

Clover Health

Provider Manual

2021

A guide to working better, together.

Clover Health

We are a Medicare Advantage company changing the way people are cared for by capturing and analyzing patient data in powerful new ways.

Our goal is to improve quality of life for our members by offering providers like you the resources and support they need.

By establishing a close, collaborative partnership, we can share and exchange rich health data about your patients—our members. We can then start to identify conditions earlier and move closer to preventing them.

Working together, we can drive continuous improvements in patient care and help Medicare patients live longer, healthier, more fulfilling lives.

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We accept Clover Health!

Quick Reference Guide

cloverhealth.com/providers is the simplest, quickest way to check member eligibility and benefits, submit or check on a prior authorization request, check the status of a claim, find other Clover providers, access documents and forms, and much more. Be sure to have your National Provider Identifier (NPI) handy.

FREQUENTLY USED SERVICES	QUICK LINKS	
To submit a claim If you need to make any changes to an original claim, you can resubmit a corrected claim using one of the channels to the right.	interconnect via Change Healthcare: Payer ID#: 13285	via mail: Clover Health P.O. Box 981704 El Paso, TX 79998-1637
To find an in-network provider	cloverhealth.com/findprovider	
To view prior authorization criteria	cloverhealth.com/preauth	
To set up electronic payments	Go to changehealthcare.com or call 1-866-371-9066 to set up an account. Enter Clover Health's payer ID #13285.	
To verify patient eligibility, benefits, and copays	navinet.navimedix.com	
For all other routine forms and documents	cloverhealth.com/providerforms	
For Part D prior authorization criteria	cloverhealth.com/en/members/formulary (under relevant links)	
To submit a Part D prior authorization electronically	covermy meds.com/main/	
For any Clover Assistant inquiries/support	call: 1-800-619-5541 email: cloverassistantsupport@cloverhealth.com	

If you need additional assistance, you can call or fax using the numbers below.

DEPARTMENT	CONTACT	
Provider Services	T: 1-877-853-8019	F: 1-866-201-3008
Care Management	T: 1-888-995-1689	
Authorization Requests (UM)	T: 1-888-995-1690	F: 1-800-308-1107
Pharmacy (CVS Caremark®)	T: 1-855-479-3657 (PPO) 1-844-232-2316 (HMO)	F: 1-855-633-7673
CVS Caremark Coverage Determinations & Appeals	T: 1-855-344-0930	
Appeals & Grievances	T: 1-888-657-1207	F: 1-732-412-9706 (Appeals)
		F: 1-551-227-3962 (Grievances)
Member Services	T: 1-888-778-1478	

New Correspondence Addresses

Clover has new mailing addresses! Effective August 1st, 2020, Clover has launched 5 new P.O. boxes in order to more effectively route incoming mail to our various departments. We request that your office use the addresses listed below for your future mailings to Clover.

Non-Clinical Claims Payment Disputes

Use except when mailing eviCore appeals; see eviCore denial letter for address.

If you have attachments (e.g., medical records) **you will need to mail or fax in the Claims Payment Dispute form and supporting documents** regardless of when the claim was processed.

Clover Health
Attn: Claims
P.O. Box 2092
Jersey City, NJ 07303

Email: PO_Box_2092@cloverhealth.com
Fax: 1-888-240-7243

Clinical Claims Payment Disputes

If you have attachments (e.g., medical records) **you will need to mail or fax in the Claims Payment Dispute form and supporting documents** regardless of when the claim was processed.

THIS ADDRESS IS NOT FOR CLAIMS SUBMISSIONS.

Clover Health
Attn: Appeals
P.O. Box 2091
Jersey City, NJ 07303

Email: PO_Box_2091@cloverhealth.com
Fax: 1-732-412-9706

Payment Integrity (Pre-Pay)

Clover Health
Attn: Payment Integrity – Pre-Pay
P.O. Box 2044
Jersey City, NJ 07303

Email: PO_Box_2044@cloverhealth.com
Fax: 1-866-509-4325

Payment Integrity (Post-Pay)

Clover Health
Attn: Payment Integrity – Post-Pay
P.O. Box 2045
Jersey City, NJ 07303

Email: PO_Box_2045@cloverhealth.com
Fax: 1-866-509-4325

General mailing

Please use only when the recipient is unknown.

Clover Health
P.O. Box 471
Jersey City, NJ 07303

Email: PO_Box_471@cloverhealth.com
Fax: 1-866-508-0865

Legal Overview

Except where otherwise indicated, this Provider Manual is effective as of January 1, 2021 for providers currently participating in the Clover Health network.

This Provider Manual will serve as a resource for navigating Clover Health's operations and processes. As an in-network provider, you are expected to be familiar with this manual and to abide by the operations and processes contained herein. In the event of a conflict or inconsistency between this Provider Manual and the express provisions of your Provider Agreement with Clover Health, including any regulatory requirements appendices attached to it, the provisions of your Provider Agreement will prevail. We reserve the right to periodically update this Provider Manual.

Clover Health Members

We believe that doctors care best for their patients when their time together is efficient and productive. This section outlines the benefits, rights, and responsibilities of Clover Health members, and shows you how to verify member eligibility.

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IDENTIFICATION OF CLOVER HEALTH MEMBERS AND ELIGIBILITY

You (or your office staff) are responsible for verifying the eligibility of each member before rendering non-emergency services or treatment. Clover Health issues identification cards that you can use to verify member eligibility. When a Clover Health member arrives in your office, you should confirm the member's eligibility by:

- Logging on to NaviNet at navinet.navimedix.com (where applicable), selecting Clover Health, and entering the member ID from the Clover Health ID card.

Clover Health identification cards contain the following information:

- Member plan name (e.g., Clover Health Choice PPO or Clover Health Classic HMO)
- Member first and last name
- Member ID
- Plan ID

A sample of the ID card can be found in the [Appendix](#).

Some Clover Health members have additional insurance coverage, like Medicaid. Clover Health members who have dual eligibility should present identification cards for each of their coverages, including any Medicaid benefits that might be administered by another payer. Additional coverage can pay for costs that are not covered by the Clover Health plan as long as all services and items are covered by each plan. Members should refer to the Evidence of Coverage documents for both their Clover Health plan and their other insurance to learn what's covered by each plan.

COVERED SERVICES

Clover Health offers PPO plans in select counties of New Jersey, Texas, Georgia, Mississippi, Pennsylvania, South Carolina, Tennessee, and Arizona and HMO plans in select counties of New Jersey and Texas.

Our PPO plans don't require a referral by a PCP to access care, but we anticipate that the providers our members trust for their primary care will help them understand how to access care within our network to maximize their plan benefits.

Our HMO plans also don't require a referral, but access to care is limited to providers who are in-network or contracted with Clover Health, except for services outlined in [Chapter 4](#) of the Medicare Managed Care Manual.

Clover Health members enjoy a comprehensive benefit package, including the primary, preventive, and specialty care necessary for good health. Covered services must be medically necessary and appropriate. We do not pay claims for services excluded from Original Medicare. You can learn more about Medicare excluded services [here](#). To obtain member benefit information:

Online

- Log on to cloverhealth.com/members/plan-documents/plan-details.
- Select the applicable ZIP code.
- Click **See plan details** and then select a plan you would like to obtain more information about.

A member who elects to receive medical care for services not included in the contract, or for services that are determined by Clover Health to not be medically necessary, will be responsible for payment. In those instances, direct the member to the EOC and document prior approval from the member for such out-of-pocket expenses, or [submit an organizational determination](#). All services can be subject to applicable member share-of-cost.

COORDINATION OF BENEFITS (COB)

Coordination of benefits (COB) and services is intended to avoid duplication of benefits and at the same time preserve certain rights to coverage under all plans in which the member is covered. COB is an important part of Clover Health's overall objective of providing healthcare to members on a cost-effective basis. Clover Health members cannot be billed for covered services rendered except for any copays for which the member can be responsible. Clover Health members who have Medicaid with the QMB (Qualified Medicare Beneficiary) Program as other coverage are not responsible for cost-shares. Your contract with Clover Health requires you to accept Clover Health's payment as payment in full or you can bill the appropriate state Medicaid source for the balance.

DEFINITIONS

Primary plan: Determines a member's health benefits without taking into consideration the existence of any other plan.

Secondary plan: Can pay the remaining costs after the primary plan has paid for services or items covered by both payers. All Clover Health members must follow these procedures:

- All Clover Health members will be responsible for paying copays at the time of their office visit. If the member has additional coverage (like Medicaid), that coverage can reduce or eliminate the amount owed if the service rendered is billable to the other payer.
- If Clover Health is the secondary insurance, attach the explanation of benefits from the primary carrier and send the claim to Clover Health for consideration of the remaining balance.
- Under no circumstances can members be directly billed beyond the amount due for their cost-share.

Coordination of benefits for Medicare Advantage members with Medicaid

Clover Health members who have limited income and resources can receive help paying out-of-pocket medical expenses from Medicaid. If a member is identified as having secondary insurance coverage through Medicaid, you should obtain a copy of the member's Medicaid card, and/or the card for the plan that administers the benefit to bill Medicaid after receiving the EOP from Clover Health.

No share of cost should be collected at the time of the visit from a member with Medicaid coverage. For further information, your office can contact Provider Services at **1-877-853-8019**. We're available 8 am–5:30 pm local time, Monday–Friday, to assist you. Or, you can contact the number listed on the member's Medicaid card.

Coordination of benefits for Medicare Advantage members with multiple payer sources

If a member has coverage from more than one payer or source, we coordinate benefits with the other payer(s) in accordance with the provisions of the member's benefits. If you have knowledge of alternative primary payer(s), you must bill the other payer(s) with the primary liability based on such information prior to submitting claims for the same services to Clover Health.

You are also expected to provide us with relevant information you have collected from members regarding coordination of benefits and to bill payer(s) with the primary liability based on such information prior to submitting bills for the same services to Clover Health. To the extent permitted by law, if Clover Health is not the primary payer, your compensation by Clover Health will be the difference between the amount paid by the primary payer(s) and your applicable rate, less any applicable copays or coinsurance.

Because members accept Clover Health benefits by their participation in the COB program, they are legally responsible to adhere to the rules and regulations required of all Clover Health members, such as use of the PCP and/or prior approval for out-of-plan services.

Clover Health cannot deny a claim, in whole or in part, on the basis of "coordination of benefits," unless we have a reasonable basis to believe that the member has other insurance coverage that is primary for the claimed benefit. In addition, if we request information from the member regarding other coverage and do not receive the information within 45 days, we must adjudicate the claim. However, the claim cannot be denied on the basis of nonreceipt of information about other coverage.

SUBROGATION

In the event that there is a third party responsible for the cause of a member's injury or illness, Clover Health reserves the right to recover benefits previously paid to a provider for related healthcare services. Recoveries can be pursued by Clover Health or its contracted vendors to the extent permitted under applicable law.

EXTRA BENEFITS AND SERVICES

Most Clover Health plans offer the following supplemental benefits and extra services that are not covered by Original Medicare.

Supplemental preventive dental

All Clover Health plans include coverage for preventive dental services (e.g., oral exams, cleanings, and x-rays). Most Clover Health plans include an allowance for comprehensive dental services (e.g., fillings, crowns, and dentures). We partner with [DentaQuest](#) to provide supplemental dental services. For more information please see the Evidence of Coverage, which can be found on [cloverhealth.com](https://www.cloverhealth.com).

Dental claim submission

DentaQuest requires providers to submit claims on the member's behalf; claims that are received directly from the member will not be processed.

Dental claims can be sent to DentaQuest online, by fax, or by mail. Claims must be submitted on ADA-approved claim forms (2006 or newer).

- **Online:** [Click here for more information.](#)
- **Fax:** 1-262-834-3589
- **Mail:** Dental claims can be sent to the following address or the fax number above. Claims must be submitted on ADA-approved claim forms (2006 or newer):
DentaQuest
PO Box 2906
Milwaukee, WI 53201-2906

Procedures normally offered by a physician in a hospital, and that involve the conditions listed below, are not covered through DentaQuest and should be billed under Part B. Refer to the [Claims and Billing section](#) of this manual for more information about Part B claims submission.

- Conditions involving the jaw or related structures
- Setting fractures of the jaw or facial bones
- Extraction of teeth to prepare the jaw for radiation treatments of neoplastic (cancer) disease and other related services

Dental care that is not covered includes routine dental care procedures that are performed after the underlying health condition has been treated, such as:

- Tooth removal due to facial injury from a car accident
- Any dental care related to the car accident that can arise at a later time
- Some dental-related hospitalizations; for example, we can cover treatment for a member who develops an infection after having a tooth extraction or requires observation during a dental procedure because of a health-threatening condition

If you have questions or concerns, please call DentaQuest's Dental Provider Services at:

- **New Jersey:** 1-855-398-8409
- **Georgia:** 1-800-516-0124
- **Mississippi:** 1-800-235-6147
- **Pennsylvania:** 1-855-343-7401
- **Texas:** 1-888-308-9345
- **Tennessee:** 1-888-554-5542
- **Arizona:** 1-800-440-3408
- **South Carolina:** 1-800-685-2371

Supplemental dental benefits are subject to the same [appeals process](#) as any other benefits.

Supplemental vision

All Clover Health plans offer routine vision exams and eyewear through our partner [EyeQuest](#).

Supplemental vision benefits are subject to the same [appeals process](#) as any other benefits.

Vision claim submission

Vision claims can be sent to [EyeQuest](#) electronically, by fax, or by mail.

- **Online:** [Click here for more information](#).
- **Fax:** 1-888-696-9552
- **Mail:** Vision claims can be sent to the following address or faxed to the number above. Be sure to include a copy of the member's Clover Health ID:
EyeQuest
Attn: Vision Claims Processing
PO Box 433
Milwaukee, WI 53201-0433

If you have questions or concerns, please call EyeQuest's Vision Provider Services at:

- **New Jersey:** 1-844-824-2014
- **Georgia:** 1-800-516-0124
- **Mississippi:** 1-800-235-6147
- **Pennsylvania:** 1-844-824-2014
- **Texas:** 1-844-824-2014
- **Tennessee:** 1-844-824-2014
- **Arizona:** 1-844-824-2014
- **South Carolina:** 1-844-824-2014

Supplemental hearing

All Clover Health plans include a routine hearing exam, as well as access to state-of-the-art hearing aids through [TruHearing](#). Supplemental hearing benefit includes:

- One routine hearing exam per year, \$0 copay
- Two TruHearing hearing aids, one per ear, per year:
 - **Advanced aid**, \$699 copay for each hearing aid, or
 - **Premium aid**, \$999 copay for each hearing aid

TruHearing hearing aid purchase includes:

- Three TruHearing provider visits for evaluation and fitting within the first year of the hearing aid purchase
- 45-day trial period and 3-year extended warranty
- 48 batteries per aid (for non-rechargeable hearing aid models)

If you have questions or concerns, please call TruHearing Provider Relations at **1-866-581-9462**.

To use the TruHearing benefit, members must call TruHearing at **1-855-205-5570**.

Gym/fitness

Each Clover Health member will receive one [**SilverSneakers®**](#) membership at a participating fitness center.

Members who misplaced their SilverSneakers ID card can request a new card by calling SilverSneakers Customer Service at **1-888-423-4632**, Monday–Friday, from 8 am to 8 pm EST.

Over-the-counter (OTC)

Clover Health has partnered with OTC Health Solutions and Healthy Benefits to provide members with a quarterly allowance to use towards the purchase of select OTC products, available through their mail delivery service or select retail stores. Benefit allowance is available at the beginning of each quarter of the calendar year (January, April, July, and October). Please note any unused amounts are not carried over to the following quarter. OTC benefits are included on all 2021 Clover Health plans.

If the plan is in Arizona, Mississippi, New Jersey, Pennsylvania, Tennessee, or Texas, members can order OTC items online at cvs.com/otchs/clover or by calling **1-888-628-2770** (TTY 1-877-672-2688) 8 am–8 pm local time, Monday through Friday. If the plan is in Georgia or South Carolina, members can order OTC items online at healthybenefitsplus.com/cloverhealthotc or by calling **1-844-529-5869**, 8 am–11 pm EST, Monday–Friday.

Teladoc

Clover Health plans include 24/7 access to Teladoc, a phone consultation service with mental health professionals and board-certified doctors. For more information, call **1-800-835-2362** or visit teladoc.com.

Transportation

Some Clover Health plans cover one-way non-emergent trips within the plan service area to any health-related location. Each one-way trip must not exceed 50 miles. Members must contact Clover Member Services at **1-888-778-1478** to arrange a ride. Arrangements should be made at least 24 hours in advance.

MEMBERS' RIGHTS AND RESPONSIBILITIES

We ensure the following rights and responsibilities for our members.

Members' rights

- Protection and privacy of personal health information
- Timely access to covered services and drugs
- Clear, simple presentation of health-related information
- Fair and respectful treatment
- Opportunity to make complaints and ask that we reconsider decisions we have made
- Opportunity to make their own decisions about their care
- Opportunity to ask for reconsideration about claims payment
- To be provided with information about the plan, its network of providers, and covered services

Members' responsibilities

- Familiarity with covered services and the rules required to receive them
- Full disclosure of plans enrolled in, and of changes in health status, geography, and other pertinent health-related personal information
- Full and/or timely payments toward any and all amounts owed
- Understanding of their health problems and participation in developing treatment goals mutually agreed upon with their healthcare providers

Members can contact Member Services for help or with questions or concerns. For additional details on members' rights and responsibilities, refer to the Clover Health [Evidence of Coverage](#) booklet or call Member Services at **1-888-778-1478 (TTY 711)**. We're available 8 am–8 pm local time, 7 days a week. From April 1st through September 30th, alternate technologies (for example, voicemail) will be used on the weekends and holidays.

MEMBERS' PRIVACY RIGHTS

The protection and security of our members' personal information is one of our top priorities at Clover Health. Our Notice of Privacy Practices describes how medical information about our members may be used and disclosed and how our members can get access to relevant information including copies of their health information and an accounting of disclosures. A copy of our [Notice of Privacy Practices](#) can be found on our website.

CULTURAL COMPETENCY

To help integrate cultures of diverse backgrounds within Clover Health and across the organizations we partner with, we follow Culturally and Linguistically Appropriate Service (CLAS) standards—a collective set of linguistic services, mandates, guidelines, and recommendations issued by the United States Department of Health and Human Services Office of Minority Health.

Learn more at thinkculturalhealth.hhs.gov.

ADVANCE DIRECTIVES

In the event that a member becomes incapacitated and/or unable to communicate their needs, we follow the instructions as outlined in the member's advance directive, if the member has one in place. Examples of an advance directive include a living will, durable power of attorney for healthcare, healthcare proxy, or do-not-resuscitate (DNR) request.

In accordance with advance directive guidelines, we look to you to assist your patients in developing advance directives. We recommend that you discuss advance directives with your patients (as appropriate) and file a copy of any advance directive document in the medical record. Each medical record that contains an advance directive should clearly indicate that such document is included.

You can find more information on advance directives on your state department of health website:

New Jersey: nj.gov/health/advancedirective

Pennsylvania: aging.pa.gov/aging-services/caregiver-support/Pages/Caregivers-of-Adults.aspx

Texas: hhs.texas.gov/laws-regulations/forms/advance-directives

Georgia: fcs.uga.edu/docs/Georgia_Advance_Directive_for_Healthcare_Form.doc

South Carolina: aging.sc.gov/

Tennessee: tn.gov/aging.html

Arizona: azag.gov/seniors/life-care-planning

Mississippi: msdh.ms.gov/msdhsite/_static/42,0,241.html

Provider Responsibilities

Clear and transparent communication is integral to the success of our partnership. We will strive to explicitly articulate our provider expectations and share how we can be a valuable resource for you.

