates	1-866-214-2569 www.radmd.com
Vision Services	Envolve Vision©	1-800-334-3937 www.envolvevision.com
Dental Services	Envolve Dental©	www.envolvedental.com
Pharmacy Services	Pharmacy Services	1-866-399-0928 (Phone) 1-866-399-0929 (Fax)

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Questions & Answers

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