



Avera Health Plans At a Glance

Avera 
Health Plans

YOUR LIFE, YOUR PLAN.

Section 1: Welcome

1.1 About Avera Health Plans

[Avera Health Plans](#) is a wholly owned subsidiary of Avera Health. We provide health care benefit options to individuals, families, seniors and employers based in South Dakota, Iowa and Nebraska. We maintain a provider network that includes a comprehensive health care delivery system throughout South Dakota, southwest Minnesota, northwest Iowa and northeast Nebraska. Avera Health Plans contracts with regional and national networks to provide coverage for members who reside out of our area.

1.2 Avera Health Plans Philosophy

Mission

Avera is a health ministry rooted in the Gospel. Our [mission](#) is to make a positive impact in the lives and health of persons and communities by providing quality services guided by Christian values.

Vision Statement

We intend to maintain an outstanding health insurance financing and administration service guided by Christian values, with health care provided within a fully integrated care delivery system.

Objectives

- To provide excellent, affordable, convenient health care services to members
- To develop and maintain effective long-term alliances with providers who envision the future as a fully integrated care delivery system
- To develop and successfully manage the most cost-effective care delivery system, offering a full array of managed care services
- To develop and offer innovative products that place emphasis on health promotion, health education, wellness, early health-risk detection, screening and disease prevention
- To provide a strong, comprehensive care delivery system guided by Christian values, aligning incentives to promote quality and cost-effective care delivery

- To be recognized as the industry leader in:
 - Member services
 - Provider network and relationships
 - Care delivery outcomes
 - Health benefits financing
 - Health benefits administration

Values

Avera Health Plans adheres to three important values that guide the actions of our participating providers and staff: compassion, hospitality and stewardship.

Compassion

The compassion of Jesus, especially for the poor and the sick of body and spirit, shapes the manner in which Avera's employees, physicians, administrators, volunteers and sponsors deliver health care. We express compassionate care through sensitive listening and responding, understanding, patience, support and healing touch.

Hospitality

Jesus' encounters with individuals were typified by openness and mutuality. The Avera community expresses hospitality by means of a welcoming presence, attentiveness to needs and a gracious manner, seasoned with a sense of humor.

Stewardship

Threaded through the mission of Jesus was the restoration of all the world to right relationship with its Creator. In that same spirit and mission, the members of Avera treat persons, organizational power and Earth's resources with justice and responsibility. Respect, truth and integrity are foundational to right relationships among those who serve and those who are served.

Guiding Principles

- To maximize the quality of care delivered with continuous evaluation for opportunities for improvement
- To provide for the most efficient use of resources
- To provide an approach to medical diagnosis and treatment that is based on medical necessity

- To require the involvement, input and support of the medical staff for the preservation of clinical judgment
- To recognize the value of prevention and health maintenance through programs and services
- To implement methods and tools of systems thinking and systems approach to problem solving
- To support operations that receive the highest satisfaction rate from customers, members, providers and employees

1.3 Avera Health Plans Accreditation

Avera Health Plans is accredited with the [National Committee for Quality Assurance \(NCQA\)](#). NCQA Health Plan Accreditation includes rigorous evaluation of standards across multiple areas and includes results on clinical performance and consumer experience from Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS). The NCQA framework provides a roadmap for improvement for Avera Health Plans.

1.4 Provider Rights and Responsibilities

Rights

1. To join Avera Health Plans subject to our credentialing plan
2. To receive notice of revisions to our policies
3. To receive claims payments directly, based on the provider's contractual agreement with Avera Health Plans
4. To receive information, education and support from our provider relations department regarding plan policies and operations as well as for problem resolution

Responsibilities

1. To utilize our participating specialty providers, hospitals and facilities unless otherwise approved by Avera Health Plans

2. To provide services to our members in the same manner and quality as those services provided to patients who are not our members
3. To close enrollment, if applicable, to new members with 60 days' notice to Avera Health Plans
4. To accept our reimbursement as payment in full (minus any co-pays, deductibles or coinsurance) for each covered service under the member's contract
5. To recognize all payments are subject to the Coordination of Benefits provisions of Avera Health Plans
6. To keep all member medical record information complete and confidential
7. To open medical and administrative records with notice from Avera Health Plans regarding the member, for review by our staff for the purpose of performing medical management, quality improvement, credentialing, and/or peer review activities
8. To cooperate with Avera Health Plans to provide precertification, case management, quality improvement and peer review as requested
9. To comply with all policies and procedures as outlined in the Provider Agreement
10. To provide the necessary information and documentation regarding any appeal
11. To promptly notify Avera Health Plans regarding the following occurrences:
 - A change in status of license, certification, specialty board status or DEA registration
 - Any circumstance that is required to be reported to the National Practitioner Data Bank, the Health Protection and Integrity Data Bank or any other reporting agency
 - If a provider is no longer employed, contracted or otherwise affiliated with a clinic or facility
 - Any change or loss of liability insurance coverage
 - If a provider is no longer compliant with our credentialing criteria
 - Any circumstance in which a provider is sanctioned (e.g., to be suspended, debarred or excluded from participation in/or convicted of any criminal offense related to the delivery of health care)

- Any situation where a provider is charged with a felony or is under formal investigation for fraud or felony
- 12. To notify us of a change in address, ownership, tax identification number or network participation
- 13. To notify our members in a timely manner if the provider no longer participates with our network
- 14. To maintain adequate medical records incorporating medical record standards
- 15. To actively participate in the provider directory accuracy activities of the health plan every 90 days as required by the No Surprises Act (NSA)

1.5 Avera Health Plans Contact Information

Service Center

Email: Service@AveraHealthPlans.com

Phone: [888-322-2115](tel:888-322-2115)

Provider Relations

Email: AHP.Providers@avera.org

Phone: [888-322-2115](tel:888-322-2115)

Credentialing

Email: AHP-Credentialing@avera.org

Phone: [605-591-1601](tel:605-591-1601)

Section 2: Avera Health Plans Products and Networks

2.1 Avera Health Plans Products

Overview

Avera Health Plans promotes prevention as the best and most cost-effective medicine. Our products focus on preventive health care and wellness. We offer a series of benefit plan designs for fully-insured and self-insured clients, including multiple plan designs with a range of deductibles, out-of-pocket maximums and pharmacy benefits.

Avera Health Plans offers products through six main product lines:

- a. **Avera Health Plans** – Fully-insured health insurance plans for large and small employers
- b. **Individual health insurance** – Policies for single and/or families
- c. **Avera Health Plans Benefit Administrators** – Self-funded or level-funded employer groups have access to the Avera Health Plans network, medical management services, eligibility and claims processing experience
- d. **Medicare Supplement Insurance** – Products for senior citizens
- e. **Avera Care System** – Provider network choices for members of the City of Sioux Falls, Minnehaha County and Home Federal Bank. For members who have chosen the Avera Care System as their network, claims must be sent to Avera Health Plans for pricing, and we then forward the claims to United Medical Resources (UMR) for claim processing. Avera Health Plans also performs preauthorization for these members
- f. **Association Health Plans** – Fully-insured plans for associations

Definitions

- **Product:** A discrete package of health insurance coverage benefits that are offered using a particular product network type (such as HMO or PPO) within a service area. Any set of plans that share a network type and a set of benefits is a product.
- **Network:** The PPO or HMO networks offered by Avera Health Plans.
- **Plan Types:** With respect to a product, plans are the pairing of the benefits under the product with a particular cost sharing structure, provider network and service area that are offered to consumers.