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STANDARDS OF PARTICIPATION

It is important to keep your provider data up to date to ensure accurate claims payment and proper representation in our provider directories. Please let us know if any of the following information about your practice changes:

- Office or billing address information, including telephone number
- Billing information, including National Provider Identifier(s) and Taxpayer Identification Number
- Group affiliation
- Clover Health participation status
- Medicare participation status
- Sanction information

Acceptance of new patients

If you decide not to accept additional Clover Health members, please give us 60 days notice.

Hospital Privileges

You can submit updates to Clover Health in the following ways:

- Go to cloverhealth.com/providers/provider-tools and click on the **Update your information** button in the Provider Resources section to submit an update request.
- Email provider-data@cloverhealth.com
To include attachments, please send requests via email.
- Go to cloverhealth.com/providers/provider-tools and click on the **Update your information** button in the Provider Resources section to submit an update request
- Email provider-data@cloverhealth.com.

Clover Health reserves the right to require admission privileges with its in-network providers. If you or any of your group practice providers lose privileges at any hospital, please notify us no later than 10 business days following the date of the termination of privilege.

APPOINTMENTS AND ACCESS STANDARDS

We are dedicated to arranging quality access to care for our members. To help with this process, we ask that you and your office staff adhere to the following recommendations:

- **Telephone coverage after hours:** An answering service or a telephone recording that directs a member to call another telephone number or 911 in the event of an urgent or emergent situation.
- **Telephone access during normal business hours:** Immediate responses to any urgent or emergency health events, within 4 hours for non-urgent calls, and within 1–2 business days for routine calls.
- **Covering provider:** When you are on extended leave (vacation, illness, etc.) you must arrange with another participating primary care provider or specialist to provide accessible 24-hour coverage. Coverage must extend beyond 911, except in the event of an emergency or urgent situation.
- **Appointments:** You must make every effort to see a member within the following time frames:

- **Emergent:** Immediately; member should be directed to call 911 in the event of an emergency or go to the emergency room for treatment
- **Urgent:** Within 24 hours
- **Routine/Symptomatic:** Within 7 days
- **Wellness/Nonsymptomatic:** Within 30 days
- **Office waiting time:** Should not exceed 30 minutes from the time of the scheduled appointment.
- **Minimum office hours:** You must practice for a minimum of 16 hours a week and must promptly notify Health Plan of changes in your office hours and locations as soon as this information becomes available, but no later than 3 business days after the change takes effect. The minimum office hour requirement can be reduced under certain circumstances for good cause, with Health Plan's prior written approval.
- **Accessibility:** You are expected to meet the federal and state accessibility standards and those defined in the Americans with Disabilities Act of 1990. Healthcare services provided through Clover Health must be accessible to all members.

Clover Health tracks and evaluates issues relating to waiting times for appointments, appropriateness of referrals, and other indications of capacity.

MEMBER REFERRALS

In the event that you are responsible for providing or arranging for a covered service, you agree to direct the member to an appropriate participating provider in Clover's network. You may direct a member to a non-participating provider only where:

- (a) no participating provider is reasonably available to perform the necessary services;
- (b) when member requires emergency services and directing such member to a non-participating provider would expedite diagnosis or treatment;
- (c) Clover Health and provider mutually agree that the member may be referred to a non-participating provider; or
- (d) if referral to a non-participating provider is reasonably determined by provider to be in the best interest of the member.

Refer to your specific **Provider Agreement** for additional details.

ACCESS TO MEDICAL RECORDS

Clinical documentation of disease burden is central to collaborative management and is the cornerstone to care. As needed, Clover Health will request medical records to ensure an accurate representation of patients' clinical disease and needs. Medical records can also be requested for audits, quality assurance purposes, as well as to ensure proper billing and claims payment practices. Unless otherwise specified in your Provider Agreement, medical records shall be provided at no cost.

MEDICAL RECORD STANDARDS

We believe that updated, complete documentation is an essential component to the delivery of quality medical care and collaboration. We reserve the following rights to ensure our member profiles are comprehensive.

Access and confidentiality

We reserve the right to inspect (at reasonable times) any and all records, specifically any medical records you maintain pertaining to members. This includes, but is not limited to, assessing quality of care, collecting data for Healthcare Effectiveness Data and Information Set (HEDIS®) reporting, collecting data for risk adjustment reporting, coordinating medical care evaluations and audits, determining on a concurrent basis the medical necessity and appropriateness of any care being provided, and ensuring proper billing and claims payment. Federal and state regulatory bodies can determine other purposes for having access to members' medical records.

For information on member rights as they relate to the above, refer to the Members' Privacy Rights section of this Provider Manual.

Medical record documentation

- Medical information must be legible and follow a logical and consistent format, with page numbers indicated (e.g., "Page 1 of 2") if an encounter spans multiple pages.
- The record must contain complete encounter information for each encounter in the chart.
This includes:
 - Member's full name and date of birth
 - Provider's full name and title
 - Facility name
 - Date(s) of service
 - Documentation of all services provided by the physician as well as other nonphysician services (e.g., physical therapy, diagnostic or laboratory services, home healthcare)
- The record must indicate:
 - All illnesses and medical conditions
 - Medications list
 - Consultations/referrals
 - Present issue
 - Treatment plan
 - Follow-up plan
 - Preventive screenings and health education offered
 - Documentation on advance directives
- Information should be stored within a secure folder in a safe place.
- No record should be altered, falsified, or destroyed. If a correction is introduced, the individual correcting the record should draw a single line through the item to be corrected, and date and initial the correction.
- All telephone messages and consult discussions must be clearly identified and recorded.
- The medical record system should provide a mechanism to ensure member confidentiality.

Electronic medical record integrations

Clover Health partners directly with electronic medical record (EMR) and integration vendors to automate the transmission of member charts via a secure and HIPAA-compliant connection.

Integrations automate the transmission of member charts to Clover Health without any additional effort or disruption to your practice. Under no circumstances does Clover Health have access to patient data for non-Clover Health members as a result of this integration. Benefits of participating in a Clover Health EMR integration include:

- Enhanced care coordination with Clover Health through incorporation of EMR data into Clover Health's advanced analytics platform
- Giving time back to your office staff that would have otherwise been spent responding to traditional medical record requests
- Reduced waste and environmental impact of printing charts, made possible through a paperless medical record retrieval
- Automated identification and transmission of member charts to Clover Health

Although we encourage participating providers to use EMR to help streamline your administrative processes, help protect your patients' information, and result in faster processing, Clover Health will also accept paper chart submissions and can occasionally request a paper chart to verify the accuracy of EMR data.

NON-ADHERENT CLOVER HEALTH MEMBERS

We recognize that you may need help in managing non-adherent members. If you have an issue with a member regarding behavior or treatment cooperation and/or completion, or if you have a member who cancels or does not appear for necessary appointments and fails to reschedule, even after follow-up attempts by you and/or your office, contact Provider Services at **1-877-853-8019**. We're available 8 am–5:30 pm local time, Monday–Friday, to assist you.

MEDICARE RISK ADJUSTMENT PROCESS

We understand that meeting members' medical needs is the first step to improving their health. Accurately defining members' risk levels allows us to better meet patients' needs and manage their care. In light of this, we use standard Centers for Medicare & Medicaid Services (CMS) Medicare guidelines to measure our members' health relative to their peers using a risk adjustment model that considers their demographic and diagnoses. We then use these measures to assess healthcare utilization needs and cost, allowing both you and payers to organize around these needs.

PROVIDER DATA COLLECTION

Initial roster and facility data collection

Clover Health requires a fully complete and up-to-date practitioner or facility roster in order to load practitioners, groups, and facilities into our internal systems and provider directory. Inaccurate provider data may result in incorrect claims payment and incorrect representation in our provider directories.

Directory validation

Clover Health may conduct outreach to every provider in our provider directory to validate demographic and contact information. Outreach is performed on a regular basis by email or by phone.

For health systems and large groups, Clover Health will request the organization's provider roster by email or phone on a quarterly basis. The organization is responsible for the accuracy of the information sent to Clover Health and any inaccurate data discovered by Clover Health will be quickly communicated back to the provider for verification.

Additions, changes, and terminations should be reported to Clover Health promptly so internal systems and the provider directory remain current.

Any refusal to share updated provider data with Clover Health can result in the withholding of payment to the provider for services provided to Clover Health members.

Updating provider information

You can submit updates to Clover Health in the following ways:

- Go to cloverhealth.com/providers/provider-tools and select Update your information in the Provider support section to submit an update request.
- Email providers@cloverhealth.com – To include attachments, please send requests via email.

If you have questions or require assistance, contact Provider Services at 1-877-853-8019. We're available to assist you 8 am–5:30 pm local time, Monday–Friday.

CAQH Profile

To help ensure accurate provider directory information, it is important to keep your CAQH profile up to date. While you are required to re-attest every 120 days, it is a good idea to review and attest your data on a monthly basis. Follow these steps to update and re-attest to your information:

- Log in to CAQH ProView.
- Correct any outdated information, and complete other incomplete questions applicable to your provider type.
- Confirm there are no errors on your profile and attest to its accuracy.

If you have questions, please review the materials provided on the CAQH ProView for Providers and Practice Managers page at caqh.org/solutions/caqh-proview-providers-and-practice-managers.

Additionally, you may contact the CAQH ProView Help Desk for assistance:

- Log in to CAQH ProView and click the Chat icon at the top of the page or call **1-888-599-1771**.
- Please have your CAQH ProView Provider ID readily available.

COMPLIANCE WITH FEDERAL LAWS AND NONDISCRIMINATION

The Code of Federal Regulations (42 CFR 422.504) requires that Medicare Advantage Organizations have oversight for contractors, subcontractors, and other entities. The intent of these regulations is to ensure services provided by these parties meet contractual obligations, laws, regulations, and CMS instructions. Clover Health is held responsible for the compliance of its providers and subcontractors with all contractual, legal, regulatory, and operational obligations.

The contracted provider represents and warrants to Clover that he or she will not discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, HIV status, source of payment, veteran status, plan membership, or geographic location. Payments received by contracted providers from Medicare Advantage plans for services rendered to plan members include federal funds; therefore you, as a contracted provider, are subject to all laws applicable to recipients of federal funds, including but not limited to: Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, and all other laws that apply to organizations that receive federal funding. In addition, as a contracted provider, you must not discriminate against our members based on their payment status, specifically if they receive assistance from a state Medicaid program.

Treatment of Immediate Relatives or Members of the Household

Clover Health follows the exclusion of payment guidance for charges imposed by immediate relatives of the patient or members of the patient's household as outlined within Section 130 of the Medicare Benefit Policy Manual. Per this section, providers will not be reimbursed for services provided to those who are immediate relatives or those who share the same household.

Immediate relatives:

- Spouse
- Biological or adoptive parent or child
- Sibling
- Stepparent, stepchild, stepbrother, or stepsister
- In-law
- Grandparent or grandchild
- Spouse of grandparent or grandchild

Members of household:

- Persons sharing a common home with the patient as part of a single family unit

The intent of this exclusion is to bar Medicare Advantage payment for items and services that would ordinarily be furnished free of charge..

Claims and Billing

We know that you prefer to spend your time with patients, so we do what we can to make it easier to manage billing and paperwork. This section describes our claims process, and how we can work together to ensure you're paid accurately and on time.

CLAIMS SUBMISSION

Electronic submission

We encourage participating providers to use electronic claim submissions whenever possible. Doing so can help streamline your administrative processes, help protect your patients' information, and result in faster claim processing and payment. Clover Health supports electronic submission via the HIPAA transaction set (837P and 837I) and upholds Medicare guidance requiring electronic claim submission as defined by the American Simplification Compliance Act.

You should submit claims via **Change Healthcare** with Clover Health's Payer ID #13285.

Paper submission

Clover Health also accepts the [CMS-1500](#) and the [CMS-1450](#) paper claim forms.

Paper claims must be submitted to:

Clover Health Insurance
PO Box 981704
El Paso, TX 79998-1637

Timely filing of claims

You should refer to your Provider Agreement for filing guidelines and documentation requirements. Unless otherwise specified in your Provider Agreement, Clover Health's standard timely filing limit is 90 days from the claim date of service for in-network providers. As set forth in your Provider Agreement, you cannot bill members for services submitted beyond the timely filing limit. Corrected claims must also be submitted within 90 days from the claim date of service, unless otherwise specified in your Provider Agreement.

Claims processing

We use a combination of guidelines established by CMS and internal claims processing policies to assist in determining proper coding. These guidelines and policies dictate claims edits, adjustments to payment, and/or a request for review of medical records that relate to the claim.

You can refer to one of the following CMS guidance documents on electronic and paper claim submissions:

[Medicare Billing: 837P and Form CMS-1500](#)

[Medicare Billing: 837I and Form CMS-1450](#)

You can check the status of claims you've submitted:

Online

Log on to NaviNet at navinet.navimedix.com; or Provider Portal under the provider claims tools at cloverhealth.com/providers/provider-tools.

Clean claims

Clover Health uses the [CMS Medicare Advantage definition of a clean claim](#), which consists of a properly completed claim that can be processed as soon as it is received.

Clean claims include:

- Complete coding
- Provider information
- Itemization
- Date of service
- Billed amounts
- Substantiating documentation needed to meet the requirements of an encounter with a member

Failure to submit a clean claim can result in a delay of payment and/or rejection of a claim. Common types of errors include incomplete fields, invalid codes, lack of supporting medical records, provider data mismatches, and use of the wrong claim form(s).

Timely processing of claims

Clover Health is required to uphold standard claims timeliness guidelines, which either are stipulated in your Provider Agreement or follow [CMS timeliness requirements](#).

Refer to the [CMS guidelines](#) for more information.

Claims payment

You will be reimbursed according to the compensation provisions of the Compensation Schedule included in your Provider Agreement.

Sequestration

At Clover Health, we use the same sequestration reductions as those imposed by the Centers for Medicare & Medicaid Services (CMS). All providers are reimbursed using a fee schedule based on the Medicare payment system, percentage of Medicare Advantage premium or Medicare-allowed amount (e.g., resource-based relative value scale [RBRVS], diagnosis-related group [DRG], etc.) and will have the 2% sequestration reduction applied the same way it would be applied by CMS. This reduction applies to all Medicare Advantage plans.

The amount of the sequestration reduction for each affected claim will be identified as "Sequestration" on the Remittance Advice document that providers will receive from Clover Health.

Claim corrections

We will deny a claim if it is determined to be incorrect or incomplete due to missing or invalid information. In this event, you can resubmit a corrected claim within the timely filing period. Unless otherwise specified in your Provider Agreement, Clover Health's standard timely filing limit is 90 days from the claim date of service for in-network providers. As set forth in your Provider Agreement, you cannot bill members for services submitted beyond the timely filing limit. As stated above, corrected claims must be submitted within 90 days from the claim date of service, unless otherwise specified in your Provider Agreement.

Correcting or Voiding Electronic Claims

- **Professional claims (837p):** Enter Frequency Code 7 for corrections, or Frequency code 8 to void, in Loop 2300 Segment CLM05-3. Enter the original claim number on the 2300 loop in the REF*F8*.
- **Institutional claims (837i):** Submit with the last character of the Type of Bill as 7, to indicate Frequency Code 7 for corrections, or Type of Bill as 8, to indicate Frequency Code 8 to void.

Correcting or Voiding Paper Claims

- **Professional claims CMS-1500:** Stamp "Corrected Billing" on the CMS 1500 form. Complete box 22 when resubmitting a claim. Enter the appropriate bill frequency code left-justified on the left-hand side of the field:
 - 6 - Corrected Claim
 - 7 - Replacement of prior claim
 - 8 - Void/Cancel prior claim
- **Institutional claims UB-04:** Submit with the last digit of 7 in the Type of Bill for corrections, or last digit of 8 for void claims.

Corrected claims should be submitted with all line items completed for that specific claim, and should not be filed with just the line items that need to be corrected. Please share this information with your practice management software vendor, as well as your billing service or clearinghouse, if applicable.

The following CMS guidance can help you to determine what information to include on claim submissions:

- [Physician and nonphysician practitioner services](#)
- [National Correct Coding Initiative](#)
- [CMS Fee Schedule Administration and Coding Requirements](#)
- [Medicare Administrative Contract \(MAC\)—Jurisdiction H \(Texas\)](#)
- [Medicare Administrative Contract \(MAC\)—Jurisdiction L \(New Jersey\)](#)
- [Physician Fee Schedule \(Georgia\)](#)
- [CMS Transmittals](#)
- [DME Fee Schedule—Jurisdiction A \(New Jersey\)](#)
- [DME Fee Schedule \(Texas\)](#)
- [Items and Services Not Covered Under Medicare](#)

PROGRAM INTEGRITY

Accurate payment is important to us at Clover Health. We strive to ensure that the care you provide to our members is effectively administered and fairly paid—by the responsible party, for eligible members, according to contractual terms, not in error or duplicate, and free of wasteful or abusive practices. To ensure that claims payments are issued in accordance with CMS guidelines, the integrity of our payment programs is overseen by dedicated staff and can include the use of contracted vendors. All claims can be subject to prospective, concurrent, or retrospective review for both billing and payment accuracy.

Readmissions Review Program

Clover Health reviews the following as part of the Readmissions Review Program:

- Same-day readmission for a related condition
- Same-day readmission for an unrelated condition
- Planned readmission/leave of absence
- Unplanned readmission less than 30 days after the prior discharge

If a patient is readmitted to a facility on the same day as a prior discharge for the same or a related condition, CMS and Clover Health require the facility to combine the two admissions on one claim. Clover Health will deny both the initial and subsequent admissions for payment as separate DRGs. The facility must submit both admissions combined on a single claim to receive reimbursement. For a same-day readmission to qualify for separate reimbursement, the medical record must support that the conditions are clinically unrelated. Consistent with CMS billing requirements, if a patient is readmitted during the same day for an unrelated condition, two properly coded claims must be submitted to Clover Health.

If a patient is readmitted to a facility as part of a planned readmission or leave of absence, the admissions are not considered two separate admissions. Clover Health requires the facility to submit one claim and receive one combined DRG payment for both admissions because they are for the treatment of the same episode.

Reimbursement for readmissions may be denied (see [Medicare QIO Manual](#), Chapter 4, Section 4240) if the readmission:

- Was medically unnecessary
- Resulted from a premature discharge from the same hospital
- Was a result of circumvention of the PPS by the same hospital

For a complete description of the program, visit cloverhealth.com/providers.

Overpayment recovery

We abide by [CMS guidelines for overpayment recoupments](#), including: provider notification, opportunity for rebuttal, and the possibility of automatic recoupments from future claims payments. Clover Health can reopen and revise its initial determination or redetermination on a claim on its own motion:

- Within 1 year from the date of the initial determination or redetermination for any reason; or
- Within 4 years from the date of the initial determination or redetermination for good cause as defined in CMS Medicare Handbook §10.11; or
- At any time if:
 - There exists reliable evidence that the initial determination was procured by fraud or similar fault as defined in the Code of Federal Regulations (42 CFR §405.902); or
 - The initial determination is unfavorable, in whole or in part, to the party thereto, but only for the purpose of correcting a clerical error on which that determination was based. Third party payer error does not constitute clerical error or similar fault as defined in the [Code of Federal Regulation \(42 CFR§ 405.986\)](#).

We will provide written documentation that identifies affected claims and justifies the reimbursement request. Overpayments can stem from coding edits, improper coordination of benefits, technical denials, and medical necessity review among other reasoning outlined by applicable law. Clover Health will not, however, base a reimbursement request for a particular claim on extrapolation of other claims, except where applicable law permits, including any of the following circumstances:

- In judicial or quasi-judicial proceedings, including arbitration
- In administrative proceedings
- Where relevant records you were required to maintain have been improperly altered or reconstructed, a material number of the relevant records are otherwise unavailable
- Where there is clear evidence of fraud by you, and Clover Health has investigated the claim in accordance with its fraud prevention plan

Clover Health can collect a monetary penalty against a reimbursement request including, but not limited to, an interest charge.

Except as expressly otherwise stated in the Provider Agreement, Clover Health attempts to collect overpayments according to the following guidelines:

- Clover Health generally initiates recoupments 41 days after the date of our refund request letter if no refund check or written dispute is received.
- If you submit a written dispute to us, we will not initiate recoupment activity (or will cease recoupment activity) to the extent administratively feasible while the dispute is under review.
- If we uphold our original determination, we will provide written notification. We will also retain any recoupments already processed and/or proceed with recoupments previously put on hold.
- If we overturn our original determination, we will provide written notification. We will also repay any recoupments already processed and/or remove claims from the recoupment process.

When refunding an overpayment by check, be sure to include all appropriate information to help us identify the overpaid claim:

- Member name and Clover Health ID
- Date of service
- Billed and paid amounts
- Provider remittance advice that you received for the claim and/or the refund request letter you received from Clover Health or one of our contracted vendors

Overpayment refund checks can be sent to:

Clover Health
Attn: Payment Integrity
P.O. Box 2045
Jersey City, NJ 07303

If we determine upon investigation that our overpayment was a result of fraud you have committed, we will report the fraud to the appropriate state and federal regulators as required by law. We can then take action to collect an overpayment by assessing it against payment of any future claim submitted by you.

If you have any questions about Overpayment Recoveries, please contact Provider Services at 1-877-853-8019, available 8 am–5:30 pm local time, Monday–Friday, to assist you.

Fraud, Waste, and Abuse

We trust that our providers will work ethically to deliver the highest-quality medical care and abide by the proper administrative guidelines. In the rare event that a provider compromises this integrity, we support the laws put in place to combat fraud, waste, and abuse.

STATE AND FEDERAL LAWS

Clover Health recognizes the importance of preventing, detecting, and investigating fraud, waste, and abuse (FWA), and is committed to protecting and preserving the integrity and availability of healthcare resources for members. Clover Health must ensure that First Tier, Downstream, or Related Entities (FDR) receive general compliance training, as well as fraud, waste, and abuse training.

Federal and state fraud and abuse laws that apply to you include the False Claims Act, the Anti-Kickback Statute, and the physician self-referral law (Stark Law). Violations of these laws can result in nonpayment of claims, civil monetary penalties (CMP), exclusion from all federal healthcare programs, and criminal and civil liability.

CLOVER HEALTH'S FRAUD WASTE AND ABUSE OBLIGATIONS

As a partner of CMS, we are obligated to monitor for signs of fraud, waste, and abuse; and to ensure well-managed care through a payment integrity review both before and after payment is issued. Clover Health uses software tools to identify providers and facilities whose billing practices match patterns associated with suspicious conduct.

If a claim, provider, or facility is identified as a behavioral outlier, further investigation is conducted by Clover Health to determine the reason(s) for the outlier behavior or approximate explanation for an unusual claim, billing, or coding practice. If the investigation results in a determination that the provider's or facility's actions can involve fraud, waste, or abuse, the provider or facility is notified and given an opportunity to respond, and Clover Health can institute an overpayment recovery process as described above.

These claim types, providers, or facilities can be placed under prepayment review and be subject to one or more clinical utilization management guidelines. The impacted providers and/or facilities are notified of a request for additional clinical information in support of the medical necessity of services billed and coded on the identified claims in prepayment review.

Reporting fraud, waste, and abuse

If you think you are in a problematic relationship or have been following billing practices and you realize you were wrong:

1. Immediately cease filing the problematic bills.
2. Seek knowledgeable legal counsel.
3. Determine what money you collected in error and report and return overpayments.
4. Undo the problematic association by taking all steps to free yourself.
5. Consider using the OIG or CMS self-disclosure protocols.

To report suspicious activity, contact:

OIG Fraud Hotline:
1-800-HHS-TIPS (1-800-447-8477)
TTY 1-800-377-4950
oig.hhs.gov/fraud/report-fraud

You can also report suspicious activity by calling Clover Health's Compliance and Ethics Hotline at **1-877-284-6962** or by email at compliance@cloverhealth.com.

Compliance training

CMS requires Medicare Advantage (MA) organizations and Part D plan sponsors, including Clover Health, to annually communicate specific compliance requirements, and FWA requirements to their “first tier, downstream, and related entities” (FDRs), which include contracted physicians, healthcare professionals, facilities, and ancillary providers, as well as delegates, contractors, and related parties. This training may be completed by accessing the General Compliance Training available on the CMS Medicare Learning Network® at cms.gov. You can download this training material and add information specific to your organization but you cannot alter the CMS training material. This training must be completed annually. You must retain a record (e.g., training materials, sign-in sheets of the completed training, etc.) for 10 years.

Access to medical records

Medical records access is central to our assessment of payment integrity and the evaluation of medical necessity. In the processing of claims, if more clinical data is required, our team or a trusted third-party requests medical records and pends the processing of the claim until the records are received and evaluated.

MEMBER COST-SHARE

As a provider, you play a critical role in our network and in the provision of healthcare services to our members. In accordance with CMS regulations and as included in your Provider Agreement, you can only bill or collect payments for applicable copays, coinsurance, or deductibles. You cannot bill members directly or request additional payment from our members beyond the cost-share stipulated in the member's plan for covered services rendered.

Clover Health encourages you to collect all applicable copays at the time services are rendered but to defer the collection of coinsurance and outstanding deductibles until Clover Health has processed the claim and an explanation of payment (EOP) has been received. The primary care physician and emergency room copays are printed on the member's Clover Health ID card; alternatively, all member copays can be obtained:

Online

Log on to [NaviNet](#).

Phone

Call Provider Services at **1-877-853-8019**. We're available 8 am–5:30 pm local time, Monday–Friday, to assist you.

If the amount you collect from a member exceeds that member's payment responsibility, you must reimburse the excess amount to the member within 60 days or by the time frame that is specified in your Provider Agreement with Clover Health. To determine the member's responsibility, refer to the EOP. If a correction to a claim or a payment must be made, the result of which indicates that the original amount collected in member cost-share exceeds the member's actual responsibility, it is your responsibility to reimburse the excess amount to the member. Furthermore, you must advise members of any charges that will accrue that are not covered by Clover Health and obtain prior approval from the member before requesting payment for such out-of-pocket expenses.

Balance billing and inappropriate billing of members

If you are a Medicare-participating provider or you contract with Clover Health, you cannot balance bill or inappropriately bill members. Any such billing is a violation of the Provider Agreement and applicable state laws. Providers who willfully or repeatedly balance bill members will be referred by Clover Health to the relevant regulatory agency for further action.

Inappropriate member billing includes billing members for services where payment from Clover Health has not been obtained due to claim cleanliness or other billing issues.

Utilization Management

Our goal at Clover Health is to help provide the right care to your patients at the right time. Our utilization management (UM) program was designed to apply CMS Medicare criteria and guidelines, along with evidence-based criteria, to our clinical decision making to ensure members have access to quality care that is medically necessary.

PRIOR AUTHORIZATION REVIEW

Prior Authorization is required to assess the need for an elective admission, procedure, or service; however, it is not required for emergency services care. A provider is available immediately for emergency services and on a timely basis for all other cases as required by the medical needs of the situation. The provider is under the clinical direction of the physician responsible for medical services provided to the members. Such determinations are made in accordance with clinical and medical necessity criteria. Clover Health is partnering with eviCore to review a subset of prior authorizations, effective August 1, 2020.

As a contracted provider, if you do not obtain prior authorization before providing the service, the claim for services can be denied and you, as the provider, can be held financially responsible.

Clover Health does not apply prior-authorization requirements and utilization controls that effectively withhold or limit medically necessary services, or establish prior authorization requirements and utilization controls that might result in a reduced scope of benefits for a member.

Clover Health's approval of a prior authorization does not guarantee payment of all procedure codes that are provided on your claim submission.

Prior authorization submission

Prior authorization requests can be submitted 24 hours a day, 7 days a week. Clover Health staff are available to respond to authorization requests 8 am–5:30 pm, local time, Monday–Friday.

Our online prior authorization tool lets you securely submit new requests and check the status of requests on our website. You don't even need a special login. You simply submit requests using your National Provider Identifier (NPI). There's no need to wait on hold or to send documents by fax. Then you can log in any time to check the status of your request.

To submit a new prior authorization request or to check if a prior authorization is needed:

1. Log on to cloverhealth.com/providers.
2. Click the **Start request** button.
3. Enter the required information about the procedure and the patient, and upload any documentation.
4. Click the **Submit request** button.
5. Be sure to write down the Request ID.

To check the status of a prior authorization request:

1. Log on to cloverhealth.com/providers.
2. Click the **Check request status** button.
3. Enter the Request ID you received and the National Provider Identifier (NPI) you used on the original prior authorization submission.

Alternatively, you can call or fax your prior authorization request to Clover Health:

- Call: **1-888-995-1690**
- Fax: **1-800-308-1107**

eviCore will review the following authorization requests:

1. Advanced Imaging
2. Cardiac Imaging
3. Medical Oncology
4. Radiation Therapy
5. Musculoskeletal - Interventional
6. Pain, Spine and Joint Surgery
7. Sleep Covered Services and Related Equipment

To submit a new prior authorization request to eviCore or to check if a prior authorization is needed, log on to evicore.com/resources/healthplan/cloverhealth.

Timeliness of prior authorization requests

Prior authorizations can be requested 24 hours a day, 7 days a week (including holidays). Prior authorizations can be requested as expedited or standard based on the member's health needs.

Failure by Clover Health to make a determination within the required time periods constitutes an adverse organization determination and can be appealed.

Urgent or expedited prior authorization requests

Clover Health resolves urgent or expedited prior authorization requests per CMS organization determination guidance.

Urgent or expedited prior authorization requests table

EXPEDITED AUTHORIZATION	PROCESSING TIMEFRAME
Expedited: Pre-Service	72 hours
Expedited: Part B Drug	24 hours

Standard prior authorization requests table

ROUTINE AUTHORIZATION	PROCESSING TIMEFRAME
Pre-Service	14 calendar days
Part B Drug	72 hours

Providers will be notified of the determination by phone and/or in writing in the case of urgent or expedited requests. If a phone call or fax notification is unsuccessful or a phone number or fax number was not provided, notifications will be mailed.

Written notification of adverse determinations includes instructions regarding reconsideration options, an explanation of the reason for the determination, and other rights and information. Clover Health reserves the right to convert a request for expedited processing to a standard/routine time frame if you do not state why applying the standard time for making a determination could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Standard prior authorization requests

Determinations are communicated to providers within a time frame appropriate to the medical exigencies of the case, but not more than 14 calendar days after the request for prior authorization was received. You are notified of the determination by fax in the case of standard requests. If a fax notification is unsuccessful or a fax number is not provided, notifications will be made by phone and/or mail.

Written notification of adverse determinations includes instructions regarding reconsideration options, an explanation of the reason for the determination, and other rights and information.

Request for information

If Clover Health requires additional information to make a determination, Clover Health will notify the provider by phone, fax, email, or other means of written communications within the time frames for issuing a determination and will identify the specific information required.

If you fail to respond to Clover Health's request for additional information necessary to render a determination, the request for authorization may be denied.

CONCURRENT REVIEW

Concurrent review is conducted on hospitalizations and other services that require review for continued care, specifically, SNFs, acute rehab, LTACH, inpatient psych, and inpatient detox. Concurrent review includes utilization management activities that take place during inpatient level care or an ongoing outpatient course of treatment. The concurrent review process includes obtaining necessary clinical information from facility staff, practitioners, and providers to determine medical necessity and appropriate ongoing level of care.

If a member's discharge is expected to be greater than the length of stay as determined in the preceding decision, clinical documentation must be provided to support the continued stay.

Notifications

When an adverse determination is issued, Clover Health will notify the member and provider of the results. Notices made in writing meet the CMS language and format requirements and are written to ensure understanding.

The Integrated Denial Notice is used for denials of pre-service authorization requests and indicates the following for both the member and provider:

- The effective date of the denial, reduction, stoppage, or termination of service, or other medical coverage determination
- The action taken by Clover Health on the request for prior authorization and the reason for such action, including the clinical review criteria relied upon to make the determination and a clinical rationale

- A member's right to a standard or expedited appeal and the right to appoint a representative who will act on the member's behalf
- A member's right to have benefits continued pending resolution of the appeal and to request that benefits be continued

The Notice of Denial of Covered Services notice is used for denials of authorization requests where the member is receiving or has received services and indicates the following for the provider:

- The effective date of the denial or other medical coverage determination
- The action taken by Clover Health on the request for prior authorization and the reason for such action, including the clinical review criteria relied upon to make the determination and a clinical rationale

To dispute a Notice of Denial of Covered Services, refer to your provider contract or the payment dispute instructions in the [Disputes, Appeals, and Resolutions](#) section of this manual.

For discontinuation of covered services that require concurrent review in regard to Skilled Nursing Facility, Comprehensive Outpatient Rehabilitation Facility, and Home Health, the Notice of Medicare Non-Coverage and Detailed Explanation of Non-Coverage are used to inform the member of the last covered day for services to be rendered and the rationale, specific to the member's condition, for why the service is being discontinued. Providers are responsible to ensure the notice is delivered to the member in a timely manner.

Administrative denials

If, based upon review of member enrollment, eligibility status, and benefits coverage, the member is found to not be eligible for the requested service, an Integrated Denial Notice will be issued with one of the following statements of administrative denial:

- The member was not enrolled in a benefit plan on the date(s) of service in question
- The service being requested is not covered by the benefit plan in which the member is enrolled (e.g., benefit exclusions)

The denial notification clearly and directly addresses the member or designee to ensure the member/designee can make an informed judgment about filing an appeal or grievance with Clover Health. The denial notification includes the following:

- Appeals or grievances filing instructions
- Time frames within which an appeal or grievance determination must be made
- A stipulation of the member's right to designate a representative to file an appeal or grievance on his or her behalf

Peer-to-peer review for organization determinations

Providers or the Clover Health Medical Director can initiate a peer-to-peer (P2P) review prior to rendering a decision on an organization determination. This provides the opportunity to discuss the case with the Clover Health physician reviewer responsible for the determination. To initiate a P2P review request, call **1-888-798-1728**. We're available 8:30 am–5 pm local time, Monday–Friday, to assist you.

- For pre-service requests: The adverse determination that is issued on the Integrated Denial Notice (IDN) cannot be reversed (overturned) by a P2P discussion if conducted after the determination has been made by the Clover Health medical director.
- For inpatient hospitalizations: Notice of Denial of Coverage for Services (NDCS) must be based on medical necessity to qualify for a P2P review.
- Peer-to-peer is not available for non-hospitalization retrospective requests.
- For SNF, Home Health, and CORF:
 - A peer-to-peer review can be initiated after a Notice of Medicare Non-Coverage (NOMNC) is issued, when there is a change in the member’s medical condition requiring ongoing medical care, and before the last covered date.
- Appeals will be filed with the Quality Improvement Organization (QIO) if there is no change in the member’s medical condition after the NOMNC is issued, if the appeal request is completed by 12 pm local time and is submitted on the day prior to the last covered date, or if the appeal request is with Clover Health’s Appeals Team and cutoff time for the QIO appeal is missed.

RETROSPECTIVE REVIEW

For retrospective reviews, please refer to the Clover Health Part C Retrospective Review Policy. The link to the policy is provided below.

[Clover Health Part C Retrospective Review Policy](#)

DECISION-MAKING CRITERIA

The Clover Health Medical Management Committee and Quality Improvement (QI) Committee review and approve clinical criteria on a yearly or ad hoc basis. Currently, Clover uses the Clover Health Utilization Review Policies, CMS National and Local Coverage Determinations, and MCG Criteria. This suite of guidelines cover the spectrum of inpatient, outpatient, rehabilitation, and care for medical, surgical, and behavioral health issues. In addition, our partnering vendor eviCore will also provide clinical expertise for the specific outpatient services. eviCore guidelines are consistent with best practices. Both Clover and eviCore guidelines are available on the Clover provider website, cloverhealth.com/providers.

Clover Health consults with participating providers in adherence to Clover Health’s medical policies, treatment protocols, medical management policies, and the like, as determined by Clover Health.

MEDICAL MANAGEMENT INFORMATION SYSTEM

The Medical Management Information System is a unique health information technology platform developed by our engineering, data, and medical teams to be utilized by:

- The Utilization Management Department for case development and medical necessity decision-making
- Care managers to coordinate care and develop, monitor, and modify plans of care, and check on members’ gaps in care

- The Appeals and Grievances Department for processing reconsiderations and complaints
- Customer experience representatives to check eligibility and process inbound telephone prior authorization requests

STEP THERAPY FOR PART B DRUGS

Clover Health may require a trial of a Part B preferred drug to treat a medical condition before covering another non-preferred Part B drug. Note: The step therapy requirement does not apply to members who've already received treatment with a non-preferred drug within the past 365 days.

Clover Health's Part B Preferred Drug List can be found at the link below for your convenience.
cloverhealth.com/part-b-st.

MEDICARE OUTPATIENT OBSERVATION NOTICE

Hospitals and CAHs must provide the MOON to Clover members who receive observation services in the outpatient setting for more than 24 hours. The MOON is intended to inform beneficiaries who receive observation services for more than 24 hours that they are outpatients receiving observation services and not inpatients, and the reasons for such status, and must be delivered no later than 36 hours after observation services begin.

This also includes members in the following circumstances:

- Members who are subsequently admitted as an inpatient prior to the required delivery of the MOON
- Members who are transferred or discharged after having received outpatient services for more than 24 hours
- Members for whom Medicare is either the primary or secondary payer

The start time of observation services, for purposes of determining when more than 24 hours of observation services have been received, is the clock time observation services are initiated (furnished to the patient), as documented in the patient's medical record, in accordance with a physician's order. This follows the elapsed clock time, rather than the billed time, associated with the observation services.

Hospitals and CAHs must issue the CMS approved MOON and follow all notice instructions published by CMS online at cms.gov/Medicare/Medicare-General-Information/BNI. In general, the MOON must remain two pages, unless inclusion of additional information per section 400.3.8 or state-specific information per section 400.5 of Chapter 30 of the CMS Claims Processing Manual results in additional page(s). The pages of the notice can be two sides of one page or one side of separate pages, but must not be condensed to one page.

PARTICIPATING SNF REFERRAL FOR HOSPITAL DISCHARGE PLANNING

In accordance with CMS hospital discharge planning requirements providers are reminded discharge planning must include options for post acute care (PAC) providers. Hospitals must advise members of PAC providers that participate with the plan (INN). If the patient is enrolled in a managed care organization that utilizes a network of exclusive or preferred providers, the hospital must make reasonable attempts, based on information from the insurer, to limit the list to HHAs and SNFs that participate in the insurer's network of providers. Hospitals requesting authorization to a non-participating PAC provider may be requested to detail their attempts to seek care from a participating PAC provider.