If you have any questions or would like more product information, please contact our service center or you may email inquiries to Service@AveraHealthPlans.com.

2.2 TotalChoice

Overview

TotalChoice is Avera Health Plans' newest PPO network with the broadest network available, including South Dakota's major health systems and many trusted regional providers. TotalChoice plans also include a travel network, using the UnitedHealthcare® Options PPO network for national coverage.





The TotalChoice service area includes:

- All South Dakota counties
- 13 northwest Iowa counties

Both small and large employers that are based in this service area can purchase the TotalChoice products.

Member ID Card

Members who have purchased the TotalChoice plan will have a distinctive TotalChoice logo on the front of their ID card.

			
Subscriber: Bugs Bunny		Subscriber #: 10002222201	
Group: Dakota Tube		Group #: A0005982	
Member: Bugs Bunny		Member #: 10002222201	
PCP Copay \$35 Specialist Copay \$70 In-Network Ind Ded \$5000		Out-of-Network Ind Ded \$10000 In-Network Ind OOP \$6000 Out-of-Network Ind OOP \$15000	
If services are rendered outside South Dakota or surrounding counties in the Avera Service area, please reference the back of the card.		 RXBIN: 026952 RXPCN: AVERA	
		MEMBERS: Customer Care: 1-888-322-2115 Pharmacy Member Services: 1-833-464-7663 Log in to see benefit information at: AveraHealthPlans.com This card does not guarantee eligibility for benefits or payment of claims.	
		PROVIDERS: Providers outside South Dakota or surrounding counties in the Avera Service area, submit medical claims to: UHSS, PO Box 30783, Salt Lake City, UT 84130-0783. Payor ID 39026 UHSS Provider Services: 888-830-0179 https://uhss.unm.com  UHSS Member ID: UN1000145202 UHSS Group ID: 78-800328 For Prior-Authorizations call UHSS: 865-397-7466 Failure to get prior-authorization may reduce benefits.	
		Providers inside South Dakota or surrounding counties in the Avera Service Area, submit medical claims to: First Choice Health Network, PO Box 2289, Seattle, WA 98111-2289. Payor ID AH002. Avera Health Plans Provider Services: 833-964-0711. Visit Avera.org/PA for details. For Prior-Authorizations: https://Avera.org/PA . Failure to get prior-authorization may reduce benefits.  	

Claims

Because Avera Health Plans has a robust participating provider network in South Dakota and Iowa, most claims will be passed directly to Avera Health Plans where claims will be adjudicated using Avera Health Plans' contracted rates. Providers who are not contracted directly with Avera Health Plans will have claims repriced by First Choice Health network.

For services rendered inside the TotalChoice service area:

- Send all claims to First Choice Health, at PO Box 2289, Seattle, WA 98111-2289 using Payer ID AH002.

For services rendered outside the TotalChoice service area:

- Send all claims to UnitedHealthcare Options PPO Network, at UHSS, PO Box 30783, Salt Lake City, UT 84130-0783 using Payer ID 39026.

Prior Authorizations

Submit prior authorizations like you normally do for all product lines at Avera.org/PA.

Questions/Resources

Participating Providers with both the Avera Health Plans and/or the First Choice Health PPO Network should log in to the Avera Health Plans [provider portal](#).

If you have any questions regarding TotalChoice, call us at [888-322-2115](tel:888-322-2115) or visit the [TotalChoice webpage](#) for more information.

2.3 DirectConnect

Formerly Avera Direct Network, [DirectConnect](#) is an HMO network offered to members or employers in select South Dakota counties.

DirectConnect plans only provide in-network benefits when a DirectConnect provider is utilized. There is no out-of-network area solution.

2.4 ConnectPlus

Formerly Avera Health Plans Network, [ConnectPlus](#) is a broad, regional PPO network that includes Avera Health and Monument Health systems, as well as many independent providers.

Refer to the Summary Plan Description or ID card to determine if a member has access to an out-of-network solution.

2.5 Medicare Supplement Plans

Avera Health Plans offers a variety of [Medicare Supplement Insurance](#) plans in South Dakota, Iowa and Nebraska to help Original Medicare beneficiaries keep costs down for out-of-pocket health care expenses.

Avera [Medicare Supplement](#) offers two plans: Standard and Select. The Standard plan serves all South Dakota counties. A hospital directory for those enrolled in the Select plan is found [here](#).

The Avera [AgilityPlus](#) Standard plans are available in three states (SD, IA and NE). The service areas for each state consists of all [South Dakota](#) counties, 13 counties in northwest [Iowa](#) and 17 counties in northeast [Nebraska](#).

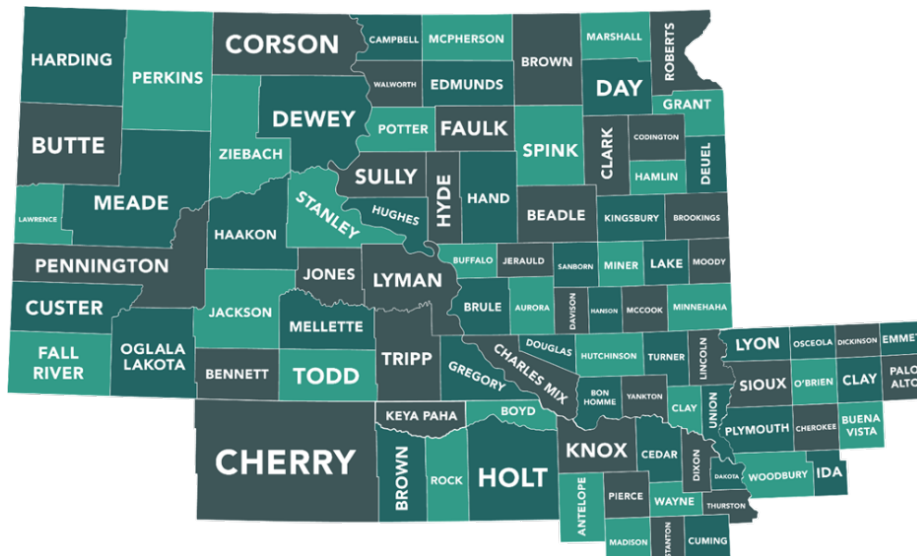
The Avera [AgilityPlus](#) Select plan is only available in South Dakota. The service area consists of nine counties in South Dakota, and the hospital directory is located [here](#).

Please refer to the member's identification card to know which distinct plan they are enrolled in.

If you have further questions regarding our Medicare Supplement plans, please contact us at [888-322-2115](tel:888-322-2115) or Service@AveraHealthPlans.com. For further information on Medicare, please visit medicare.gov or cms.gov.

2.6 Service Area

A graphic of Avera Health Plans' [service area](#) is below.



Avera Health Plans serves all counties in South Dakota.

In Iowa, Avera Health Plans serves the following counties: Buena Vista, Cherokee, Clay, Dickinson, Emmet, Ida, Lyon, O'Brien, Osceola, Palo Alto, Plymouth, Sioux and Woodbury.