Additional reading: [CFR 482.43, CMS Memo - section A-0823, CMS' Discharge Planning Rule Supports Interoperability and Patient Preferences](#)

NOTICE OF MEDICARE NON-COVERAGE (NOMNC):

CMS requires the Notice of Medicare Non-Coverage (NOMNC) to be delivered to all Medicare Advantage (MA) health plan members at least two days prior to termination of skilled nursing facility (SNF), home health agency (HHA) or comprehensive outpatient rehabilitation facility (CORF) services. It is important the member receives the NOMNC in accordance with form requirements and instructions published by CMS online at <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices>. No modification of the text on the CMS NOMNC is allowed.

Note: *If the member's SNF admission is expected to last less than two calendar days, the NOMNC should be delivered to the member upon admission.*

For HHA or CORF services, the notice needs to be given no later than the next-to-the-last time services are furnished. The NOMNC informs members how to request an expedited determination from their QIO if they disagree with the termination.

Providers must ensure valid delivery of the NOMNC to the member pursuant to CMS standards:

- The notice must be the standardized CMS NOMNC form
- The member must be able to comprehend and fully understand the notice contents.
- The member or his/her authorized representative must sign and date the notice as proof of receipt.
 - If a member refuses to sign the NOMNC, the member's refusal to sign, the date, time, name of the person who witnessed the refusal and their signature must be documented on the NOMNC.
 - If the member is unable to sign and their authorized representative is not present to sign on the member's behalf, the provider must annotate the NOMNC with the name of the representative, the date and time the representative was informed, and the method of communication (phone, fax, email) by which the representative was informed of NOMNC delivery.
 - If delivery is made by phone, the representative must be informed of all pertinent information related to the notice including but not limited to, the last approved date, the member's right to appeal and instructions on how to file the appeal.
- Any assistance used with delivery of the notice also must be documented.

For more information about notification of termination requirements, practitioners can visit the CMS website at: Medicare Claims Processing Manual Chapter 30 - Financial Liability Protections, Section 260.3.3 - Provider Delivery of the NOMNC

Disputes, Appeals, and Resolutions

Clover Health wants to ensure that as our providers, you understand your options if you have any questions about—or disagree with—a decision we've made about billing, claims, or prior authorizations. This section will walk you through appeals and disputes, grievances, and more.

PAYMENT DISPUTES

Payments that are made to our in-network providers are based on the terms of the Provider Agreement with Clover Health. Although second-level disputes are not applicable, a payment dispute can be filed for:

- A dispute of medical necessity
 - A denial of services for the requested treatment of a member that does not appear to meet medical necessity criteria and cannot be medically certified based on the information provided by the treating clinician(s)
- A dispute of administrative determinations resulting in no payment, or
- A dispute of the amount Clover paid on a claim and a request to obtain a higher level of payment

Payment dispute submission

You can create your dispute within the contractually agreed-upon time frame, upon receipt of your remittance notice, or within 60 days if not specified otherwise in your Provider Agreement. Submissions can be made through NaviNet, mail, or fax:

- Non-Clinical Claims Payment Disputes
- NaviNet, and initiate a Claim Investigation
 - If you have attachments (e.g., medical records) you will need to mail or fax in the Claims Payment Dispute form and supporting documents regardless of when the claim was processed.
 - Fax your request to **1-888-240-7243**.
 - Mail your dispute to:
 - Clover Health**
Attn: Claims
P.O. Box 2092
Jersey City, NJ 07303
- Clinical Claims Payment Disputes
 - If you have attachments (e.g., medical records) you will need to mail or fax in the Claims Payment Dispute form and supporting documents regardless of when the claim was processed.
 - Fax your request to **1-732-412-9706**.
 - Mail your dispute to:
 - Clover Health**
Attn: Appeals
P.O. Box 2091
Jersey City, NJ 07303

Along with your dispute, be sure to submit the following relevant documents:

- A copy of the original claim form
- Date(s) of service
- The basis for the dispute
- The remittance notice showing the denial
- Any clinical records or CMS documentation supporting your request for reimbursement

We make reasonable efforts to review and resolve a dispute within 60 days of receiving the [Provider Dispute Form](#) and supporting documentation. The resolution can result in reprocessing the claim(s) and issuing an Explanation of Payment (EOP), or if the determination was upheld and no additional payment will be made, a letter will be sent or a phone call will be made concerning the outcome. All decisions made in connection with our payment dispute reviews are final.

Demonstrating good cause for late filing of dispute

If Clover Health does not receive the dispute within the contractually agreed-upon time frame, or as required under this Provider Manual, the dispute can be resubmitted with a [“good cause” reason and supporting documentation](#) added on the dispute form for untimely filing. If a “good cause” reason for untimely filing is not shown, Clover Health can dismiss the dispute as untimely. In such case, a resolution letter that explains the reason for dismissal will be sent or a phone call will be made to you. If a favorable “good cause” determination is made, Clover Health will issue a redetermination and send out a notification to inform you.

Medical necessity determination disputes

If the claim determination indicates that the healthcare services for which the claim was submitted were (i) not medically necessary, (ii) experimental or investigational, (iii) cosmetic (rather than medically necessary), or (iv) noncovered dental rather than medical, a Clover Health physician reviewer will review the dispute within the time frame listed above. In addition, please refer to the Utilization Management section of the Provider Manual for information on Clover Health’s Retro Authorization Policy regarding provider appeal and dispute rights when a prior authorization was not received prior to the service.

Administrative determination disputes

If the claim determination indicates that the services for which the claim was submitted involved issues not related to medical necessity, then Clover Health’s Disputes Management Team, in consultation with our Claims Team, reviews the dispute within the time frame listed above. The following are reasons for which an administrative denial is issued:

- Missing/invalid modifier, procedure code, or provider NPI
- The diagnosis is invalid for the submitted procedure

Disputes of eligibility-related determinations

If the claim determination indicates that the person to who received the healthcare services for which the claim was submitted is ineligible for coverage because (i) the healthcare services are not covered under the terms of the relevant health benefits plan, or (ii) the individual is not a Clover Health member, you can submit a complaint directly to Clover Health’s Disputes Management Team if you wish to do so.

For more information about the complaint submissions process or payment disputes, contact Provider Services at **1-877-853-8019**. We’re available 8 am–5:30 pm local time, Monday–Friday, to assist you.

APPEALS

Pre-service appeals

When services have not yet been rendered, a member, a member representative, and you or any other provider acting

on behalf of the member with the member's consent can appeal any adverse determination made by Clover Health's Utilization Management Team that resulted in a denial, termination, or other limitation of covered healthcare services. Pre-service appeals must be requested within 60 calendar days from the notice of the initial adverse determination.

For Clover Health members, the appeal is reviewed internally by Clover Health (Level 1 appeal). If an adverse determination is upheld, Clover Health initiates a formal external review (Level 2 appeal) by an independent review entity (IRE). Further stages of appeals include an Administrative Law Judge hearing, a Medicare Appeals Council review, and a judicial review. Detailed instructions about how to file each of these additional levels would be included in the denial notification you or the member receives.

Pre-service appeals can be submitted in writing or verbally if the member's medical condition requires an expedited decision. Written appeals can be submitted to:

Clover Health
Attn: Appeals
PO Box 2091
Jersey City, NJ 07303

Or they can be emailed to: Appeals@cloverhealth.com

Verbal appeals for expedited pre-service requests can be initiated by calling Provider Services at 1-877-853-8019. We're available 8 am–5:30 pm local time, Monday–Friday, to assist you.

Clover Health is partnering with eviCore healthcare to provide pre-service appeals processing for some Radiology, Cardiology, Radiation Therapy, Medical Oncology, Sleep Management and Musculoskeletal Management for Interventional Paid, Spine and Joint Surgery services. Pre-service appeals for these services should be submitted directly to eviCore. Services and Pharm B drugs managed by eviCore can be found at cloverhealth.com under Provider Resources.

eviCore
Attn: Clinical Appeals
400 Buckwalter Place Blvd.
Bluffton, SC 29910
Phone: 1-888-657-1204 (TTY 711)
Fax: 1-866-699-8128

Appeals (reconsiderations) involving medical necessity are reviewed by Clover Health staff members who are licensed healthcare professionals. If Clover Health issues a partial or fully denied determination, that determination is made by a physician who has a current and unrestricted license to practice medicine and who was not involved in the original determination.

Expedited pre-service appeal

You are allowed to submit an expedited appeal when applying the standard timeframe could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

If Clover Health requires information necessary to conduct an expedited appeal, Clover Health immediately notifies the member and you by phone or fax.

Clover Health will make a determination on expedited appeals within 72 hours of receiving the request and communicate the determination to the member and/or the member's designee, and you, as a provider acting on behalf of the member. Determination notifications are made within 72 hours, if applicable.

Under certain circumstances, Clover Health can extend the time frame for an expedited appeal determination by up to 14 calendar days at either the member's request or Clover Health's. Clover Health will inform the member of his/her right to file an expedited grievance, should he/she not agree with the request for an extension.

If Clover Health fails to make an appeal determination within the 72 hours, such failure constitutes an affirmation of Clover Health's initial adverse determination and Clover Health forwards the entire file to the IRE. The IRE will send notice that they are reviewing the case.

If Clover Health does not accept the request for an expedited appeal, Clover Health sends notice to the member or member's designee within 24 hours of the appeal receipt to notify of the conversion from expedited to the standard time frame. Clover Health provides an explanation of the member's right to file an expedited grievance and to submit additional supporting information from you explaining the basis for the expedited request.

Clover Health does not expedite post-service disputes involving payment.

Standard pre-service appeal

Standard appeals are available for pre-service issues. These appeals may be filed verbally or in writing by the member or the member's designee, or by you—as the provider—acting on behalf of the member. A standard appeal can be made within 60 calendar days of an initial adverse determination notice. Clover Health can grant a good-cause late filing exception under certain circumstances.

If a written pre-service appeal is received, Clover Health sends a written acknowledgment of receipt of the appeal to the appealing party within 5 calendar days of the date of receipt. If the plan requires information to conduct the appeal, the plan identifies and requests the necessary information from the member and from you, as the member's provider. Clover Health assigns a clinical peer reviewer different from the one who rendered the adverse determination.

The appeal determination is rendered within 30 calendar days from receipt of the request for an appeal. If the initial adverse organization determination is affirmed, the member, member's designee, and/or you—acting on behalf of the member—will be notified once your case is received by the IRE.

Higher-level appeals

Medicare Advantage members' cases are automatically sent to the Independent Review Entity (IRE) when an original adverse determination is upheld as a result of a pre-service appeal process and the member is notified.

Files are sent to the IRE within 30 calendar days of receipt of the request for a standard pre-service appeal and within 24 hours of the final adverse determination for an expedited pre-service appeal.

If the IRE reverses a final adverse determination, Clover Health must approve or provide the services no later than 14 calendar days from the standard pre-service appeal overturn date or 72 hours from the expedited appeal overturn date.

If the member, member designee, or you—acting on behalf of the member—are dissatisfied with the determination of the IRE, the member, member designee, or you can request a hearing with the Administrative Law Judge (ALJ) provided the request is within 60 calendar days of receipt of the IRE adverse determination and the minimum monetary threshold is met.

If the member and member designee or you—acting on behalf of the member—are not satisfied with the ALJ determination, either party can request within 60 calendar days of receipt of the ALJ determination a review by the Medicare Appeals Council (MAC). The request should be sent to the following address:

**Department of Health and Human Services Department Appeals Board,
MS6127 Medicare Appeals Council**

330 Independence Avenue, S.W. Cohen Building, Room G-644, Washington, DC 20201

If the member and member designee or you—acting on behalf of the member—are not satisfied with the MAC determination, either party can request, within 60 days of receipt of the MAC determination, a judicial review, provided that the minimum monetary threshold is met.

Furthermore, any reconsideration can be requested to be reopened in 1 to 4 years after final determination, depending on the circumstance.

Documentation for clinical appeals

When submitting a reconsideration to Clover Health for review, clinical information is required to reconsider the original medical necessity determination.

Pre-service appeals

If an initial pre-service organization determination was denied due to lack of medical necessity, the most recent and relevant clinical information is required to make a reconsideration of the appeal. Be sure to include the clinical information you believe constitutes medical necessity.

For outpatient procedures, this includes the most recent physician notes and medication lists required for the requested procedures. Similarly, for *prospective inpatient procedures*, the most recent physician notes and orders relevant to the requested services should be submitted with the appeal. For *inpatient rehabilitation*, the most recent physical and occupational therapy, and nursing notes within the last 48 hours are required.

Post-service disputes

Clover Health provides you the opportunity to file a post-service dispute when you disagree with a payment(s) you received from Clover Health after rendering a service to our members. Clover Health will deny any post-

service dispute for services we've denied through our prior authorization process and/or for services that require an authorization but for which there is no authorization on file. Be sure to include medical records that support medical necessity in addition to a completed payment dispute form for any inpatient stays that you are disputing for payment; for example:

- Emergency room records
- Admission history and present illness
- Inpatient specialist/physician consultation notes
- Electrocardiogram (EKG/ECG) reports
- Procedure reports
- Vitals, nursing notes
- Labs
- Radiology reports
- Medication administration records
- Medicine reconciliation form
- Physical therapy/occupational therapy/speech therapy evaluation and notes
- Discharge planning details
- Discharge summary
- Discharge medication list
- Discharge status (e.g., home, SNF, SAR, etc.)

Post-service dispute submission

For any other services that fall under *outpatient*, *prospective inpatient*, or *inpatient rehabilitation*, see the Pre-Service Appeals section. You can submit medical records in one of the following ways:

- Fax your request to **1-262-834-3589**
- Mail the medical records to:

Clover Health

Attn: Appeals

PO Box 2091

Jersey City, NJ 07303

Provider complaints not involving claims payment or medical necessity issues

If you have complaints or disputes that are not within the scope of the Claims Payment Disputes sections and do not relate to compensation matters, a claim determination, or a utilization management decision, you should first seek to informally resolve them by contacting Provider Services at **1-877-853-8019**. A Provider Services representative will work with you, and if the dispute is not resolved on an informal basis, you can submit a formal written complaint to:

Clover Health

Attention: Director, Provider Solutions

PO Box 471

Jersey City, NJ 07303

While the initial, informal channel described above is made available to you, you also have the option of submitting formal complaints directly to the address above without having previously tried to resolve the matter informally.

Upon receipt of a formal, written provider complaint, Clover Health conducts an internal review at no cost to you.

Clover Health uses commercially reasonable efforts to complete the internal review and communicate the results of such review in writing within 30 business days of receiving the complaint. The written response will include:

- The names, titles, and qualifying credentials of the persons participating in the internal review
- A statement of your complaint
- The decision of the reviewer(s), together with a detailed explanation of the basis for such decision (if applicable)
- A description of the evidence or documentation that supports the decision

GRIEVANCES

Member grievances and resolution overview

Federal law guarantees Clover Health members the right to file complaints if they are dissatisfied with their coverage. Medicare has established a variety of rules around how members should file complaints and how Clover Health must process them fairly. A Clover Health member cannot be disenrolled or penalized in any way for making a complaint. Depending on the subject, a complaint is handled as an organization determination, an appeal, or a grievance.

A grievance is any expression of dissatisfaction regarding the health plan and/or provider, including quality of care, concerns, disputes, and requests for reconsideration or appeal made by the member or the member's representative.

Filing a member grievance

Clover Health members or their representatives—with the member's consent—can file a grievance in one of the following ways:

Phone

Call Member Services at **1-888-778-1478 (TTY 711)**. We're available 8 am–8 pm local time, 7 days a week to assist you. From April 1st through September 30th, alternate technologies (for example, voicemail) will be used on the weekends and holidays.

Fax

Grievances can be faxed to **1-551-227-3962**.

Mail

Grievances can be mailed to the following address:

Clover Health
Attention: Grievances
PO Box 471
Jersey City, NJ 07303

Notification

Clover Health contacts members (by phone or mail) to acknowledge their grievance within 5 calendar days of receiving it. We are required to notify members of the results of our investigation no later than 30 days after we receive their grievance. However, on some occasions, after the conclusion of the 30 days, Clover Health can initiate an extension of up to 14 calendar days in order to appropriately resolve the grievance. Clover Health members are notified in writing if an extension is taken.

Clover Health members also have the right to file complaints directly with Medicare by filling out the [Medicare Complaint Form](#).

Care Management Program

One of the core components of our company is our care coordination program, which includes our telephonic nurse care coordination and clinical care visit teams. Here, you'll see how this vital ecosystem works—in unison with your guidance and expertise—to deliver better patient outcomes.

PREVENTIVE HEALTH AND CHRONIC CARE MANAGEMENT

Clover Health works with you to improve your patients' well-being by encouraging them to pursue healthy behaviors. This includes ensuring that your patients obtain needed screenings and stay adherent to their medication regimens and receive appropriate vaccinations.

As part of these initiatives, Clover Health focuses on the following clinical areas:

- Breast cancer screening
- Cholesterol management
- Colorectal cancer screening
- Diabetes screening and management
- Drug and alcohol use screening
- Hypertension screening and management
- Influenza and pneumonia vaccinations
- Medication access and management
- Osteoporosis identification and management
- Prevention of hospitalizations and readmissions
- Respiratory assessment (spirometry)
- Rheumatoid arthritis management

These clinical areas are also foci of Clover Health's Quality Improvement Program, which is described in detail in the following section of the manual.

CHRONIC CARE COORDINATION AND MANAGEMENT

Clover Health also provides chronic care coordination and management services. These include:

- Telephonic care coordination delivered by Clover Health nurses, who can help members access medications and durable medical equipment, provide health education and coaching, and book appointments with both primary care providers and specialists.
- Yearly in-home health assessments, including comprehensive medication reviews, screening for under-recognized health conditions, and evaluation for Clover Health care coordination and management programs.
- Care transitions support for high risk members discharged from the hospital, rehabilitation facilities, and skilled nursing facilities to home.

Clover Health's most medically complex members, many of whom are homebound, frail, and with advanced illness, may also elect to receive care through our In-Home Care program. Members in In-Home Care receive primary care visits from a team of physicians, nurse practitioners, medical assistants, and social workers. Visits last up to an hour in duration. Participating members also receive in-home laboratory and radiology testing services. Members with difficulties leaving home to attend specialist visits receive additional transportation support. It is our aim to collaborate closely with network providers to identify appropriate members for the program and coordinate care following member enrollment.

CLINICAL PRACTICE GUIDELINES

Clover has curated the best-practice guidelines listed below for your reference. This list includes evidence-based guidelines intended to be utilized in order to provide the best care for our members whom you serve every day and to assist you in making appropriate healthcare decisions based on sound clinical judgment and application of knowledge. Adherence to these guidelines will not ensure successful treatment in every situation. Furthermore, these guidelines should not be interpreted as setting a standard of care or be deemed inclusive of all proper methods of care nor exclusive of other methods of care reasonably directed to obtaining the same results. Please be advised that while Clover supports the following guidelines, specifically in the Utilization Management arena, we utilize best practice guidelines from MCG and CMS to reach our final decisions.

All guidelines reflect the most current views of the relevant medical community as gleaned from the scientific evidence, professional standards, and expert opinion from recognized sources. The areas covered by these guidelines include the following conditions, medical calculators, and topics:

- MD Calculator
- Prognosis Calculator
- Shared Decision Making
- Prepare for Your Care
- Adult Obesity
- Asthma
- Atrial Fibrillation: Tools/Anticoagulation
- Chronic Kidney Disease
- Cholesterol Management
- Chronic Obstructive Pulmonary Disease
- COVID-19
- CVD (Cardiovascular Disease) Prevention
- Diabetes Mellitus: Guidelines/Risk Assessment in CVD
- Congestive Heart Failure
- HIV/AIDS
- Hypertension
- Low Back Pain
- Mental Health: Depression Screening, CAGE Questionnaire, Opioids for Chronic Pain
- Osteoporosis
- Tobacco Cessation
- AAFP Clinical Preventive Services
- USPSTF Screening
- Recommendations

For the most up-to-date clinical practice guidelines, visit the Provider Portal on the Clover Health [website](#). You can also contact Provider Services at **1-877-853-8019**. We're available 8 am–5:30 pm local time, Monday–Friday, to assist you.