In Nebraska, Avera Health Plans serves the following counties: Antelope, Boyd, Brown, Cedar, Cherry, Cuming, Dakota, Dixon, Holt, Knox, Keya Paha, Madison, Pierce, Rock, Stanton, Thurston and Wayne.

Out-of-Area Network

Avera Health Plans utilizes the UnitedHealthcare® Options PPO network to serve its members when they are out of its service area. Access to the UnitedHealthcare Options PPO network depends on which plan the member is enrolled in. Refer to the member's ID card for determining their access. A provider directory can be found [here](#).

While our PPO members have full access to the UnitedHealthcare Options PPO network, our HMO members only have access to UnitedHealthcare Options PPO for urgent and emergent care or care that has been preauthorized because of a gap in network access.

When services are rendered outside of the Avera Health Plans' service area, claims should be submitted directly to UnitedHealthcare. For UnitedHealthcare Provider Services, call 888-830-0179 or visit <https://uhss.umar.com>. For UnitedHealthcare Prior-Authorizations call 866-397-7466.

Section 3: Provider and Member Resources

3.1 Provider Resources

Overview

For more information, access the [Provider Resources](#) webpage on our website.

Avera Health Plans Service Center

The [Avera Health Plans Service Center](#) can be reached at [888-322-2115](tel:888-322-2115) or Service@AveraHealthPlans.com.

Provider Portal

The [Avera Health Plans provider portal](#) allows users to check eligibility, manage claims, review policies and submit preauthorizations. If you are experiencing security/login issues with your portal account, please contact 877-814-9909.

Provider Relations Representatives

This staff assists with issues regarding contract language, fee schedule requests, overall plan operations, plan policies and procedures, ensuring the integrity of providers' data and site visits.

To contact provider relations, please reach out to AHP.Providers@Avera.org.

Avera Health Plans Website

The [Avera Health Plans website](#) contains information regarding topics such as forms, policies, important updates and claims/eligibility information.

Provider Directory

Our [provider directory](#) serves as a tool to search for participating providers in our different networks.

ProviderView

[ProviderView](#) is our monthly newsletter that is emailed to participating providers. Editions are archived on our website.

Member Eligibility Verification

Log in to the [provider portal](#) and click on the Eligibility tab, then enter the member's ID number found on their member ID card.

3.2 Member Resources

Avera Health Plans Service Center

The [Customer Care Center](#) for members can be reached at [888-322-2115](tel:888-322-2115) or Service@AveraHealthPlans.com.

Online Resources

The [member resources](#) page on our website has information for members regarding topics such as coverage, renewal and FAQs.

MyHealthPlan Mobile App

Avera Health Plans has a [free mobile app](#) that all our members can download to access the information found on our member website, quick references to their claims, year-to-date deductible balances and contact information. Members need to create an account before they can log in to the app.

Complaint and Appeals Process

All members have the right to file a complaint or an appeal with Avera Health Plans. If the member wishes to file a complaint or contest the disposition of a claim, they may do so in writing by contacting our [service center](#). Additional information and forms are online under Member Benefits after logging in to our [website](#).

Interpreter Services

Our Customer Care Center has access to [translation services](#) in more than 100 languages to help members receive information about benefits and how to access medical services.

Member Rights

[Member rights and responsibilities](#) are listed on our website.

Section 4: Operational Processes

4.1 Closing Practice to New Patients

In order for a provider to close their practice to new patients, a provider must complete the following:

1. Provider must notify Avera Health Plans' provider relations department in writing at least 60 days before closing the practice to new patients.
2. Provider must close the practice to all new patients. The provider will not deny care based on age, gender, ethnicity, life expectancy, present or predicted disability, degree of medical dependency, quality of life or other health conditions.
3. Provider must notify Avera Health Plans' provider relations department in writing if and/or when the practice reopens to new patients.

Our service center will notify inquiring members that the provider's practice is closed to new patients.

4.2 Effective Date of Participation and Claims Filing During the Credentialing Period

Providers who have submitted a credentialing application for participation with Avera Health Plans are required to withhold submission of their claims until they have been notified that they have been successfully credentialed.

We have provided these guidelines to help providers understand our policies on participation effective dates under several possible circumstances.

Participation Effective Date Guidelines:

- The credentialing period begins on the date that a completed provider application has been accepted by Avera Health Plans Credentialing Services that contains all necessary information to process the application and ends when the final credentialing determination has been made and notice has been sent to the provider.
- If an application is received that is incomplete or is missing information necessary for processing, Avera Health Plans Credentialing Services will send a notice to the provider that will provide a detailed description of all documentation or additional information necessary to complete the credentialing application. These notices shall be sent as soon as possible and no more than 30 days after the receipt of an application that requires additional information for processing.
- Final determinations on completed credentialing applications are typically made within 30 to 45 days, with an outer limit of no more than 90 days. In some circumstances, the Avera Health Plans Credentialing Committee may request additional information regarding the application if a special review is required. Additional time to complete the credentialing process is permitted and may be necessary if a special review is required.
- Providers should not submit claims to Avera Health Plans during the credentialing period. Claims submitted by providers during the credentialing period will be subject to denial. After the credentialing determination notice has been sent, the provider should submit all claims to Avera Health Plans for services that were provided during the credentialing period and those claims will be processed. Considerations on timely filing requirements will not begin until the credentialing determination has been made and notice has been sent to the provider.
- Claims filed in error by a provider that have been denied during the credentialing period will need to be refiled using a Provider Request for Reconsideration once the credentialing determination notice has been sent to the provider. Avera Health Plans will not be responsible for identifying and adjusting any claims that were denied during the credentialing period.

- Non-participating providers who wish to contract with Avera Health Plans must submit a signed participating provider contract with associated reimbursement exhibits as may be applicable to their situation before credentialing invitations will be extended. The process of credentialing is contingent upon contracting. Intent to contract is not considered a substitution for a signed agreement.
- For providers who have joined an existing group practice that has contracted with Avera Health Plans as a provider group, our expectation and the expectation of our members is that the provider’s effective date of participation shall be that provider’s start date with the group practice. If claims are received from what appears to be a new provider who has joined a contracted group practice and a completed credentialing application has not been submitted for consideration, our Provider Relations Team will be notified and will reach out to the group practice to determine the circumstances. In an effort to protect the in-network benefits for our members, Avera Health Plans reserves the right to deny these claims as a provider billing error and will work with that provider group practice to get the necessary credentialing paperwork filed as promptly as possible to minimize revenue disruption and ensure accurate in-network application of benefits for its members.