Quality Improvement Program

We're a data-driven company, focused on helping you provide actionable insights to help you provide better care and treatment plans for your patients. We leverage multiple data points to drive clinical insights that help us understand the real story “behind the numbers” so that we can better support you and your patients with innovative solutions that continually evolve and adapt to meet your needs.

We design our Quality Improvement Program to hold ourselves to the highest standards in quality of care and are driven to providing a best-in-class experience for our providers and members.

GOALS AND OBJECTIVES

We have one goal—to improve the quality of life of our members and providers. We strive to continually improve the quality of care and service our members receive by aligning with providers to reduce doctor-insurer friction and increasing visibility into the health of each member, leading to improved care and member health outcomes. Our commitment to using member-centered analytics and dedicated complex care programs enables us to identify potential risks a member may face and directly provide preventive care and innovative programs to provide value and optimize their health outcomes. Providers must cooperate with Quality Improvement activities. To that aim, the specific goals of our Quality Improvement (QI) Program have been adopted to support Clover Health’s vision and values and to promote continuous improvement in quality of care/service and patient safety for our members and providers:

- Utilize clinically driven data insights through standardized and collaborative activities that work to identify opportunities for improvement on the health status of members. (This enables us to develop and implement thoughtful health promotion, preventive health education, and disease and case management programs to maximize safety and quality of healthcare delivered to members through the continuous quality improvement process.)
- Maintain a high-quality provider network through a formalized credentialing and recredentialing process.
- Ensure that adequate resources are arranged to provide available, appropriate, accessible, and timely healthcare services to all members according to evidence-based guidelines.
- Ensure easy and timely access to accurate information through member experience representatives, written materials, and our website.
- Attend to the needs and expectations of our customers by resolving inquiries, complaints, grievances, and appeals in a timely manner, evaluating performance and taking action to meet those needs and expectations.
- Maintain compliance with local, state, and federal regulatory requirements

As part of the QI program, initiatives in key areas include, but are not limited to:

- **Provider and Clinical Engagement:** Clover focuses on member and provider collaboration for a broad range of areas such as ensuring members receive a follow up visit to their PCP after a post hospitalization discharge, chronic conditions such as diabetes, medication adherence, and preventative health services such as cancer screenings and immunizations. Improvements in these areas are demonstrated in improved clinical metrics including HEDIS® (Healthcare Effectiveness Data and Information Set)¹, Part D Star Ratings, and other quality measures. A full set of Star ratings can be obtained on request by contacting your Network Management team.
- **Member Experience:** Clover is passionately driven to provide a best-in-class member experience. To that end, Clover focuses on showing members we care in a variety of ways such as listening to the voice of the member, making it easier for the member to access care and other healthcare services, making care convenient, and supporting cultural competency and health literacy. Clover uses CMS-required CAHPS® (Consumer Assessment of Health Plan Survey) data, which measure a member’s experience (not satisfaction) with their health plan and healthcare services (including their providers). Clover also uses data from the HOS® (Health Outcome Survey), which measures a member’s perception of the improvement/decline of their health and if certain PCP conversations occurred two years after an initial assessment.

Our QI Program is designed to harness clinically driven data analytics to assess and continuously improve plan performance and quality as evidenced in key metric outcomes such as our Medicare Star rating.

1. HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA)

The QI Program Description defines the quality infrastructure that supports Clover's QI strategies:

- The QI Program Description establishes QI Program governance, scope, goals, measurable objectives, structure, and responsibilities, which encompass the quality of medical and behavioral health care and services providers to members.
- Annually, a QI Work Plan is developed and implemented which reflects ongoing progress made on QI activities during the year. The QI work plan includes our approach to member safety and improving medical/behavioral health care: quality of clinical care, safety of clinical care, and quality of service.
- Annually, the QI Evaluation assesses outcomes of Clover's clinical quality programs, processes, and activities. This evaluation also assesses whether the QI Program goals and objectives were met.

MEDICARE STAR RATING SYSTEM

The Medicare Star Ratings system is used by CMS to rate plan performance and quality of Medicare Advantage plans on a scale of 1 to 5 stars (5 representing the highest and best score) to allow members to compare plans.

Clover Health's program is designed to ensure that the quality-of-care opportunities that are identified as priorities by CMS are comprehensively addressed.

Star ratings are focused around key goals for the quality provision of healthcare, including:

- Effectiveness of care
- Access/availability of care
- Experience of care
- Utilization of services and relative resource use

HEDIS®

HEDIS® is a set of standardized performance measures created by the National Committee for Quality Assurance (NCQA) to report and compare health plans on the basis of quality of care, services, and performance. HEDIS® is coordinated and administered by NCQA and is one of the most widely used sets of healthcare performance measures in the United States. Clover Health uses its HEDIS® reporting to assess, compare, and report, and to encourage resultant improvements in the quality of care that Clover and its contracted providers, practitioners, and delegated entities provide to Medicare Advantage members.

CMS Star Ratings system is based in part on these measures. HEDIS® measures included in the Star rating are:

- Breast cancer screening
- Colorectal cancer screening
- BMI assessment

- Osteoporosis management in women after a fracture
- Diabetes care: A1c, retinal eye exam, kidney disease monitoring
- Rheumatoid arthritis management
- Medication reconciliation after discharge
- Plan all cause readmissions
- Statin therapy in persons with cardiovascular disease

When applicable, Clover asks that Providers adhere to HEDIS® guidelines and specifications for all members during each measurement year and to collaborate in the data collection process by facilitating Clover staff access to members' medical records. Clover Health's Star Quality Improvement team is responsible for collecting clinical information from provider offices in accordance with HEDIS® specifications. Medical record requests to provider offices will occur in the measurement year, and Clover requests that the records be returned within five (5) business days to allow time for the team to abstract the records and request additional information from other providers, if needed. Clover will communicate HEDIS® results to members and to you to encourage the use of preventive measures and thus improve healthy behaviors and outcome.

CAHPS®

CMS requires that Medicare Advantage plans administer the patient-satisfaction survey called the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)² survey, which represents an effort to accurately and reliably capture key information from Clover's members about their experience with Clover. Medicare plans in the past year. This includes the member's access to medical care and the quality of the services provided by Clover's network of providers. Clover analyzes this feedback to identify issues causing member dissatisfaction and works to develop effective interventions to address them. The CAHPS® survey is sent to a random sample of members in the spring. Several questions relate to member experience with physicians. CAHPS® includes questions about the patient-physician relationship, such as:

- Coordination of care: measures patients' perception of their personal physicians' knowledge about the care received from specialists and other healthcare providers
- Getting care quickly: measures the experiences patients had in receiving care or advice in a reasonable time, including time spent in waiting rooms
- Getting needed care: measures the experiences patients had when attempting to obtain care, treatments, and tests from their PCP and specialists
- Getting needed prescription drugs: measures the experiences patients had when attempting to fill a prescription at a local or mail-order pharmacy
- Rating of healthcare: gives patients an opportunity to rate all the healthcare they have received in the last 12 months
- Rating of health plan: measures patients' overall experiences with their health plan over the last 12 months
- Rating of drug plan: measures patients' overall experiences with their drug plan over the last 12 months

Clover Health encourages providers to assess their own practices to identify opportunities to improve member's access to care and improve interpersonal skills to make the patient care experience a more positive one.

2. CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

HOS

The Health Outcomes Survey (HOS) is a CMS survey that gathers health data from Medicare participants over time. A random sample of Medicare patients are selected and the surveys are administered in the spring. HOS includes a baseline survey, and 2 years later a recheck survey is sent to the same patients. Patients are asked about overall physical and mental health status. Patients are also asked if they had a discussion with their physician about:

- Urinary incontinence
- Physical activity
- Fall risk
- Pharmacy measures
- Pharmacy measures take into consideration adherence to medications prescribed to treat different disease states, including:
 - Diabetes
 - Hypertension
 - Hypercholesterolemia

Actions taken by physicians to improve medication adherence include:

- Proactively assessing whether the patient is taking medication as prescribed. Many times patients will split pills or take them irregularly. Encourage patients to take medications as you prescribe them and do not encourage patients to split pills unless instructed to do so as part of the prescription.
- Discussing patient-specific adherence barriers. Many times patients may have problems like financial and transportation issues getting to a pharmacy. Discussing a cheaper mail-order option may work better for chronic medications.
- Providing 90-day prescriptions for maintenance medications.

If you have questions, you can contact Provider Services at **1-877-853-8019**.

We're available 8 am–5:30 pm EST.

PROGRAM REVIEW

Clover Health's Star rating strategy is consistent with CMS's aims of better care, healthier people and communities, and lower costs through continuous improvement.

Our interdisciplinary Quality Improvement Committee is tasked with reviewing and analyzing QI activities at Clover Health for impact and effectiveness. With that aim, we work with our provider network to promote best practices, which employ evidence-based guidelines, and make modifications to our program when opportunities for improvement are identified.

THE CLOVER ASSISTANT

The Clover Assistant is built on a proprietary web-based platform that aggregates and integrates health data across every spectrum of the member's healthcare experience. The Clover Assistant Visit dynamically surfaces up-to-date, patient-specific information including gaps, medications, and potential diagnoses as well as provides clinicians and office staff with a comprehensive view, populated with data from anywhere our members have received care and where Clover has received the data.

Provider Responsibilities:

As a Participating Provider, you agree to partner with Clover Health to provide care management of Clover Health members and coordinate their care across the healthcare continuum. You agree to:

- Encourage Provider's physician and clinical staff providing Covered Services to Clover Health Members under Provider's Provider Services Agreement ("Participating Physicians") to participate in onboarding training ("Onboarding") on the Clover Assistant, in order to learn how to use the technology, scheduled for a mutually agreeable time convenient for Participating Physician.
- Clover Health may delay onboarding until Participating Physician has five (5) or more Clover Health Members in its patient population. During this transition, Provider and Participating Physician will be compensated according to the Medicare Fee-for-Service Schedule then in effect.
- Clover Health will contact Participating Physician to schedule an Onboarding session ("Initial Scheduling Call"). Thirty (30) days after the Initial Scheduling Call, Participating Physician will be activated on the Clover Assistant Payment model and Fee-for-Service payments for evaluation and management and annual wellness visits will not be processed. Participating Physician, therefore, must schedule and complete Onboarding within thirty (30) days of the Initial Scheduling Call.
- As necessary, participate in additional trainings designed to assist Participating Physician in understanding how best to make use of the Clover Assistant in the treatment and management of patient care.
- Make use of Clover Health Tools and Technologies for any and all evaluation and management, and annual wellness visits. Specifically, Provider and Participating Physicians agree to use the Clover Assistant as directed by Clover Health for any and all Member visits to Participating Physician for health care services at the time of the patient encounter.
- Identify and note Clover Health Members who may benefit from Clover Health's care management programs (including, but not limited to, Clover Health's in-home complex care programs).

Clover Assistant Payments:

Clover Health will remit payment to Participating Providers of two hundred dollars (\$200) within seven (7) days for use of the Clover Assistant during the office visit (the "Clover Assistant Payment") when complete and accurate information is submitted. Please note, Participating Physicians and Providers will not be entitled to the Clover Assistant Payment until Onboarding has been completed. Provider and Participating Physician agree to accept the Clover Assistant Payment for performing an in-office evaluation and management (CPT 9920(1-5), 9921(2-5), 9938(5-7), 9939(5-7), physical exam (CPT G0402), and annual wellness visit (CPT G0438 and G0439). Note, Member expenses (as defined in the Agreement) are not affected. Additionally, Clover Health will compensate Provider and Participating Physicians for all other Covered Services provided outside of the Clover Assistant (excluding the Covered Services provided for the above listed CPT codes) at the agreed-upon Medicare FFS rate.

All fax submissions must follow the below steps in order to ensure payment is received within seven business days of a complete submission. Any submission with missing/unmatched information will be sent back automatically to the provider via the Clover Assistant for correction/resubmission.

Payment for Clover Assistant Visits will not be made for any incomplete submissions (including submissions with errors/missing information or failure to submit the associated encounter note). In addition, Clover reserves the right to deny payment for a Clover Assistant Visit not completely and accurately submitted within 30 days of the date of service.

For ease of use and to minimize the likelihood of incomplete or inaccurate submissions, we strongly encourage all Clover Assistant providers to submit encounter notes using either the Manual Upload within the Clover Assistant or the upload for Athena Users.

For Clover Assistant Participating Providers who continue to fax in encounter notes, we encourage you to do the following to ensure proper submission. Fax in your encounter note within 48 hours after you submit the Clover Assistant Summary via the Clover Assistant. Ensure that key administrative information on the encounter note matches the Clover Assistant Summary. Please double-check that the date of service, the associated provider name/NPI, and patient name/DOB on the encounter note all match the information contained on the Clover Assistant Summary.

Clover will continue to provide timely payment within seven days of receiving a complete Clover Assistant Visit submission, which must include the Clover Assistant summary and matching encounter note. We thank you in advance for your diligence in continuing to submit complete Clover Assistant Visits.

Important Note Regarding Clover Assistant Reimbursement for Virtual Visits Due to the COVID Public Health Emergency (PHE):

COVID-19 has had, and continues to have, a profound effect on our providers and their day-to-day operations. To assist our providers, the Clover Assistant team rapidly released several upgrades designed to help our providers adapt to the changing marketplace.

Based on guidance issued by CMS, we revised our telehealth payment policy and rolled out a new program to allow you to receive Clover Assistant Payments for both video (two-way audiovisual communication) and voice-only (telephonic without video) visits. Clover has added voice-only (telephonic without video) evaluation and wellness codes to the list of CPT codes eligible for reimbursement through the Clover Assistant (99441-3). Clover Assistant Visits completed using only voice (telephonic without video) will be reimbursed at a rate of \$100 per visit. Visits completed using video (two-way audiovisual communication) and visits completed in-person, will continue to be reimbursed at a rate of \$200 per visit. When creating a new Clover Assistant Visit, simply specify whether the appointment will be in-person, voice-only, or video. Support for this payment structure will remain in place until such time that the PHE lapses and/or CMS amends its policy for reimbursement of virtual visits. Clover Assistant providers will be given advance notice should this occur.

CareConnect Tasks:

In order to assist Participating Physician in using the Clover Assistant and to improve the efficiency and efficacy of the Program, Clover Health has developed and continues to develop certain functionalities within the Clover Assistant for use by Participating Physician's office staff ("CareConnect Tasks").

- The CareConnect Tasks and corresponding payments (the "CareConnect Payments") are described below.
- The Clover Assistant and other informational materials will provide additional guidance for these tasks. These documents will provide information on (i) specific requirements and actions to be taken to accomplish the tasks and (ii) description of the confirmatory events that must occur in order for each task to be considered completed.

CareConnect Tasks and Payments:

Task	CareConnect Payment	Required actions for payment
Medication Adherence	\$30 per member per quarter in which task is completed	Task is marked as "Renewed" or "Patient will pick up" AND Clover Health receives a claim for the medication fill within two weeks OR Task is marked as "Appointment scheduled" AND Clover Health receives a claim for the medication fill within two weeks
Post-Admission Follow Up Appointment	\$10 per member per quarter who has follow up appointment after task is completed	Task is marked as "Appointment scheduled" AND there is a completed Clover Assistant visit with a date of service within 21 days of CareConnect task completion

Additional CareConnect Tasks to be rolled out in future releases may include, but are not limited to, (a) making appointments at doctors or specialists offices, (b) collecting and confirming patient demographic information in Clover Assistant, (c) providing Clover Health educational materials to patients, and (d) informing the provider that Clover Assistant should be used with a patient. Clover Health reserves the right to add additional tasks to this list and to modify the payments per task. Any such changes will become active upon 30 days' notice to Provider.

Please note that, in order to participate in Clover Assistant or the CareConnect program, providers must have signed an agreement containing the above terms. If you have not yet done so, but wish to participate in this program, please contact the Network Team at **1-800-619-5541** or cloverassistantsupport@cloverhealth.com or see "Legal Documents" section within the Clover Assistant tool.

Pharmacy Services

We want to ensure your patients have the most cost-effective prescriptions and drug therapy treatments available to them. That is why, in addition to providing unique offerings like 100-day prescriptions, we make sure to contract with the highest-quality pharmacies to administer them.

FORMULARY OVERVIEW

Clover Health contracts with CMS to provide drug coverage for Medicare Part D members using the Medicare Part D Drug Formulary, utilization management programs, and pricing structure. The pharmacy benefit does not cover all medications. Some medications require prior authorization or have limitations on age, dosage, and/or maximum quantities. Clover Health works with CVS Caremark to administer pharmacy benefits, including the prior authorization process.

The Clover Health Medicare Advantage Formulary contains all drugs covered by our plans, and is organized by section. Each section is divided by therapeutic drug class primarily defined by mechanism of action. Products are listed by generic name or by brand name, depending on formulary coverage. Unless exceptions are noted, generally all applicable dosage forms and strengths of the drug cited are included in the Clover Health Medicare Advantage Formulary.

Medications selected for inclusion in the Clover Health Medicare Advantage Formulary are reviewed by Clover Health's Pharmacy Benefit Manager's pharmacy and therapeutics committee (P&T). Members of the P&T come from various clinical specialties and are practicing physicians and pharmacists. The P&T meets regularly to keep the formulary current, while providing optimal results for our members and controlling the cost of medication therapy.

Formulary documents can be found on the Clover Health website: cloverhealth.com/en/members/formulary.

CVS CAREMARK MAIL SERVICE PHARMACY™

Clover partners with CVS Caremark Mail Service Pharmacy to provide mail-order maintenance medications for chronic conditions. CVS Caremark Mail Service Pharmacy can send members up to a 100-day supply of medications, with their physician's approval.

With this service, your patients will enjoy the benefits listed below.

- Safety and peace of mind: Discreet packages which are tamper-proof, weather-proof and temperature controlled, if needed. Licensed pharmacists ensure accuracy and safety before shipping and are available to answer medication questions.
- Convenience: Medications delivered by mail with standard shipping at no cost. Members can sign up to receive order status alerts, and can track orders and more by phone, email, or text message.
- Flexibility: Manage medications anytime, anywhere at caremark.com or by using the CVS Caremark mobile app.
- Savings: Depending on the Clover Health pharmacy benefits plan, members may save money by using CVS Caremark Mail Service Pharmacy.

How your patients can learn more

Encourage members to visit our Clover Health member website and select “Mail Order Rx” at the top of the page. Members may call our Member Services team at **1-888-778-1478** (TTY 711) 8 am–8 pm local time, 7 days a week or log onto [caremark.com](https://www.caremark.com) to get started.

How to send up to 100-day prescriptions to CVS Caremark Mail Service Pharmacy

- To ePrescriber choose:
 - CVS Caremark
 - MAILSERVICE Pharmacy
 - NCPDP ID: 0322038
 - 9501 E Shea Blvd.
 - Scottsdale, AZ 85260
- To fax prescriptions: **1-800-378-0323**
- Faststart direct toll-free phone number: **1-800-378-5697**

PART D UTILIZATION MANAGEMENT

Certain prescription drugs on the formulary have additional requirements or limits on coverage. These requirements and limits ensure that members use these drugs in the safest and most and effective way and help to control drug costs.

Certain drugs require prior authorization. This means that you will need to get approval from us before the members fill their prescription. If you don't get approval, we cannot cover the drug.