Circumstance	Participation Effective Date
A new provider who signs a participating provider agreement.	Participation effective date shall begin with 1) the practice effective date, on the condition that the receipt of the completed provider application is received within the first 30 days of the practice start date and is contingent upon successful credentialing, or 2) upon receipt of the completed provider application. <i>Provider is responsible for holding claims until credentialing is completed.</i>
A non-participating provider who has been actively submitting claims and chooses to become a participating provider.	Participation effective date shall begin with the receipt of the completed provider application and is contingent upon successful credentialing. <i>Provider is responsible for holding claims until credentialing is completed.</i>
A new provider who joins an existing participating provider group practice.	Participation effective date shall begin with the provider's start date with the group practice and is contingent upon successful credentialing. Our members should have a reasonable expectation that any new provider joining an existing

	participating provider group practice will be participating under the group practice from their start date. <i>Provider is responsible for holding claims until credentialing is completed.</i>
A new provider group practice seeking to contract as a participating provider group.	Participation effective date for the group shall be established as the date of receipt of the completed application for the first successfully credentialed provider. All eligible providers must complete credentialing before the contract can be executed. <i>Provider group is responsible for holding claims until credentialing is completed.</i>
A provider who is already credentialed who starts a new practice.	Participation effective date shall correspond to the date of receipt of their signed participating provider agreement. <i>We recommend working with your Provider Relations Representative before submitting claims to make sure all appropriate steps have been taken to confirm that our claims system is ready to accept claims.</i>
A hospital-based provider who is participating under a provider agreement held by the facility that is not required to be credentialed individually by NCQA credentialing standards.	Participation effective date shall be equal to the provider's start date as a hospital-based provider. This is contingent upon timely notice of the provider addition to the facility's provider agreement and may be limited by timely filing criteria. <i>We recommend working with your Provider Relations Representative before submitting claims to make sure all appropriate steps have been taken so our claims system is ready to accept claims.</i>
An existing provider group or individual provider who is already contracted that adds participation for an additional line of business for which they are not currently contracted.	Participation effective date for the additional line of business shall be equal to the date of receipt of the signed Reimbursement Exhibit for the additional line of business. <i>We recommend working with your Provider Relations Representative before submitting claims to make sure all appropriate steps have been taken so our claims system is ready to accept claims.</i>

4.3 Medical Record Standards

The provider must maintain a record of health services rendered to each member. The provider is responsible for assuring the medical records of members are secure, complete, accurately documented, organized and readily accessible. All records should be maintained in a format that facilitates retrieval of information in an efficient manner.

Availability

Providers shall make Avera Health Plans members' medical records, or a copy thereof, available to other participating providers and to the individual member.

Confidentiality

The provider will be responsible for assuring that the security and privacy of medical records and information contained therein is held in confidence and in conformity with the Health Insurance Portability and Accountability Act of 1996, and the regulations promulgated there under. It is understood that at the time of enrollment, our members have signed a consent giving access of the medical record to the member, his or her representatives, regulatory and/or accreditation bodies, and for all other purposes that relate to the member's treatment, payment of claims for services rendered or other health care operations.

The provider shall ensure that staff receive periodic training in confidentiality of member information.

Assessment

Avera Health Plans may periodically conduct a review of medical records to assess, ensure or improve the quality of patient care. The results of this review will be communicated to the provider and are used in conjunction with our quality improvement activities.

We will provide professional consultations on medical record assembly and maintenance as needed or when requested.

Modification of Medical Records

Avera Health Plans will not accept corrections or legally amended medical records after the medical necessity review is completed or after the submission, adjudication or payment of a claim. If these changes appear in the medical record following medical necessity review or payment determination, only the original record will be reviewed in determining payment of services billed to Avera Health Plans.

4.4 Network Access Standards

All network access standards are measured following NCQA guidelines. It is important that both Avera Health Plans and providers work to maintain a network of primary, specialty and behavioral health care providers.

Primary Care: A primary care provider is a participating provider who is a medical doctor (MD), doctor of osteopathy (DO), nurse practitioner (NP) or a physician assistant (PA). Primary care providers include general/family practitioners, internists and pediatricians. Participating care providers are available in the fields of family practice, internal medicine, general practice, obstetrics / gynecology and pediatrics.

Specialist: Any provider who has a specific practice of medical care other than primary care.

- **High-Impact Specialty Care Provider** - A provider who specializes in oncology, which has a high mortality and morbidity rate and requires significant resources.
- **High-Volume Specialty Care Provider (SCP)** - A provider who is a licensed individual in any of the following fields and as determined by number of patient encounters using evaluation and management services: obstetrics and gynecology.

Behavioral Health: A behavioral health provider is a participating provider including psychiatrists, psychologists and other providers with a master's-level behavioral health degree. Examples include:

- Psychiatrist
- Addiction medicine specialist
- Clinical psychologist
- Clinical social worker
- Psychiatric clinical nurse specialist
- Substance abuse counselor
- Marriage and family therapist
- Psychiatric nurse practitioner

Access is evaluated based on providers who are prescribers and non-prescribers. Of the behavioral health providers above, psychiatrists, addiction medicine specialists and psychiatric nurse practitioners are prescribers.

Secret Shopper Survey

The Centers for Medicare & Medicaid Services (CMS) require health insurance plans to conduct a Secret Shopper Survey to assess appointment wait times. The survey ensures compliance with federal standards for timely access to care and helps maintain a high level of service for our members.

The wait time standards mandated by CMS are below:

<u>Provider Specialty Type</u>	<u>Appointments Must Be Available Within</u>
Primary Care (Routine)	15 business days
Behavioral Health	10 business days

4.5 Compliance

Referral to Participating Providers

We will work with providers to educate and inform them of available in-network providers when patterns of referrals outside of the network are identified.

4.6 Patient Waivers

Patients may elect to sign a Patient Waiver Form assuming financial responsibility for services(s) that will or are likely to be deemed by Avera Health Plans to be not medically necessary, [experimental](#), [investigational](#) or unproven, and therefore not covered under the plan. The provider must explain both verbally and in writing to the patient that the services in question do not or may not meet Avera Health Plans' medical necessity criteria. The provider must give the patient a reasonably accurate estimate of the patient's potential financial liability, the patient must sign the Patient Waiver Form prior to services performed and the provider must bill for such services with an appropriate modifier.

A Patient Waiver Form must be completed with each incident. Keep on file with your patient's records as evidence of his or her informed consent. NOTE: Do not file the Patient Waiver Form with the claim.

The Patient Waiver Form must contain the following elements to be valid:

- Date

- Place of service
- Description of the service(s)
- An attached copy or summary of Avera Health Plans medical policy or preservice adverse determination
- A reasonably accurate cost estimate of the service(s)
- A statement acknowledging the provider informed the patient that the services provided may not be considered medically necessary by the patient's health insurance policy and that the patient is agreeing to accept full financial liability for the services.

The process of offering the Patient Waiver Form for patient signature must be a deliberate and specific preservice action by the provider. Therefore, blanket or generic waivers that attempt to preserve the provider's right to bill for any and all services may be denied as not medically necessary, experimental, investigational or unproven will not be considered valid.

4.7 Contract Disputes

Contract disputes are a way for providers to contest claims processing determinations.

Complaints and grievances against Avera Health Plans can be filed by a member, or a provider can file a grievance on behalf of the member as the member's authorized representative if the member specifies this in writing. Avera Health Plans strictly adheres to all state regulations and guidelines pertaining to this matter. All complaints and grievances will be acknowledged and decided on within a specified time frame specified by federal, state and accreditation entities.

Please utilize our [Provider Request for Reconsideration Form](#) and review the Provider Reconsideration Guidelines to help expedite the contract dispute process.

If you have any questions pertaining to the process, please call our service center at 888-322-2115.