Please refer to the Part D Coverage Determination section in this manual for how to submit a prior authorization.

Prior authorization criteria can be found on the Clover Health website:

[cloverhealth.com/en/members/formulary](https://www.cloverhealth.com/en/members/formulary).

Quantity limits

For certain drugs, there are limits on the amount we will cover per prescription or for a defined period of time.

Step therapy

In some cases, we require the members to try one drug for treatment of a medical condition before we cover another drug for the same condition. For example, if Drug A and Drug B both treat a certain medical condition, we can require you to prescribe Drug A first. If Drug A does not work for the member then we will cover Drug B.

More about step therapy can be found on the Clover Health website:

[cloverhealth.com/en/members/formulary](https://www.cloverhealth.com/en/members/formulary).

FORMULARY-LEVEL OPIOID POINT-OF-SALE SAFETY EDITS

Clover Health's drug management program consists of several pharmacy-based edits to assist in addressing safety concerns regarding opioid prescriptions.

To align with CMS Medicare Part D Opioid Overutilization Policy, we partnered with our pharmacy benefits manager CVS Caremark and developed point-of-sale edits to advocate patient safety for our members and encourage appropriate prescription opioid use.

The drug management program or point-of-sale edits are not intended as prescribing limits.

Summary: Med D opioid management requirements

7-day supply edit for opioid-naive patients

- Hard reject for initial opioid prescription (short- and long-acting) for acute pain exceeding 7 days
- 60-day minimum look-back period; CVS Caremark implementing a 108-day look back
- Safety edit, not transition fill eligible
- Patients in active cancer treatment, patients with sickle cell disease, LTC residents, patients in hospice or palliative care, and Buprenorphine for medication-assisted treatment (MAT) are exempt from the edit

Update 90 mg/day MME soft reject (care coordination edit)

- Cumulative 90 mg/day MME soft edit
- Long-term care residents, patients in hospice or palliative care, patients in active treatment for cancer-related pain, patients with sickle cell disease, and Buprenorphine for MAT are expected to be excluded from the edit

Opioid/benzodiazepine POS (point of service) soft reject edit

- Soft reject POS safety edit for the concurrent use of opioids and benzodiazepines

Duplicate long-acting opioid POS soft reject edit

- Soft reject POS safety edit

Additional CVS Caremark opioid changes for standard Med D formularies

- Immediate Release before Extended Release prior authorization
- Quantity limits for opioid-containing products based on limitations of up to 90 MME/day (when possible) and/or the FDA-approved maximum dose
 - MME = morphine milligram equivalent

CVS Caremark implementation details: 7-day limit for opioid naive patients

CMS Mandate for opioid naïve patients: All Med-D plans are expected to have a hard reject for an initial opioid prescription for acute pain that exceeds 7 days; patients in active cancer treatment, patients with sickle cell disease, hospice, LTC, and palliative care are excluded from this edit.

Edit overview

- Hard reject for opioid-naive patients filling over 7-day supply of opioid (safety edit, not transition fill eligible)
- Buprenorphine products for medication-assisted treatment for opioid use disorder not subject to this edit
- Edit will reject with reject code 925 (Initial Fill Days Supply Exceeds Limits) and 569 (Provide Notice: Medicare Prescription Drug Coverage and Your Rights) upon initial rejection
- Once 7-day reject is resolved, all opioid formulary or UM rejects with Transition Fill (TF) logic will execute applicable Transition Fill logic

Ensuring access for patients excluded from edit and avoiding unnecessary disruption

- Exception criteria will apply and allow member to bypass 7-day edit for members in:
 - Active cancer treatment using oncology GPIs or cancer ICD 10 diagnosis codes
 - Long-term Care using patient residence codes 03 or 09
 - Hospice using member-level indicator
 - Palliative care using ICD 10 code Z51.5
 - Diagnosis of sickle cell disease or if member has a medication used to treat sickle cell disease in their prescription history
- CVS Caremark Pharmacy Help Desk can override edit if exception cannot be determined based on prescription claim/member data; conversation will be documented

CVS Caremark implementation details: improving drug utilization review (DUR) controls in Part D

CMS mandate POS DUR edits

- Cumulative Morphine Milligram Equivalent (cMME) soft reject edit at 90 mg/day MME
- Soft reject for the concurrent use of an opioid and benzodiazepine and duplicate long-acting opioids

Edit overview

Current POS MME edit updated to meet new opioid coordination of care safety edit requirements:

- New result of service override codes allow pharmacist to override edit—if appropriate—after consultation with prescriber, or if the pharmacist has documented an appropriate exception for edit
- Will change reject code 88 to add new MME reject code 922 (Morphine Equivalent Dose Exceeds Limits)
- Members excluded from edit include:
 - Hospice - using the member-level indicator
 - Long-term care (LTC) - using appropriate patient residence codes 03 (Skilled Nursing Facility) and 09 (Intermediate Care Facility/Individuals with Intellectual Disabilities)

- Active treatment for cancer-related pain using oncology GPIs with 180 day look-back
- Members receiving buprenorphine for medication-assisted treatment (MAT) using MAT GPIs
- Diagnosis of sickle cell disease or if member has a medication used to treat sickle cell disease in their prescription history

Two soft reject POS safety edits:

- Concurrent use of opioids and benzodiazepines edit (using current drug-drug interaction edit functionality)
- Duplicate long-acting opioids edit (using current duplicate therapy edit functionality)

We request that you respond promptly to pharmacy requests for additional information related to opioid safety alerts. Please ensure your on-call staff is aware and responds with a sense of urgency to pharmacy outreach. This will avoid delays in needed drug therapy.

If you have questions, please call the CVS Caremark Help Desk number on your patient's Clover Health member ID card. For PPO plans, call **1-855-479-3657**. For HMO plans, call **1-844-232-2316**.

MEDICARE ADVANTAGE PART D FORMULARY COVERAGE EXCLUSIONS

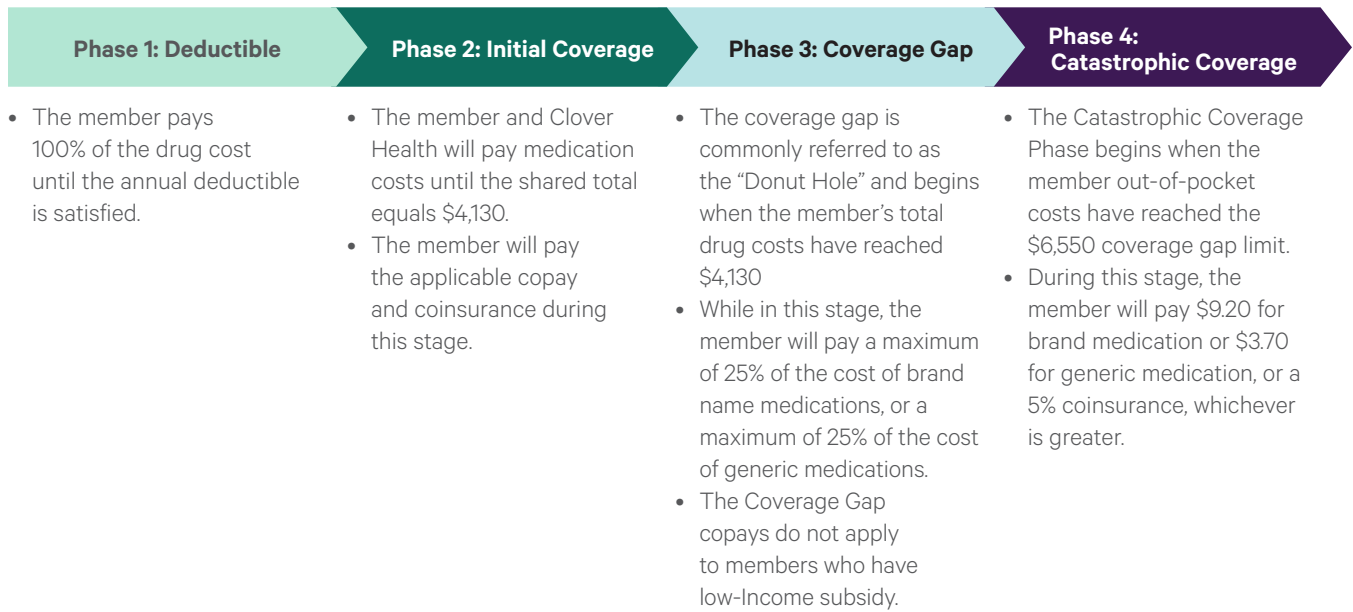
The following is a list of noncovered (i.e., excluded) drugs and/or categories:

- Agents when used for anorexia, weight loss, or weight gain (even if used for a noncosmetic purpose, such as for morbid obesity)
- Agents when used to promote fertility
- Agents when used for cosmetic purposes or hair growth
- Agents when used for the symptomatic relief of cough and colds
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Nonprescription over-the-counter (OTC) drugs
- Covered outpatient drugs that the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee
- Agents when used for the treatment of sexual or erectile dysfunction; erectile dysfunction drugs will meet the definition of a Part D drug when prescribed for medically accepted indications approved by the Food and Drug Administration (FDA) other than sexual or erectile dysfunction (such as pulmonary hypertension). However, ED drugs will not meet the definition of a Part D drug when used off-label, even when the off-label use is listed in one of the compendia found in section 1927(g)(1)(B)(i) of the Act: American Hospital Formulary Service Drug Information, and DRUGDEX® Information System.

Medicare Part D coverage phases

Medicare Part D prescription drug plans have four coverage stages. How members are affected depends on the prescription drug plan and medication costs. If the plan has a deductible, the member's responsibility begins at Phase 1. If their plan does not have a deductible, the member's responsibilities begin at Phase 2. The dollar amounts listed below can change each year.

You can log into [NaviNet](#) or reference the Benefits section of this manual to determine if the member has a Part D deductible on his or her plan.



PART D FORMULARY TIERS

Drugs represented in the Clover Health Medicare Advantage Formulary can have varying costs to the plan member. We categorize costs of prescription drugs with the following tiered format:

Tier 1

- The lowest cost-sharing tier
- Includes preferred generic plus adherence generic drugs

Tier 2

- Includes generic drugs
- May have Tier 1 alternatives
- Low- to mid-range cost

Tier 3

- Includes preferred brand drugs and non-preferred generic drugs classified by Clover Health based on safety, efficacy, and cost
- Mid-range costs

Tier 4

- Includes non-preferred brand-name and some non-preferred generic drugs for which alternatives are available at lower tiers
- Mid- to higher-range costs

Tier 5

- The highest cost-sharing tier
- Includes specialty drugs that are typically self-injected and used to treat complex medical conditions
- Specialty drugs can require more involvement from you, require special storage and handling and/or require close monitoring

PART D COVERAGE DETERMINATIONS

What is a coverage determination?

A coverage determination is an approval or denial decision made by Clover Health when members ask for coverage or payment of a drug they believe Clover Health should provide.

You, as well as members, can ask for a coverage determination. Members can also appoint someone else (such as a relative) to request a coverage determination on their behalf.

Upon receipt of any request, Clover Health responds to coverage determination requests within 72 hours of routine requests and within 24 hours of expedited requests.

You must provide medical history and/or other pertinent patient information when submitting a [Request for Medicare Prescription Drug Coverage Determination form](#) for formulary exceptions.

A coverage determination request is required for:

- Drugs not listed on the formulary
- Drugs listed on the formulary with a prior authorization
- Duplication of therapy
- Prescriptions that exceed the FDA daily or monthly quantity limits, or prescriptions that exceed the permitted limit noted on the formulary
- Drugs with a step edit, where the first-line therapy is inappropriate
- A request by a member for a lower copay tier for a prescribed drug on a higher copay tier

The goal of the coverage determination program is to ensure that medication regimens that are high-risk, have a high potential for misuse, or have narrow therapeutic indices are used appropriately and according to FDA-approved indications.

Part D coverage determination submission

Follow these guidelines for efficient processing of your Medicare prescription drug coverage determination requests:

1. Complete the “Request for Medicare Prescription Drug Coverage Determination” form found on the [Clover Health website](#) and fax it to CVS Caremark at **1-855-633-7673**.
2. Coverage determination requests can also be submitted electronically at [covermy meds. com/main/](#) or telephonically by calling CVS Caremark at **1-855-344-0930**.
3. Respond timely to requests for additional information. CVS Caremark will notify you of the decision by

fax. If the request is approved, information in the online pharmacy claims processing system changes to allow the specific members to receive this specific drug. If the request is denied, information about the denial will be provided to you.

If the request is denied, information about the denial will be provided to you.

In the event you or a member disagrees with the decision regarding coverage of a medication, you can request a free copy of the criteria or guidelines used in making the decision and any other information related to the determination by calling CVS Caremark toll-free at **1-855-344-0930**.

PART D APPEALS

If your prescription drug coverage request is denied, you have the right to file an appeal through our Pharmacy Benefit Manager, CVS Caremark, within 60 calendar days from the date of our first decision. We accept standard and expedited requests by telephone and in writing.

Part D appeals submission

Follow these guidelines for efficient processing of your appeal requests:

1. Call CVS Caremark Part D Appeals department at **1-855-344-0930** (TTY 711) 24 hours a day, 7 days a week.
2. Complete the [Request for Redetermination of Medicare Prescription Drug Denial form](#).
3. Fax the form to CVS Caremark at **1-855-633-7673**; or,
4. Mail the appeal to:
CVS Caremark
Attn: Part D Appeals
PO Box 52000, MC109
Phoenix, AZ 85072-2000

CVS Caremark will notify you of the decision by fax.

PART D GRIEVANCES

A Part D grievance is any complaint other than one that involves a coverage determination related to prescription drug benefits. A grievance is filed if Clover Health members have any type of problem with us or one of our network pharmacies that does not relate to coverage for a prescription drug. Medicare Part D grievances related to the following topics are processed by Clover Health's contracted Pharmacy Benefit Manager (PBM) CVS Caremark:

- Benefits
- Confidentiality and privacy
- Customer service
- Exceptions
- Pharmacy network

- Quality of care
- Mail order

Part D grievance submission

Members can contact CVS Caremark at **1-855-479-3657** (PPO plans) or **1-844-232-2316** (HMO plans) to file a grievance, or mail the grievance to:

CVS Caremark
Medicare Part D Grievances
PO Box 30016,
Pittsburgh, PA 15222-0330

Part D grievances related to the following are handled by Clover Health:

- Enrollment/disenrollment
- Fraud and abuse
- Marketing
- Other premium billing
- Provider prescribing

Members can file these types of grievances using the contact information listed in the [**“File a member grievance”**](#) section of the Provider Manual.

Laboratory Services

We believe in catching conditions earlier and doing our best to prevent them from developing in the first place—and that the best way to do both is with regular lab work.

We encourage you to refer your patients' samples to LabCorp, our trusted laboratory partner. Search our Provider Directory for in-network labs at cloverhealth.com/members/find-provider.



Credentialing

To ensure that everyone we partner with meets the industry regulatory requirements, all Clover Health network providers, physicians, nonphysician healthcare professionals, and ancillary providers must get credentialed. This section will show you how.

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CREDENTIALING PROCESS

If you fall under any of the following categories, you require credentialing:

- Medical doctors (MD)
- Osteopathic doctors (DO)
- Doctoral-level and master-level psychologists (PhD, MS)
- Chiropractors (DC)
- Dentists—oral maxillofacial surgeons (DMD)
- Ophthalmologists (MD)
- Podiatrists (DPM)
- Certified nurse midwives (CNM)
- Master-level clinical social workers (MSW, CSW)
- Physical therapists (PT), occupational therapists (OT), speech/language therapists (ST)
- Audiologists (AUD)
- Nutritionists and dietitians (RD)
- Certified nurse practitioners (CNP), clinical nurse specialists (CNS), nurse practitioners (NP)
- Physicians assistants (PA)

Clover Health's Credentialing Committee is composed of a community of physicians representing several specialties and is responsible for the approval and oversight of all participating providers. The Credentialing Committee recommendations are reviewed and acted upon by our Chief Medical Officer.

Clover Health can delegate credentialing and recredentialing activities as appropriate. If any portion of the process is delegated, Clover Health's delegated credentialing and recredentialing policies are followed. We monitor compliance with our policies and procedures of all delegated entities at least annually.

Clover Health completes credentialing activities for a "clean" file within 90 days of receiving a completed application and signed contract. If additional information is needed, we will reach out to you to amend or correct any incomplete or erroneous information.

INITIAL CREDENTIALING AND APPLICATION SUBMISSION

Physician and nonphysician healthcare professionals

Clovers uses CAQH as its primary credentialing application to process credentialing for physician and nonphysician healthcare professionals. Clover should be notified using our CAQH form or roster submission. At the time of submission, provider should have a current CAQH attestation. You can submit one of the following application options:

1. Clover uses Council for Affordable Quality Healthcare (CAQH) application, as it ensures a compliant application and a timelier online process. You only need to provide your CAQH ID.
2. An online credentialing application can be completed if CAQH is not used, but the timeline for review can be significantly longer because the review process is manual. This particular credentialing application must include the following items:
 - a. Current valid professional medical license for the practicing state
 - b. Current Drug Enforcement Administration (DEA) and Controlled Dangerous Substance (CDS) certificates for the practicing state, required for physicians and, if applicable, for that state (physicians unable to meet this requirement should provide a letter explaining why a DEA and/or CDS will not be obtained and how prescriptions will be covered)
 - c. Current Board Certification or copy of the confirmation of registration to sit for a board certification, if applicable
 - d. Current proof of adequate professional malpractice insurance with a minimum coverage amount set by the appropriate state statute
 - e. Summary of professional work history (going back a minimum of 5 years) with explanation(s) for any gaps of 6 months or more
 - f. Documentation or certificates of education and training
 - g. Summary of hospital privileges if available

In addition to an updated and complete credentialing application, the following document must also be submitted: Completed W-9 Form

During the credentialing process, we will check the following entities:

1. National Practitioner Data Bank (NPDB)
2. Applicable licensure agencies for information on sanctions or limitations on licensure
3. Office of Inspector General (OIG), Department of Health and Human Services, for the List of Excluded Individuals/Entities
4. System for Award Management (SAM) for information on providers debarred from participation or otherwise declared ineligible to participate in federal procurement or nonprocurement programs
5. Medicare Opt-Out or other federal reimbursement program for excluded or opt-out providers

Ancillary providers

You must send Clover Health a completed Facility/Ancillary Provider Credentialing Application that is signed and dated within 180 days of the credentialing date, as well as a signed agreement, and the following documents:

1. Current valid state operational license

2. State/Department of Health/Federal License
3. Accreditation/certification by a governmental accrediting body (e.g., CMS, Joint Commission on Accreditation of Healthcare Organizations [JCAHO]), if applicable
4. Current general liability coverage (i.e., documentation showing the amounts and dates of coverage)
5. Medicare certification; if you are not certified, provide proof of participation
6. IRS W-9
7. CLIA

During the credentialing review, we check the following entities:

1. National Practitioner Data Bank (NPDB)
2. Office of Inspector General (OIG), Department of Health and Human Services, for the list of excluded individuals/entities
3. System for Award Management (SAM) for information on providers debarred from participation or otherwise declared ineligible to participate in federal procurement or nonprocurement programs
4. State Medicaid Debarment
5. Medicare Opt-Out List

If an illegible and/or incomplete application packet is submitted, or if required attachments are missing, you will be contacted in an attempt to obtain this information. If the information is not received within 30 days, a cover letter detailing the missing or incomplete items, along with the incomplete application packet, is sent back to you.

When your initial application is approved by the Credentialing Committee, you are sent a welcome letter. If the application is denied, a decision letter that includes rights to appeal the committee's decision is sent out to you following the committee meeting.