4.8 Continuation of Covered Services

Avera Health Plans provides continuity of care to current members whose providers terminate from the network and members who are new to the plan and have already begun

a defined course of treatment with a non-participating provider. A course of treatment is the therapeutic interventions including what is going to be done, when the interventions will be completed and by whom. The course of treatment must consider each of the members' needs and define clear ways of dealing with each problem. Avera Health Plans also provides continuity of care to current members in the second or third trimester of pregnancy through the postpartum period whose providers terminate from the network. Avera Health Plans does not provide continued access in the following circumstances:

- The provider is unwilling to continue to treat the member or accept Avera Health Plans' payment or other terms.
 - The member accesses a provider group, rather than to an individual provider, and the other providers in the group continue to be contracted with Avera Health Plans.
 - The provider's contract was discontinued based on a professional review action, as defined in the Health Care Quality Improvement Act of 1986 (as amended, 42 U.S.C. section 1101 et seq.)
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Section 5: Credentialing

5.1 Credentialing Overview

Avera Health Plans' [credentialing program](#) involves the initial and ongoing collection, verification and review of information necessary for selection and retention of providers. These providers must meet Avera Health Plans' credentialing standards. Eligibility for providers is determined by the extent to which applicants meet defined requirements for education, licensure, professional standing, service availability and accessibility. Providers must also conform to our utilization and quality management requirements.

Only those providers meeting our participation criteria are included in the network. In addition to the credentialing standards, selection criteria may be considered in contracting with providers.

In [Avera Health Plans' Credentialing Plan](#), you can find information on our process, provider and facility types, accountability and more. Contact us at AHP-Credentialing@avera.org if you have any questions or concerns.

Section 6: Quality Program

6.1 Quality Program Overview

The Quality Program provides a framework for the evaluation of the entire spectrum of Avera Health Plans operations based upon the philosophy of continuous quality improvement.

If you have questions about our Quality Program, please contact us at [888-322-2115](tel:888-322-2115).

CAHPS and QHP Results

Each year Avera Health Plans conducts two surveys to gauge member satisfaction: [Consumer Assessment of Healthcare Providers and Systems \(CAHPS\)](#) and [Qualified Health Plan Enrollee Experience \(QHP\)](#).

The CAHPS survey goes to members who purchase insurance through their employer or on their own, while the QHP survey goes to members who purchase insurance through the Marketplace.

The data collected provides information on the experiences of our members and how well the plan and its participating physicians meet their expectations. It also serves as a public report card. The CAHPS scores, along with Healthcare Effectiveness Data and Information Set (HEDIS) scores, inform our National Committee for Quality Assurance (NCQA) accreditation and star ratings. The QHP scores, along with HEDIS, inform the star ratings available on both federal and state marketplaces.

6.2 Clinical Practice and Preventive Health Guidelines

Avera Health Plans adopts practice guidelines relevant to our members for the provision of preventive and non-preventive acute and chronic medical services. Avera Health Plans uses guidelines to help providers and members make decisions about appropriate health care.

Please visit the [provider portal](#) on the [Avera Health Plans website](#) to view our Clinical Practice and Preventive Health Guidelines.

6.3 Patient Safety

Avera Health Plans strives to serve as a critical link for providers to access patient safety information and helps to improve safety within their practices.

Helpful links for patient safety include:

- The Leap Frog Group: leapfroggroup.org
- Minnesota Alliance for Patient Safety: maps.org
- Institute for Health Improvement: ihi.org
- National Quality Forum: qualityforum.org
- Department of Health and Human Services Agency for Healthcare Research and Quality: ahrq.gov

Avera Health Plans works to create a culture that supports our providers and offers tools to improve the safety in their practices. To facilitate a culture of patient safety, Avera Health Plans conducts Quality of Care review on the following indicators:

- Readmission
- Mortality
- Surgical or Clinical Procedural Error, Complication or Infection
- Unexpected Trauma During Treatment
- Unexpected Return to Surgery
- Access/Availability to Care
- Delay in Diagnosis, Treatment or Service
- NICU Admission
- Quality of Care Complaints from members

The Avera Health Plans Chief Medical Officer reviews these cases and assigns a severity level. Selected cases are blinded to protect the confidentiality of the provider and member and sent to peer review at the Quality Improvement and Utilization Management Committee. Based on committee findings, a case may be referred back to the treating facility or provider for review of procedures.

Section 7: Utilization Management and Care Management

7.1 Preauthorization

The provider must initiate the [preauthorization process](#) before the scheduled services are rendered. Instructions for obtaining preauthorization are available on the provider portal of the Avera Health Plans website. Look online at the [List of Services Requiring Preauthorization document](#) for the services that require preauthorization.

Not all our members follow the same guidelines. It is important to view their member ID card. The back will address where you should call for the preauthorization. If the logo on the front has Benefit Administrators, you may have different phone numbers to call for preauthorizations.

To verify benefits, please contact our customer care team at 888-322-2115.

7.2 Care Coordination

Care coordination is an Avera Health Plans benefit for all members and providers. The case management role is to assist members in getting care at the right time by connecting them with the necessary providers and resources. Care coordination also improves communication between members and their providers.

Care coordination provides a single point of contact to help members find their way through the health care system. Case management staff assist members with resources and information necessary to their care.

For questions regarding care coordination, please contact our case managers at 888-605-1331, option 1 or email CareManagement@Avera.org.

7.3 Case Management Services

Avera Health Plans has case managers who can assist your patients, manage symptoms, prevent complications and improve their quality of life. Examples of patients who may benefit from working with our case managers include:

- Patients with multiple, complex or chronic conditions
- Patients undergoing transplant
- Patients with unplanned hospitalizations

Our case managers provide assistance in navigating the health care system, as well as necessary resources and information to manage their care. To be eligible, the patient must

be an Avera Health Plans member. This is not offered to members in the Avera Health Plans Medicare Supplement plan.

To connect your patient to a case manager, contact us at CareManagement@Avera.org.

7.4 Non-Participating Provider Referrals

Avera Health Plans may allow in-network benefits for non-emergency services provided by out-of-network providers when Avera Health Plans determines network inadequacy exists for the service requested. If network inadequacy exists, covered services specific to the condition are covered at the member's in-network benefit level. Emergency situations are addressed by member coverage documents.

7.5 Avera Health Plans Preauthorization Requirements Managed by Cohere Health

Avera Health Plans has a utilization and quality management relationship with [Cohere Health](#). All participating providers are required to obtain a preauthorization for certain Current Procedural Terminology (CPT) codes, which are [found on this list](#). The ordering provider is contractually responsible for obtaining the authorization on a preservice basis, and the rendering provider is responsible for ensuring preauthorization is in place before rendering the service. Failure to obtain and verify the preauthorization could result in the denial of services as a provider liability under the Provider Agreement. If your CPT code is on the list of Cohere codes, follow the instructions on the [Cohere Health portal](#).

Cohere Health Preauthorization Requirements Apply to these Avera Health Plans Members

- Commercial Fully Insured Group Members
- Commercial Administrative Services Only (ASO) Group Members
- Self-Funded Group Members
- Avera Health Employee Health Plan Members
- Hegg Memorial Plan Members
- Avera Heart Hospital Plan Members

Avera Health Plans Members Excluded from Cohere Health Preauthorizations

- Avera Care System (UMR)
- Medicare Supplement

Some self-funded clients of Avera Health Plans Benefit Administrators may have their own preauthorization requirements not managed by Cohere Health, and providers are encouraged to inquire when checking eligibility and benefits.