RECREREDENTIALING PROCESS AND REVIEW

Clover Health requires you to undergo and complete a recredentialing review every 3 years. To qualify for recredentialing, you must maintain the same minimum qualification requirements as for the initial credentialing. A recredentialing notification letter is sent out at least 4 months ahead of the 3-year anniversary.

There is no action required of you if the Council for Affordable Quality Healthcare (CAQH) application is complete and updated; or, you can complete an online application with our CVO. If you fail to respond within 60 days of your 3-year anniversary, it is considered an administrative termination, and a termination letter is sent to you. If you are terminated as a nonresponder, you will need to undergo the initial credentialing process again, which may include the signing of a new contract.

Recredentialing applications must include the following:

- Signed and dated attestation within 180 days of the recredentialing date
- Current valid professional medical license
- Current DEA and CDS certificate for the practicing state, required for physicians and if applicable for that state

- For physicians, a letter explaining why a DEA and/or CDS will not be obtained and how prescriptions will be covered
- Current board certification or copy of the confirmation of registration to sit for a board certification, if applicable
- Current adequate professional malpractice insurance with a minimum coverage amount set by the appropriate state statute
- Summary of professional work history (going back a minimum of 3 years) with explanation(s) for any gaps of 6 months or more

You are encouraged to maintain up-to-date information on your CAQH profile.

Once the recredentialing is completed and approved, you will remain in the Clover Health network. If you get denied when presented to the Credentialing Committee for decision making, you are notified in writing within 10 business days of the committee decision. The letter includes the reasons for denial and indicates your rights to appeal the committee's decision. The actual termination is not effective until the appeal process is completed and the original decision is upheld. Exceptions to this rule are terminations related to quality-of-care issues where you have caused or can cause harm to members.

DELEGATED ENTITIES

Delegation is a formal process by which a health plan provides a provider group with the authority to perform certain functions on its behalf, such as credentialing. A function can be fully or partially delegated. Full delegation allows all activities of a function to be delegated. Partial delegation allows some of the activities to be delegated.

All participating providers or entities delegated for credentialing/recredentialing are to use the same Clover Health policies and procedures as defined in the delegated credentialing agreement. Delegated oversight audits, in person or remotely, are conducted at least annually.

Although Clover Health can delegate the authority to perform a function, it cannot delegate the ultimate responsibility for fulfilling the service or obligation.

CONFIDENTIALITY

The Credentialing Department is responsible for ensuring the confidentiality of all information received and maintained in the credentialing and recredentialing processes. Information derived from peer-review functions is protected from subpoena and discovery by state immunity laws, except as otherwise provided by law. This includes proceedings, reports, and records of a peer review specialty committee.

NONDISCRIMINATION

Clover Health does not discriminate in the credentialing or recredentialing process on the basis of religion, race, color, national origin, age, gender, sexual orientation, height, weight, familial status, marital status, disability, or any other basis prohibited by law. Additionally, Clover Health does not discriminate in credentialing and recredentialing based upon the types of procedures or the risks of the population that you serve.

REVIEW OF YOUR INFORMATION ON FILE

With the exception of information determined by Clover Health to be peer-review protected, you have the right to request in writing your file information and to subsequently review and correct any erroneous information obtained by Clover Health to support its evaluation of your application.

Send written requests to:

Clover Health
Attn: Credentialing Department—Credentialing Manager
PO Box 471
Jersey City, NJ 07303

ONGOING MONITORING

Clover Health is responsible for offering its members qualified and competent providers who will be accountable for delivering appropriate and medically necessary care and services. Because of this, Clover Health monitors provider sanctions and limitations. Clover Health is responsible for regularly informing you of any findings related to performance or practice of care.

The Credentialing Department is responsible for the management of ongoing (monthly) monitoring of:

- Medicare-Medicaid sanctions, which can lead to termination/suspension of Provider Agreement
- State licensure/disciplinary actions, which can lead to termination/suspension of Provider Agreement
- Quality-of-care issues, which can lead to a corrective action plan or termination

Any findings are discussed during the monthly Credentialing Committee meeting. If the Credentialing Committee denies you inclusion into Clover Health's network, you are notified in writing within 10 business days of the committee decision. The letter includes reasons for denial and indicates your rights to appeal the committee's decision. The actual termination date is not effective until the appeal process is completed and the original decision upheld. Exceptions to this rule are terminations related to quality-of-care issues where you have caused or can cause harm to members.

Provider Termination

While we do everything we can to nurture our partnership with you, there can be times when the only reasonable resolution is to discontinue working together. This section describes what is involved when a partnership is not serving the best interests of either party.

CIRCUMSTANCE FOR TERMINATION

There can be certain circumstances in which Clover Health decides to terminate its relationship with contracted or participating providers. Depending on the cause, Clover Health can work with you to address the problem, initiate a termination per the terms of your Provider Agreement, or initiate a termination to take effect immediately.

An immediate termination can be initiated for the following reasons:

- Suspension, revocation, condition, expiration, or other restriction of your licensure, certification, and/or accreditation to perform services contemplated under your Provider Agreement
- Suspension or bar from participation in federal healthcare programs
- Determination that you engaged in or are engaging in fraud
- Noncompliance with the general and professional liability insurance requirements set forth in your Provider Agreement
- State sanctions, indictment, arrest, or conviction, or a felony or any criminal charge
- Clover Health's reasonable determination that your immediate termination is necessary for the health and safety of members

Clover Health can also terminate the participation of an individual group provider or can require that an individual group provider cease providing services to members based upon any of the foregoing events, without terminating the Provider Agreement in its entirety.

Certain terminations initiated can also not take effect immediately (terminations for cause, terminations without cause). Refer to your Provider Agreement for details around terminations that cannot take effect immediately and the effective time frames.

In the event of a termination, Clover Health sends a termination notice to you, your ancillary, or your hospital. Clover Health can require you, your ancillary, or your hospital to provide continuity of care until a safe transition to another provider has been made.

Your Provider Agreement will not be terminated or refused renewal solely because you have:

- Advocated on behalf of a member
- Filed a complaint against Clover Health
- Appealed a decision made by Clover Health

Additionally, you can have termination rights of your own. For details about provider termination rights, refer to your Provider Agreement.

Appeal hearing process

When you, your ancillary, or your hospital requests an appeal of a termination decision, Clover Health's Credentialing and Termination Committee can form a sub-committee to hear your appeal. The sub-committee consists of no fewer than 3 members. Here are the rules and regulations for holding an appeals process:

- Peers can be providers or healthcare professionals outside of the Clover Health network of providers
- No individuals involved in the investigation of an appeals case can be part of the appeals hearing committee
- The appeals hearing committee voting can be made in person, via phone, or via email
- The medical director appoints a hearing officer who serves as the presiding officer over the hearing
- The presiding officer should:
 - Determine the order and decorum of the hearing and deliberations
 - Assure that all participants have opportunity to present oral and documented evidence
 - Provide guidance to the appeals hearing committee during the hearing and deliberations
- The hearing officer does not have voting privileges

The notice of the final decision of the appeals hearing committee is delivered by certified mail to you, your ancillary, or your hospital 30 days after close of the hearing. The notice includes the final decision, the basis for that decision (affirm, modify, or withdraw the original proposed action), and the Provider Agreement provisions and facts relied upon by Clover Health during the hearing.

NONRENEWAL OF CONTRACT

Unless otherwise specified, the Provider Agreement Clover Health executes with you automatically renews on the one-year anniversary of the effective date on your Provider Agreement, unless terminated in accordance with the provisions stated in it. A nonrenewal of your Provider Agreement constitutes a termination and will be treated as final.

CONTINUITY OF CARE

In the event of a termination, whether initiated by you or by Clover Health, our goal is to ensure that your patients, our members, continue to receive the care they require until they no longer require it or until a safe transition can be made (unless otherwise specified).

In the event that you voluntarily decide to leave the network, or Clover Health terminates with/without cause (i.e., a termination that does not fit the criteria of "immediate" as defined above), you must agree to continue to provide covered services until it is safe to discontinue or safe alternatives have been confirmed.

During this continuity-of-care period, you agree to:

1. Accept Clover Health's established reimbursement rates as payment in full
2. Adhere to Clover Health's quality improvement requirements
3. Provide medical information related to the care
4. Adhere to Clover Health's policies and procedures

Prior authorization by the [Utilization Management Department](#) is required during any continuity-of-care period.

To ensure Clover Health stays aligned with its mission to build high-performing, cost-effective provider networks, Clover Health maintains discretion to select the providers with whom it decides to contract. Clover Health is able to make changes to these networks at any time during the contract year, as long as you can continue to furnish all Clover Health covered services in a nondiscriminatory manner, meet established access and availability standards and timely notice requirements, and ensure continuity of care for members.

Administrative Procedures and Compliance

We are here to ensure your practice stays aligned with compliance guidelines, our marketing policies, and other industry-standard regulations. In the following section, we provide some helpful links and overviews to make it easy for you or your staff to reference or access them.

CMS GUIDELINES

You and any persons involved in the administration or delivery of the Medicare program benefits must complete the following training requirements within 90 days of initial hire and annually thereafter:

- CMS Medicare Parts C and D Compliance training
- CMS Medicare Parts C and D Fraud, Waste, and Abuse (FWA) training

CMS has developed a web-based training module that can be used to satisfy these training requirements. It is available on the CMS Medicare Learning Network (MED Learn) [website](#).

Clover Health recommends that you read and understand the guidelines set forth by the Centers for Medicare and Medicaid Services. For additional information, visit [cms.gov](#).

MARKETING PLANS

You cannot develop materials that market Clover Health without Clover Health's prior written approval, but you can use CMS-approved materials supplied directly by Clover Health. Under Medicare Advantage program rules, Clover Health and other Medicare Advantage plans must follow CMS marketing guidelines and obtain CMS review and approval for all marketing materials before making such materials available for distribution to eligible individuals.

You can have Clover Health marketing materials, including brochures, posters, or notifications, available in your office as long as Clover Health is not exclusively represented. Materials for other Medicare Advantage plans in which you are a participant must be available as well and in the same location. Medicare Advantage marketing materials can only be displayed in common areas and not in private patient exam rooms.

If you are interested in Clover Health marketing materials to share with members, contact your Clover Health representative.

If a member has a question regarding Clover Health, direct the member to call Clover Health Member Services at **1-888-778-1478** (TTY 711). We're available 8 am–8 pm local time, 7 days a week, to assist you. From April 1st through September 30th, alternate technologies (for example, voicemail) will be used on the weekends and holidays.

AUDIT

Providers must ensure compliance with Medicare laws, regulations, and CMS instructions; agree to audits and inspections by Clover Health, CMS, and/or its designees; cooperate, assist, and provide information as requested; and maintain records for a minimum of 10 years.

CONFLICT OF INTEREST POLICY

Conflicts of interest are created when an activity or relationship renders you unable or potentially unable to provide impartial assistance or advice, impairs your objectivity, or provides you with an unfair competitive or monetary advantage. Many of the relationships discussed in this document are subject to conflict-of-interest disclosure policies. Even if the relationships are legal, you can have an obligation to disclose their existence.

Glossary

Abuse: Actions that can, directly or indirectly, result in unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between “fraud” and “abuse” depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

Appeal: Any of the procedures that deal with the review of adverse organization determinations on the healthcare services the member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the healthcare services.

Covered services: Medically necessary healthcare services to which the member is entitled under the terms of the member’s benefit agreement.

Fraud: Knowingly and willfully executing or attempting to execute a scheme or artifice to defraud any healthcare benefit program, or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any healthcare benefit program.
18 U.S.C. § 1347.

First-tier, downstream, and related entities: Includes contracted physicians, healthcare professionals, facilities and ancillary providers, as well as delegates, contractors, and related parties of the Plan.

Grievance: Any complaint or dispute expressing dissatisfaction with the manner in which Clover Health or one of its delegated entities provides healthcare services, regardless of whether any remedial action can be taken.

Group/group provider: Employees, affiliates, or any individuals contracted with a group to provide covered services to a Clover Health member.

Healthcare provider: Physicians, healthcare professionals, and/or other providers licensed and/or authorized under the laws of the state in which services are provided who are employed by or contracted by Clover Health.

Medically necessary services: Services that are necessary for the diagnosis or treatment of disease, illness, or injury, and without which the member can be expected to suffer prolonged, increased, or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort.

Member benefit agreement: The agreement between Clover Health and the member that details the benefits to which the member is entitled.

Organization determination: Receipt of, or payment for, covered items or services; the amount Clover Health requires an enrollee to pay for covered items or services; or a limit on the quantity of covered items or services.

Participating provider: A healthcare provider, hospital, healthcare facility, ancillary provider, or any other person or entity who has contracted with Clover Health to provide covered services to members.

Provider Agreement: A signed agreement between Clover Health and a provider outlining the obligations of both parties in the delivery of quality care and covered services to members, and the compensation for those services.

Provider Manual: A document that explains Clover Health's operating policies, standards, and procedures for participating providers including, but not limited to, Clover Health's requirements for claims submission and payment, credentialing, utilization review, care management, quality improvement, advance directives, members' rights, grievances, and appeals.

Quality Improvement Organization (QIO): An organization comprising practicing doctors and other healthcare experts under contract to the federal government to monitor and improve the care given to Medicare enrollees.

Representative: An individual appointed by a member or other party, or authorized under state or other applicable law, to act on behalf of an enrollee or other party involved in an appeal or grievance.

Waste: Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather by the misuse of resources.

Appendix A: Attachments

SAMPLE MEMBER ID CARD

Clover Clover Health Choice PPO (OXX)

Samantha A Sample
 Member ID CP0123456

Plan ID 80840 RXBIN 004336 RXPCN MEDDADV RXGRP RX8556

Copayment	In	Out	Copayment	In	Out
PCP Office Visit	\$X	\$X	Specialist Visit	\$X	\$X
ER Visit	\$X	\$X	Urgent Care	\$X	\$X

CMS H5141-OXX Card Issued: 2020 MedicareRx
Prescription Drug Coverage

Clover Member Services: 888-778-1478 (TTY 711)

Clover Provider Services 877-853-8019 cloverhealth.com/providers	CVS Caremark® Pharmacy 855-479-3657
Submit Claims (Medical) Clover Health Investments P.O. Box 981704 El Paso, TX 79998-1637	Submit Claims (Pharmacy) CVS Caremark - Part D Services PO Box 52066 Phoenix, AZ 85072-2066

Claims EDI# 13285 Medicare limiting charges apply. my.cloverhealth.com



Clover

Pre-Authorization Request

Need faster turnaround times?
Go online: cloverhealth.com/pre-auth



HOW TO USE THIS FORM:

- Complete** all required fields marked with an **asterisk (*)**.
Incomplete forms may be delayed unless all required information is received.
- Attach** copies of supporting clinical information.
Required clinical documentation is listed on our website: cloverhealth.com/pre-auth-list
- Fax** this form to 1-800-308-1107
- Call** us with questions, 1-888-995-1690 to chat with our Utilization Management dept.

MEMBER INFORMATION (please print clearly)

Member Name*	Member ID*	Date of Birth*
_____	_____	____/____/____ (MM / DD / YYYY)

REQUESTING PROVIDER / FACILITY INFORMATION

Requesting NPI (Provider or Facility)*			Requesting Contact Name	

Requesting MD/Facility Name*			Title/Dept.	

Address*			Email	

City*	State*	ZIP code*	Phone	Fax
_____	_____	_____	_____	_____

SERVICING PROVIDER / FACILITY INFORMATION

Servicing NPI (Provider or Facility)*			<input type="checkbox"/> Same as requesting Provider or Facility		Servicing Contact Name

Servicing MD/Facility Name*			Specialty*		Title/Dept.
_____			_____		
Address*			Email		

City*	State*	ZIP code*	Phone	Fax	
_____	_____	_____	_____	_____	

AUTHORIZATION REQUEST (please attach copies of required clinical documentation)*

Service Type*		Place of Service*			Start Date or Admission Date*		End Date or Discharge Date	
<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient		<input type="checkbox"/> MD Office <input type="checkbox"/> Home Health <input type="checkbox"/> DME <input type="checkbox"/> Amg Surg. <input type="checkbox"/> Other _____			____/____/____		____/____/____	
Primary Procedure Code (CPT/HCPCS)		Unit(s)	Modifier	Diagnosis Code (ICD 10)*		Service Description		
_____		_____	_____	_____		_____		
Additional Procedure Code(s) (CPT/HCPCS)		Unit(s)	Modifier	Diagnosis Code (ICD 10)		Service Description		
_____		_____	_____	_____		_____		

URGENT REQUEST (If applicable, explain medical need to expedite*)

Routine requests are processed on a 14 calendar day timeframe, but does not mean we will take the full 14 days as we will process according to the member's needs and no later than 72 hours if the physician documents that would place the member's health in danger.

Total Pages:

Confidentiality Notice: This electronic fax transmission (including any documents, files or previous email messages attached to it) may contain confidential information that is intended for a specific individual and purpose and that is privileged or otherwise protected by law. If you are not the intended recipient, or a person responsible for delivering it to the intended recipient, a delete this fax and notify Clover UM of the error.

Clover Health Provider Update Request

Email: providers@cloverhealth.com
Fax: Provider Services (908) 450 2059

Required Information: (please print clearly)	Contact person handling the requested change:
Provider Name:	Name:
Provider NPI: _____	Phone #: (_____) _____ - _____
Tax ID: _____	Fax #: (_____) _____ - _____
Practice Name:	Email:

Adding Address:		
New primary address? <input type="checkbox"/> Yes <input type="checkbox"/> No	Billing address? <input type="checkbox"/> Yes <input type="checkbox"/> No	Office location? <input type="checkbox"/> Yes <input type="checkbox"/> No
Street Address:		Suite Number:
City:	State:	Zip:
Phone:	Fax:	
Email:	Effective Date of Change:	

Changing Address: (use this field to update office contact information)		
Old Address		
Street Address:		
City:	State:	Zip:
Phone:	Fax:	Email:

New Address:		
New primary address? <input type="checkbox"/> Yes <input type="checkbox"/> No	Billing address? <input type="checkbox"/> Yes <input type="checkbox"/> No	Office location? <input type="checkbox"/> Yes <input type="checkbox"/> No
Street Address:		Suite #:
City:	State:	Zip:
Phone:	Fax:	
Email:	Effective Date of Change:	

Termination of Address Location:		
Street Address:		Suite #:
City:	State:	Zip:
Phone:	Fax:	
Email:	Effective Date of Change:	

Signature:	Title:	Date:
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Clover Health

Provider Tax ID Update Form

*Required Attachment: W-9

Required Information: (please print clearly)	
Provider Name:	
Current Tax ID: ____ - ____ - ____ - ____ - ____	Previous Tax ID: ____ - ____ - ____ - ____ - ____
Is this Tax ID contracted with Clover Health? <input type="checkbox"/> Yes <input type="checkbox"/> No	Effective date:

Contact person handling the requested change:	
Name:	
Phone #: (____) ____ - ____ - ____	Fax #: (____) ____ - ____ - ____
Email:	

Provider Information: (Individuals only)	
Last Name:	First Name:
National Provider Identifier (NPI): ____ - ____ - ____ - ____ - ____	

Provider Information: (Groups only)	
Group Name:	Group NPI: ____ - ____ - ____ - ____ - ____
Does this update apply to all providers under this Tax ID? <input type="checkbox"/> Yes <input type="checkbox"/> No (Please list all applicable NPIs below)	
*Attach separate roster if there are not enough fields to complete the form.	
Provider Name:	NPI: ____ - ____ - ____ - ____ - ____
Provider Name:	NPI: ____ - ____ - ____ - ____ - ____
Provider Name:	NPI: ____ - ____ - ____ - ____ - ____

Primary Office Address: (If more than one, attach a separate list of all office addresses)		
Street Address:	Suite #:	
City:	State:	Zip:
Phone #: (____) ____ - ____ - ____	Fax #: (____) ____ - ____ - ____	
Email:		

Billing Address:		Same as primary address? <input type="checkbox"/> Yes <input type="checkbox"/> No
Street Address:	Suite #:	
City:	State:	Zip:
Phone #: (____) ____ - ____ - ____	Fax #: (____) ____ - ____ - ____	
Email:		

Signature:	Title:	Date:
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Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

► Go to www.irs.gov/FormW9 for instructions and the latest information.