7.6 Obtaining and Verifying a Preauthorization with Cohere Health

The ordering provider or designee (a member of the ordering provider's office staff) is responsible for obtaining the preauthorization online via the [Cohere Health portal](#). You must register for an account prior to obtaining a preauthorization.

New users can find assistance by exploring the [Cohere Health learning page](#) and/or attending a [webinar](#).

For help in registering for the portal or submitting for preauthorization, contact Cohere Health Customer Service at: 800-249-8035.

7.7 Obtaining Utilization Management Criteria

Providers have the right to access copies of utilization management guidelines, criteria, policies or protocols used in utilization management decisions. All internally developed policies and guidelines are available on the provider portal of the Avera Health Plans website. If a provider would like copies of the utilization management guidelines, criteria, policies or protocols used in utilization management decisions, contact our medical management department at 888-605-1331 or healthservices@averahealthplans.com.

7.8 Affirmative Statement about Incentives

Avera Health Plans makes utilization management decisions based only on appropriateness of care and service and existence of coverage. Avera Health Plans does not specifically reward practitioners or other individuals for issuing denials of coverage.

Financial incentives for utilization management decision makers do not encourage decisions that result in underutilization.

Section 8: Pharmacy Management Guidelines

8.1 Pharmacy Overview

Avera Health Plans utilizes [pharmacy benefits managers](#) for all members. Check each member's identification card to determine which pharmacy benefit manager is assigned to each member. Contact information is at the link provided.

8.2 Formulary

Avera Health Plans' pharmacy benefits cover thousands of prescription drugs to help make your medications more affordable and convenient. A list of current drug formularies is on our [website](#).

8.3 Preauthorization

The current preauthorization lists are [here](#). Visit [here](#) to find the preauthorization portal.

8.4 Step Therapy

To view the most current step therapy information, visit our [webpage](#).

8.5 Mail Order

If a member would like to use mail order, new prescriptions can be ordered by calling the pharmacy benefits manager listed on the member's identification card. More information is provided [here](#).

8.6 Cost-Saving Tools

Members also have access to cost-saving tools such as the Avera Prescription Savings Card, Amazon Pharmacy, Mark Cuban Cost Plus Drug Company, Rx Savings Solutions and RxWallet.

Section 9: Claims

9.1 Claims Overview

Claims must be submitted on the standard UB-04 or CMS 1500 forms or electronically in those formats. In order to process a claim within the regulatory requirements, the claim must be submitted as a clean claim. Submitted claims must include all required fields; claims that are not complete will be denied. The denial code on the provider's Explanation of Payment will indicate what information is necessary to reprocess the claim.

Providers must also ascertain from the patient at the time of the initial visit whether an injury is work related or caused by a third party, such as an automobile accident. If an injury is work related or caused by a third party, the provider agrees to relay this information to Avera Health Plans as soon as possible. This information is required to determine if workers' compensation insurance applies and if coordination of benefits or subrogation rights should be invoked.

Electronic Claims Submission

Avera Health Plans uses clearinghouses for electronic claim submission. In order to receive electronic remittance advice, you must be able to submit claims to e-Provider Solutions. Our payer ID number is 46045.

Manual Claims Submission Avera Health Plans encourages electronic claims submission for more timely and accurate processing. Avera Health Plans uses optical character recognition (OCR) technology when processing manually submitted claims. OCR allows for a more automated process, resulting in shorter claims turnaround and improved quality; however, electronic claims submission remains the industry standard for fastest and most accurate form of claims submission.

If you must submit a manual claim, submit claims to the following address:

Avera Health Plans
5300 S. Broadband Ln.
Sioux Falls, SD 57108-2221

When a claim is returned to providers or denied by Avera Health Plans, please resubmit corrected claims to the following address:

Avera Health Plans
5300 S. Broadband Ln.
Sioux Falls, SD 57108-2221

Required Information on the UB-04 and CMS 1500



Required		Required		Required		Required	
PATIENT NAME		PATIENT ADDRESS		ADMITTING PHYSICIAN		STATEMENT COVER PERIOD	
Required		Required		Required		Required	
10 BIRTH DATE		11 SEX		12 ADMISSION DATE		13 DISCHARGE DATE	
Required		Required		Required		Required	
14 OCCURRENCE DATE		15 OCCURRENCE DATE		16 OCCURRENCE DATE		17 OCCURRENCE DATE	
Conditionally Required		Conditionally Required		Conditionally Required		Conditionally Required	
18		19		20		21	
Required		Required		Required		Required	
22		23		24		25	
Required		Required		Required		Required	
26		27		28		29	
Required		Required		Required		Required	
30		31		32		33	
Required		Required		Required		Required	
34		35		36		37	
Required		Required		Required		Required	
38		39		40		41	
Required		Required		Required		Required	
42		43		44		45	
Required		Required		Required		Required	
46		47		48		49	
Required		Required		Required		Required	
50		51		52		53	
Required		Required		Required		Required	
54		55		56		57	
Required		Required		Required		Required	
58		59		60		61	
Required		Required		Required		Required	
62		63		64		65	
Required		Required		Required		Required	
66		67		68		69	
Required		Required		Required		Required	
70		71		72		73	
Required		Required		Required		Required	
74		75		76		77	
Required		Required		Required		Required	
78		79		80		81	
Required		Required		Required		Required	
82		83		84		85	
Required		Required		Required		Required	
86		87		88		89	
Required		Required		Required		Required	
90		91		92		93	
Required		Required		Required		Required	
94		95		96		97	
Required		Required		Required		Required	
98		99		100		101	
Required		Required		Required		Required	

UB-04 Required Field Information		
Field No.	Field Name	Explanation
1	None	Enter the facility's name and address.
3a	Pat. CNTL#	
3b	Med Rec. #	<i>Conditionally required:</i>
4	Type of Bill	Enter the appropriate four-digit code (e.g., 011X) as specified in the <i>UB-04 Data Specifications Manual</i> . 1st digit Leading zero (0) 2nd digit Type of facility 3rd digit Type of care 4th digit Indicates the sequence of the bill for a specific episode of care
5	Federal Tax Number	Enter your facility's nine-digit number for the type of bill you are submitting (e.g., NN-NNNNNNN)
6	Statement Covers Period (From-Through)	Enter dates in the MM/DD/YY format.
8a	Patient Name	Enter the patient's last name, first name and middle initial.
8b	Patient ID Number	Enter the patient's ID number if different from the policyholder's ID number.
9a-d	Patient Address	Enter the patient's full address, even if the patient's address is the same as the policyholder's.
10	Patient Birth Date	Enter the correct date of birth (MM/DD/YYYY).
11	Sex	Enter the sex of the patient.
12	Admission/ Start of Care Date	Enter the date the patient was admitted for inpatient care.
13	HR	<i>Conditionally required:</i>
14	Priority (Type) of Admission or Visit	Required on inpatient only. This code indicates priority of admission (e.g., emergency=1, urgent=2, elective=3, etc.) Refer to the <i>UB-04 Data Specifications Manual</i> for a listing of codes.
15	Point of Origin for Admission or Visit (formerly Source of Admission)	<i>Conditionally required:</i> The point of origin is where the patient came from before presenting to the health care facility. Refer to the <i>UB-04 Data Specifications Manual</i> for a listing of codes.
17	Patient Discharge Status	The patient status code indicates the patient's status as of the "Through" date of the billing period (FL 6).

18-28	Condition Codes	<i>Conditionally required:</i> refer to the <i>UB-04 Data Specifications Manual</i> on how to complete FLs 18-28.
31-34	Occurrence Codes and Dates	<i>Conditionally required:</i> occurrence codes are required when there is a condition code that applies to the claim. Refer to the <i>UB-04 Data Specifications Manual</i> for a list of occurrence codes.
35-36	Occurrence Span Codes and Dates	<i>Conditionally required:</i> Enter event codes and a beginning and ending date that define a specific event relating to the billing period. Refer to the <i>UB-04 Data Specifications Manual</i> for a list of value codes.
39-41	Value Codes and Amounts	Enter the two-digit value code(s) and dollar or unit amount(s) necessary to process the claim. Refer to the <i>UB-04 Data Specifications Manual</i> for a list of value codes.
42	Revenue Code	Enter the four-digit revenue code that represents a specific accommodation, ancillary service, or billing calculation. Revenue codes must be valid for the Type of Bill (FL 4) indicated on the claim form.
44	HCPCS/Rate/HIPPS Codes	
45	Service Date	You must provide a specific date for each service billed on a line.
46	Service Units	This field identifies the number of services the patient received or the time required to provide a specific service. To calculate units, round up to the nearest whole number.
47	Total Charges	Submit a charge for each revenue code billed. Even if there is no charge, you must either enter 0.00 or N/C on the line item or the claim will be returned.
48	Non-Covered Charges	
49		
50	Payer Name	
51	Health Plan ID	
52		
54	Prior Payments	<i>Conditionally required:</i> enter any amount the facility has received toward payment of this bill prior to the billing date by the indicated payer in FL 50.

56	National Provider ID (NPI)	Enter the facility's NPI number.
58	Insured's Name	Enter the last and first name of the policyholder.
59	Patient's Relationship	Enter a code that indicates the relationship of the patient to the policyholder. Refer to the <i>UB-04 Data Specifications Manual</i> for a complete list of appropriate codes you should use to complete this field.
60	Insured's Unique ID	Enter the alpha prefix and identification (ID) number as it appears on the patient's ID card.
61	Group Name	
62	Insurance Group Number	
63	Treatment Authorization	<i>Conditionally required:</i> enter the authorization numbers. Line A: Procedure authorization number Line B: Facility authorization number
64	Document Control Number	<i>Conditionally required:</i>
65	Employer Name	<i>Conditionally required:</i>
67	Principal Diagnosis	Enter the principal ICD-9-CM diagnosis for the condition established, after study, as responsible for the patient's admission.
67a-q	Other Diagnosis Codes Present on Admission Indicator (POA)	Enter the full ICD-9-CM codes for additional conditions if they co-exist at the time of admission or develop subsequently and have an effect on treatment or length of stay.
69		
70		<i>Conditionally required:</i>
71	PPS Code	<i>Conditionally required:</i>
74	Principal Procedure Code and Date	<i>Conditionally required:</i> On inpatient claims, submit a valid principal ICD-9-CM Volume 3 procedure code when revenue codes 0360-0369, 0490-0499 and 0750-0759 are billed.
76	Attending Physician Name and Identifiers	Enter the name and NPI number of the licensed physician who normally would be expected to certify and rectify the medical necessity of the services provided, and/or who has primary responsibility for the patient's medical care and treatment during an inpatient stay.
77	Operation Physician Name and Identifiers	<i>Conditionally required:</i> required when a surgical procedure code is listed on the claim.
80	Remarks	<i>Conditionally required:</i>



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

<input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BENEFIT <input type="checkbox"/> OTHER		<input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BENEFIT <input type="checkbox"/> OTHER		14. INSURED'S ID NUMBER <input type="checkbox"/> (Required)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <input type="checkbox"/> (Required)		3. PATIENT'S BIRTH DATE <input type="checkbox"/> (Required)		4. INSURED'S NAME (Last Name, First Name, Middle Initial) <input type="checkbox"/> (Required)	
5. PATIENT'S ADDRESS (No. Street) <input type="checkbox"/> (Required)		6. PATIENT RELATIONSHIP TO INSURED <input type="checkbox"/> Self <input type="checkbox"/> 5-Conditional <input type="checkbox"/> Other		7. INSURED'S ADDRESS (No. Street) <input type="checkbox"/> (Required)	
8. RESERVED FOR NUCC USE		9. RESERVED FOR NUCC USE		10. IS PATIENT'S CONDITION RELATED TO: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> AUTO ACCIDENT PLACE (Date) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> OTHER ACCIDENT <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> CLAIM CODES (Designated by NUCC)	
11. INSURED'S POLICY GROUP OR FECA NUMBER <input type="checkbox"/> (Required)		12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to reject or to the party who accepts a claimant's claim.) SIGNED: <input type="checkbox"/> (Required) DATE:		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.) SIGNED: <input type="checkbox"/> (Required)	
14. DATE OF CURRENT ILLNESS, INJURY OR PREGNANCY (LMP) <input type="checkbox"/> (Required)		15. OTHER DATE <input type="checkbox"/> (Required)		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION <input type="checkbox"/> (Required)	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE <input type="checkbox"/> (Conditional)		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES <input type="checkbox"/> (Required)		19. OUTSIDE LAB <input type="checkbox"/> (Conditional)	
20. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) <input type="checkbox"/> (Conditional)		21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Refer to service line below (SLE)) <input type="checkbox"/> (Required)		22. RE-SUBMISSION CODE <input type="checkbox"/> (Conditional)	
23. A. DATE(S) OF SERVICE FROM <input type="checkbox"/> (Required)		23. B. PLACE OF SERVICE <input type="checkbox"/> (Required)		23. C. PROCEDURE, SERVICE, OR SUPPLIES (Specify unusual circumstances) <input type="checkbox"/> (Required)	
24. A. DATE(S) OF SERVICE FROM <input type="checkbox"/> (Required)		24. B. PLACE OF SERVICE <input type="checkbox"/> (Required)		24. C. PROCEDURE, SERVICE, OR SUPPLIES (Specify unusual circumstances) <input type="checkbox"/> (Required)	
25. FEDERAL TAX ID NUMBER <input type="checkbox"/> (Required)		26. PATIENT'S ACCOUNT NO. <input type="checkbox"/> (Required)		27. ACCEPT ASSIGNMENT <input type="checkbox"/> YES <input type="checkbox"/> NO	
28. TOTAL CHARGE <input type="checkbox"/> (Required)		29. AMOUNT PAID <input type="checkbox"/> (Required)		30. RECEIVING PROVIDER INFO & PH# <input type="checkbox"/> (Required)	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE(S) OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) <input type="checkbox"/> (Required)		32. SERVICE FACILITY LOCATION INFORMATION <input type="checkbox"/> (Required)		33. BILLING PROVIDER INFO & PH# <input type="checkbox"/> (Required)	
SIGNED: <input type="checkbox"/> (Required) DATE:		SIGNED: <input type="checkbox"/> (Required) DATE:		SIGNED: <input type="checkbox"/> (Required) DATE:	

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

All fields required except C. and H.