Print or type. See Specific Instructions on page 3.

1	Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.	
2	Business name/disregarded entity name, if different from above	
3	Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only one of the following seven boxes. <input type="checkbox"/> Individual/sole proprietor or single-member LLC <input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate <input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ► _____ Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is not disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner. <input type="checkbox"/> Other (see instructions) ► _____	4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3): Exempt payee code (if any) _____ Exemption from FATCA reporting code (if any) _____ <small>(Applies to accounts maintained outside the U.S.)</small>
5	Address (number, street, and apt. or suite no.) See instructions.	Requester's name and address (optional)
6	City, state, and ZIP code	
7	List account number(s) here (optional)	

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number									
					-			-	
or									
Employer identification number									
						-			

Part II Certification

Under penalties of perjury, I certify that:

- The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
- I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
- I am a U.S. citizen or other U.S. person (defined below); and
- The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here	Signature of U.S. person ► _____	Date ► _____
------------------	----------------------------------	--------------

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to www.irs.gov/FormW9.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)

- Form 1099-DIV (dividends, including those from stocks or mutual funds)
 - Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
 - Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
 - Form 1099-S (proceeds from real estate transactions)
 - Form 1099-K (merchant card and third party network transactions)
 - Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
 - Form 1099-C (canceled debt)
 - Form 1099-A (acquisition or abandonment of secured property)
- Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, later.

Clover Health

Appeal Form

If you are an out-of-network provider disputing a \$0 paid claim, please use this form to submit an appeal. If you believe your claim was underpaid/overpaid, please use the Payment Dispute Form.

Provider Information		Contact Information	
Provider Name:		Name:	
Provider NPI:		Address:	
Tax ID:		Phone #: ()	
Group Name:		Fax #: ()	
Patient Information		Attachments	
<input type="checkbox"/> HMO	<input type="checkbox"/> PPO	Remittance Advice <input type="checkbox"/>	Medical Records <input type="checkbox"/>
Patient Name:		WOL (REQUIRED) <input type="checkbox"/>	AOR <input type="checkbox"/>
Member ID:		Supporting Documentation <input type="checkbox"/>	
Claim Information			
Claim Number:		Date of Service: ____ / ____ / ____	
Date of Determination: ____ / ____ / ____			
*Please provide good cause if appeal is filed after 60 days from date of determination.			
Reason for Appeal (Please select one.)			
Denial Code(s): <input type="checkbox"/> _____	Whole Claim: <input type="checkbox"/>	CPT Codes: <input type="checkbox"/> _____	
Other (Please provide a description.) <input type="checkbox"/>			
Description (Please provide additional information not addressed above.)			

Provider Experience Line: 1-877-853-8019 or Appeals Fax: 1-732-412-9706

Clover Health

Claims Payment Dispute

Because Clover Health denied your claim or you believe your claim was underpaid/overpaid, you have the right to request a redetermination. If you are an out of network provider disputing a \$0 paid claim, please submit an appeal. Fill out every section of the form. If not, your inquiry may not be reviewed in a timely manner.

Provider Information <input type="checkbox"/> INN <input type="checkbox"/> OON	Contact Information
Provider Name:	Name:
Provider NPI:	Address:
Tax ID:	Phone #: ()
Group Name:	Fax #: ()

Patient Information <input type="checkbox"/> HMO <input type="checkbox"/> PPO	Attachments
Patient Name:	Remittance Advice <input type="checkbox"/> Medical Records <input type="checkbox"/>
Member ID:	Supporting Documentation for Dispute <input type="checkbox"/>

Claim Information	
Claim Number:	Date of Service: ____ / ____ / ____
Date of Determination: ____ / ____ / ____	
*Please provide good cause if dispute is filed after 90 days (INN) or 120 days (OON) from the date of determination	

Reason for Dispute (Please Select One)
Overpayment <input type="checkbox"/> Whole Claim <input type="checkbox"/> CPT Code(s) <input type="checkbox"/> _____ Amount Paid: \$ _____ Expected Amount: \$ _____
Underpayment <input type="checkbox"/> Whole Claim <input type="checkbox"/> CPT Code(s) <input type="checkbox"/> _____ Amount Paid: \$ _____ Expected Amount: \$ _____
*Inquiries are considered underpayments only if the whole claim or the code being disputed was initially paid
Denial Code(s): <input type="checkbox"/> _____ Whole Claim: <input type="checkbox"/> CPT Codes: <input type="checkbox"/> _____
Other (Please provide a description) <input type="checkbox"/>

Description (Please provide additional information not addressed above)

Clover Health

Request for Medicare Prescription Drug Coverage Determination

Send form by mail or fax:	Who may make a request: Your prescriber may ask us for a coverage determination on your behalf. If you want another individual (such as a family member or friend) to make a request for you, that individual must be your representative. Contact us to learn how to name a representative. Coverage Determination website: www.cloverhealth.com Coverage Determination phone: (844) 232-2316
Address: CVS Caremark Part D MC109; P.O. Box 52000 Phoenix, AZ 85072-2000 Fax #: (855) 633-7673	

Enrollee's Information:		
Name:		
Street Address:		
City:	State:	Zipcode:
Phone Number: (____)____-____	Birth Date:	
Enrollee's Plan ID #:		

Complete the following section ONLY if the person making this request is not the enrollee or prescriber:		
Requestor's name:		
Relationship to the Enrollee:		
Street Address:		
City:	State:	Zipcode:
Phone Number: (____)____-____		
Representation documentation for appeal requests made by someone other than enrollee or the enrollee's prescriber: Attach documentation showing the authority to represent the enrollee (a completed Authorization of Representation Form CMS-1696 or a written equivalent). For more information on appointing a representative, contact your plan or 1-800-Medicare, TTY: 1-877-486-2048, 24 hours per day, 7 days a week.		

Name of prescription drug you are requesting: (if known, include strength and quantity requested per month)

Type of coverage determination request

Please choose any that apply:

- I need a drug that is not on the plan’s list of covered drugs (formulary exception).*
- I have been using a drug that was previously included on the plan’s list of covered drugs, but is being removed or was removed from this list during the plan year (formulary exception).*
- I request prior authorization for the drug my prescriber has prescribed.*
- I request an exception to the requirement that I try another drug before I get the drug my prescriber prescribed (formulary exception).*
- I request an exception to the plan’s limit on the number of pills (quantity limit) I can receive so that I can get the number of pills my prescriber prescribed (formulary exception).*
- My drug plan charges a higher copayment for the drug my prescriber prescribed than it charges for another drug that treats my condition, and I want to pay the lower copayment (tiering exception).*
- I have been using a drug that was previously included on a lower copayment tier, but is being moved to or was moved to a higher copayment tier (tiering exception).*
- My drug plan charged me a higher copayment for a drug than it should have.
- I want to be reimbursed for a covered prescription drug that I paid for out of pocket.

***NOTE:** If you are asking for a formulary or tiering exception, your prescriber **MUST** provide a statement supporting your request. Requests that are subject to prior authorization (or any other utilization management requirement), may require supporting information. Your prescriber may use the attached “Supporting Information for an Exception Request or Prior Authorization” to support your request.

Additional information we should consider: (attach any supporting documents)

Important Note: Expedited Decisions

If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescriber indicates that waiting 72 hours could seriously harm your health, we will automatically give you a decision within 24 hours. If you do not obtain your prescriber’s support for an expedited request, we will decide if your case requires a fast decision. You cannot request an expedited coverage determination if you are asking us to pay you back for a drug you already received.

CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION IN 24 HOURS
If you have a supporting statement from your prescriber, attach it to this request.

Signature:

Date:

Supporting information for an Exception Request or Prior Authorization:

FORMULARY and TIERING EXCEPTION requests cannot be processed without a prescriber's supporting statement. PRIOR AUTHORIZATION requests may require supporting information.

REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Prescriber's Information:

Name:

Street Address:

City:

State:

Zipcode:

Office Phone:

Fax:

Office Contact Person:

Prescriber's Signature:

Date:

Diagnosis and Medical information:

Medication:

Frequency:

Strength and route of administration:

Date started:

 NEW START

Expected length of therapy:

Quantity (per 30 days):

Height/Weight:

Drug Allergies:

DIAGNOSIS – Please list all diagnoses being treated with the requested drug and corresponding ICD-10 codes. (If the condition being treated with the requested drug is a symptom e.g. anorexia, weight loss, shortness of breath, chest pain, nausea, etc., provide the diagnosis causing the symptom(s) if known):

ICD-10 Code(s)

Other RELEVANT DIAGNOSES:

ICD-10 Code(s)

DRUG HISTORY: (for treatment of the condition(s) requiring the requested drug)		
DRUGS TRIED: (if quantity limit is an issue, list unit dose/total daily dose tried)	DATES of Drug Trials:	RESULTS of previous drug trials FAILURE vs INTOLERANCE (explain):
What is the enrollee's current drug regimen for the condition(s) requiring the requested drug?		
DRUG SAFETY		
Any FDA NOTED CONTRAINDICATIONS to the requested drug?		<input type="checkbox"/> YES <input type="checkbox"/> NO
Any concern for a DRUG INTERACTION with the addition of the requested drug to the enrollee's current drug regimen?		<input type="checkbox"/> YES <input type="checkbox"/> NO
If the answer to either of the questions noted above is yes, please 1) explain issue, 2) discuss the benefits vs potential risks despite the noted concern, and 3) monitoring plan to ensure safety		
HIGH RISK MANAGEMENT OF DRUGS IN THE ELDERLY		
If the enrollee is over the age of 65, do you feel that the benefits of treatment with the requested drug outweigh the potential risks in this elderly patient?		<input type="checkbox"/> YES <input type="checkbox"/> NO
OPIOIDS (please complete the following questions if the requested drug is an opioid)		
What is the daily cumulative Morphine Equivalent Dose (MED)?		mg/day
Are you aware of other opioid prescribers for this enrollee? If so, please explain.		<input type="checkbox"/> YES <input type="checkbox"/> NO
Is the stated daily MED dose noted medically necessary?		<input type="checkbox"/> YES <input type="checkbox"/> NO
Would a lower total daily MED dose be insufficient to control the enrollee's pain?		<input type="checkbox"/> YES <input type="checkbox"/> NO

RATIONALE FOR REQUEST

- Alternate drug(s) contraindicated or previously tried, but with adverse outcome, e.g., toxicity, allergy, or therapeutic failure** [Specify below if not already noted in the DRUG HISTORY section earlier on the form: (1) Drug(s) tried and results of drug trial(s) (2) if adverse outcome, list drug(s) and adverse outcome for each, (3) if therapeutic failure, list maximum dose and length of therapy for drug(s) trialed, (4) if contraindication(s), please list specific reason why preferred drug(s)/other formulary drug(s) are contraindicated]
- Patient is stable on current drug(s); high risk of significant adverse clinical outcome with medication change** [A specific explanation of any anticipated significant adverse clinical outcome and why a significant adverse outcome would be expected is required – e.g. the condition has been difficult to control (many drugs tried, multiple drugs required to control condition), the patient had a significant adverse outcome when the condition was not controlled previously (e.g. hospitalization or frequent acute medical visits, heart attack, stroke, falls, significant limitation of functional status, undue pain and suffering), etc.]
- Medical need for different dosage form and/or higher dosage** [Specify below: (1) Dosage form(s) and/or dosage(s) tried and outcome of drug trial(s); (2) explain medical reason (3) include why less frequent dosing with a higher strength is not an option – if a higher strength exists]
- Request for formulary tier exception** [Specify below if not noted in the DRUG HISTORY section earlier on the form: (1) formulary or preferred drug(s) tried and results of drug trial(s) (2) if adverse outcome, list drug(s) and adverse outcome for each, (3) if therapeutic failure/not as effective as requested drug, list maximum dose and length of therapy for drug(s) trialed, (4) if contraindication(s), please list specific reason why preferred drug(s)/other formulary drug(s) are contraindicated]
- Other:** (explain below)

Required Explanation:



New Jersey Department of Banking and Insurance Health Care Provider Application to Appeal a Claims Determination

A Health Care Provider has the right to appeal a Carrier's claims determination(s).¹ A Health Care Provider also has the right to appeal an apparent lack of activity on a submitted claim.

Health Care Providers:

- Must submit your internal payment appeal to the Carrier. **DO NOT** submit your internal payment to the New Jersey Department of Banking and Insurance.
- May use either this form, or the Carrier's branded *Health Care Provider Application to Appeal a Claims Determination* (which the Carrier may allow to be submitted online). The Carrier will accept either form.

DO NOT submit a Health Care Provider Application to Appeal a Claims Determination IF:

- The Carrier's determination indicates that it considered the health care services for which the claim was submitted not medically necessary, experimental or investigational, cosmetic rather than medically necessary or dental rather than medical. **INSTEAD**, you may submit a request for a **Stage 1 UM Appeal Review**.²
- The Carrier's determination indicates that it considered the person to whom health care services for which the claim was submitted to be ineligible for coverage because the health care services were not covered under the terms of the relevant health benefits plan, or because the person is not the Carrier's member. **INSTEAD**, you may submit a complaint. For more information, contact the Carrier's Provider Relations Department.
- The Carrier has provided you with notice that it is investigating the claim (and related ones, if any) for possible fraud.

You MAY submit a Health Care Provider Application to Appeal a Claims Determination IF the Carrier's determination:

- Resulted in the claim not being paid at all for reasons other than a UM determination or a determination of ineligibility, coordination of benefits or fraud investigation
- Resulted in the claim being paid at a rate you did not expect based upon the payment agreement between you and the Carrier
- Resulted in the claim being paid at a rate you did not expect because of differences in the Carrier's treatment of the codes in the claim from what you believe is appropriate
- Indicated the Carrier required additional substantiating documentation to support the claim and you believe that the required information is inconsistent with the Carrier's stated claims handling policies and procedures, or is not relevant to the claim

You also MAY submit a Health Care Provider Application to Appeal a Claims Determination IF:

- You believe the Carrier failed to adjudicate the claim, or an uncontested portion of the claim, in a timely manner consistent with law, and the terms of the contract between you and the Carrier, if any
- The Carrier's determination indicates it will not pay because of lack of appropriate authorization, but you believe you obtained appropriate authorization from another Carrier for the services
- You believe the Carrier failed to appropriately pay interest on the claim
- You believe the Carrier's statement that it overpaid you on one or more claims is erroneous, or that the amount it calculated as overpaid is erroneous
- You believe the Carrier has attempted to offset an inappropriate amount against a claim because of an effort to recoup for an overpayment on prior claims (essentially, that the Carrier has under-priced the current claim)

If you do not know how to file a claims appeal with the Carrier, and you are a network provider, review your Provider Manual for instructions on how to file a Claims Appeal. If you are a not a network provider, you can find general contact information [Licensed Insurance Carriers](#) or [Managed Care Entities](#) on our website. Contact the Carrier for more specific instructions.

¹ A carrier's contractors (organized delivery systems and other vendors) are subject to the same standards as the carrier when performing claim payment and processing functions (including overpayment requests) on behalf of the carrier. Use of the word Carrier includes the carrier and its relevant contractors.

² For more information: review your Provider Manual, or contact the Carrier's Utilization Management department or Provider Relations Department, or visit the New Jersey Department of Banking and Insurance's website at: [How to File a Utilization Management Appeal](#)

**YOU MUST COMPLETE A SEPARATE APPLICATION FOR EACH CLAIM APPEALED
SIGNATURE MUST BE COMPLETE AND LEGIBLE. THIS FORM MUST BE DATED.**

A. Provider Information	1. Provider Name:		2. TIN/NPI:	
	3. Provider Group (if applicable):			
	4. Contact Name:		5. Title:	
	6. Contact Address:			
	7. Phone:	8. Fax:	9. Email:	
B. Patient Information	1. Patient Name:		2. Ins. ID:	
	3. Did You Attach a copy of (check the appropriate response):			
	a. The assignment of benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA			
C. Claim Information	1. Claim Number (if known):		2. Date of Service:	
	3. Authorization Number:			
	4. Claim filing method (check only one):			
	a. <input type="checkbox"/> electronic (submit a copy of the electronic acceptance report from Our clearinghouse or Us)			
	b. <input type="checkbox"/> facsimile (submit a copy of the fax transmittal)			
c. <input type="checkbox"/> paper claim by mail or courier service (submit a copy of the delivery confirmation evidence)				
5. Check the reason(s) why you are filing this appeal (check all that apply and be specific about billing codes and reason for dispute):				
a. <input type="checkbox"/> Action has not been taken on this claim				
b. <input type="checkbox"/> Dispute of a denied claim → provide date of denial : ____ / ____ / ____				
c. <input type="checkbox"/> Claim was paid but not in a timely manner (provide more information):				
<input type="checkbox"/> Yes <input type="checkbox"/> No Additional information was requested? If yes, date: ____ / ____ / ____				
<input type="checkbox"/> Yes <input type="checkbox"/> No Additional information provided? If yes, date: ____ / ____ / ____				
<input type="checkbox"/> Yes <input type="checkbox"/> No Prompt Payment Interest paid correctly?				
d. <input type="checkbox"/> Claim was paid, but the amount paid is in dispute:				
e. <input type="checkbox"/> Codes in dispute ____ / ____ / ____ / ____ / ____ / ____ / ____ / ____				
f. <input type="checkbox"/> Dispute of an overpayment or the amount of overpayment (Attach a copy of overpayment request)				
g. <input type="checkbox"/> Dispute of carrier's offset amount against this claim (Attach a copy of A/R)				
D. Reason for Appeal (Required)				

Provider Name: _____

Contact Number: _____

Member Name : _____

DOS: _____

You may provide additional information in an attachment to explain why you are disputing Our handling of the claim. You must be specific about billing codes and reason for dispute.

The following should be submitted with your appeal (copies only):

- The relevant claim form
- The relevant Explanation(s) of Benefits or Remittance Advice
- A statement specifying the line items that you are appealing
- Copies of any overpayment requests or A/R notice
- Information We previously requested that you have not yet submitted, if available
- Itemization of your provider contract provisions you believe We are not complying with, including a copy of the pertinent section of your contract
- Pertinent correspondence between you and Us on this matter
- A description of pertinent communications between you and Us on this matter that were not in writing
- Relevant sections of the National Correct Coding Initiative (NCCI) or other coding support you relied upon IF the dispute concerns the disposition of billing codes
- Other documents you may believe support your position in this dispute (this may include medical records)

Attachments: Yes No

Signature: _____ Date: ____ / ____ / ____

Important to Note

In order to ensure your Internal Payment Appeal is eligible to meet processing requirements for the External Binding Arbitration Program

- **The Internal Appeal Form must be sent to the address posted on the carrier's website;**
- **The Internal Appeal Form must have a complete signature (first and last name);**
- **The Internal Appeal Form Must be Dated;**
- **There is a signed and dated Consent to Representation in Appeals of UM Determinations and Authorization for release of Medical records in UM Appeals and Independent Arbitration of Claims Form**