CMS-1500 Required Field Information		
Field No.	Field Name	Explanation
1a	Insured's ID Number	Enter the policyholder's alpha prefix and ID number as shown on his/her identification card.
2	Patient's Name	Enter the patient's full given name (no nicknames).
3	Patient's Date of Birth	Enter the correct date of birth (MM/DD/YYYY) and sex of the patient.
4	Insured's Name	Enter the policyholder's name.
5	Patient's Address	Required if it is not the same as the policyholder's address
6	Patient Relationship to Insured	<i>Conditionally required:</i>
7	Insured's Address	Enter the complete address of the policyholder.
9	Other Insurance Information	Required if 11d is marked "yes." If you determine the patient has other coverage, please enter the name of the other insured.
9a	Other Insured's Policy or Group Number	<i>Conditionally required:</i> Enter the other insured's policy or group number in this field.
9b	Reserved for NUCC use	<i>Conditionally required</i>
9c	Reserved for NUCC use	<i>Conditionally required</i>
9d	Insurance Plan Name or Program Name	<i>Conditionally required:</i> Enter the insurance plan name or program.
10	Is Patient's Condition Related To	Check the appropriate box if the patient's condition is related to employment or an auto accident or check "other."
11	Insured's Policy Group or FECA Number	
11a	Insured's Date of Birth	Enter the correct date of birth (MM/DD/YYYY) and sex of the insured.
11b	Other Claim ID	Designated by NUCC
11c	Insurance Plan Name or Program Name	
11d	Is There Another Health Benefit Plan?	Request this information from the member. If the answer is "yes," go back and complete blocks 9-9d.

12	Patient's or Authorized Person's Signature	Signature on file okay
13	Insured's or Authorized Person's Signature	
17b	ID Number of Referring Physician (NPI)	<i>Conditionally required:</i> if you fill out field 17.
19	Additional Claim Information	<i>Conditionally required:</i>
20	Outside Lab? Charges	<i>Conditionally required:</i> Check the appropriate box if an outside lab was used. If "yes," list the charges.
21	Diagnosis or Nature of Illness or Injury	For dates of service through September 30, 2014, enter an ICD-9-CM code. For dates of service starting October 1, 2014, enter ICD-10 codes.
23	Prior Authorization Number	<i>Conditionally required</i>
24a	Dates of Service	If you submit office or hospital outpatient services, submit each service and/or each date of service on a separate line with the same "from" and "to" dates.
24b	Place of Service	Enter the place of service code.
24d	Procedures, Services or Supplies	Submit valid CPT or HCPCS codes. Enter a current two-digit CPT or HCPCS modifier when applicable.
24e	Diagnosis Pointer	When there is more than one diagnosis on a claim, enter the primary diagnosis reference number from field 21 that relates to the reason each service was performed. If more than one diagnosis is appropriate for a service, the first number (letter) listed in 24e must be the primary diagnosis for that service.
24f	Charges	Submit a charge for each service billed on a line.
24g	Days or Units	Enter the appropriate number of services (in whole numbers) based on the time period or amount designated by the procedure code. You must enter at least one unit.
24i	ID Qual	

24j	Rendering Provider ID	Enter the practitioner's individual rendering/performing NPI number.
25	Federal Tax ID Number	Enter your practitioner/supplier federal taxpayer identification number (TIN).
26	Patient's Account Number	Enter the patient's account number.
28	Total Charge	Enter the total of all charges from 24f. The line items submitted must equal the Total Charge in field 28 or the claim will be returned.
29	Amount Paid	
31	Signature of Physician or Supplier	The physician's signature, computer-printed name, stamp facsimile, "signature on file" or the signature of an authorized person is acceptable.
32	Service Facility Location Information	Enter the facility's NPI number.
33	Billing Provider Information	Enter the provider's or supplier's billing name, address, zip code, and phone number.
33a	NPI	If you have a group/organization NPI number, enter it in this field. If you do not have a group/organization NPI, enter your individual practitioner's/supplier's NPI number in this area.

9.2 Timely Filing Guidelines

Providers have one year from the date of service to submit, process and pay claims. This time schedule includes any corrected claims, provider requests for reconsiderations and payment adjustments. Claims submitted more than one year from the date of service will be denied as provider liability. The full text of the Claims Adjustment and Time Limitations Reimbursement Policy can be found in the Policies section after logging in to the provider portal on our [website](#).

9.3 Explanation of Payment

Avera Health Plans uses many Explanation of Payment (EOP) codes to communicate with providers. These codes assist the provider in identifying what information is needed to process the claim or why a claim was denied. These codes are listed on the last page of each EOP. Avera Health Plans has adopted the standard transaction sets for EOP codes in order to comply with HIPAA regulations.

9.4 Overpayment of a Provider

Refund Process

If Avera Health Plans processes a claim and determines that it was initially overpaid to the provider, that amount will be automatically deducted from the provider's next payment. For providers who have already requested that overpayments be automatically deducted from their next payment, there will be no charge. If you find a situation where a claim has been overpaid and the overpayment has not automatically been deducted from your next payment, you can contact our provider relations department at AHP-Providers@avera.org.

Recoupment Process

Recoupment involves offsetting the amount owed against future claim payments. Future claim payments will be reduced until the full amount of the overpayment is recovered by Avera Health Plans. Recoupment may also be used initially if the provider has requested this as their preferred recovery procedure. If you are interested in being set up for automatic recoupment, please contact our service center or email AHP-Providers@avera.org.

9.5 Denied Claims – Request for Reconsideration

When submitting your request for reconsideration, the [Provider Request for Reconsideration Form](#) is required to be attached. The form will ensure all pertinent information is included with the initial request and reduce delay within the review process.

9.6 Coordination of Benefits

Coordination of Benefits (COB) means a provision establishing an order in which plans pay their claims permit secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable charges. Coordination of Benefits helps eliminate duplicate payments when a member has health care coverage under more than one plan. Coordination of Benefits is designed to protect members and their employers from higher premiums that result when two insurance companies make duplicate reimbursements.

Avera Health Plans will take specific steps to coordinate benefits for members who have health care coverage under more than one plan. The order of benefit Determination Rules found in the Avera Health Plans Member Handbook determines which plan will pay as the primary plan. If the amount of payments made by Avera Health Plans is more than it should have paid under this COB provision, we may recover the excess from one or more of the members we have paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered member.

Additional information about coordination of benefits can also be found in member's Certificate (Evidence) of Coverage, Individual Policy or Summary Plan Document.

9.7 Subrogation

Subrogation is a legal right held by health care providers and payers to recover expenses when members or employees are injured in certain types of accidents and the expenses related to the accidents should have been reimbursed by another party. If a member is injured or becomes ill because of an action or omission of a third party who is or may be liable to the member for the injury or illness, Avera Health Plans will take steps to recover their health care costs from either the member or the party responsible for the injury or illness. Payment for health care services provided to the member due to injury or illness caused by a third party shall be in accordance with Certificate of Coverage.



YOUR LIFE, YOUR PLAN.