Contents

Welcome

Sarah Sullo
Analyst, Provider Services

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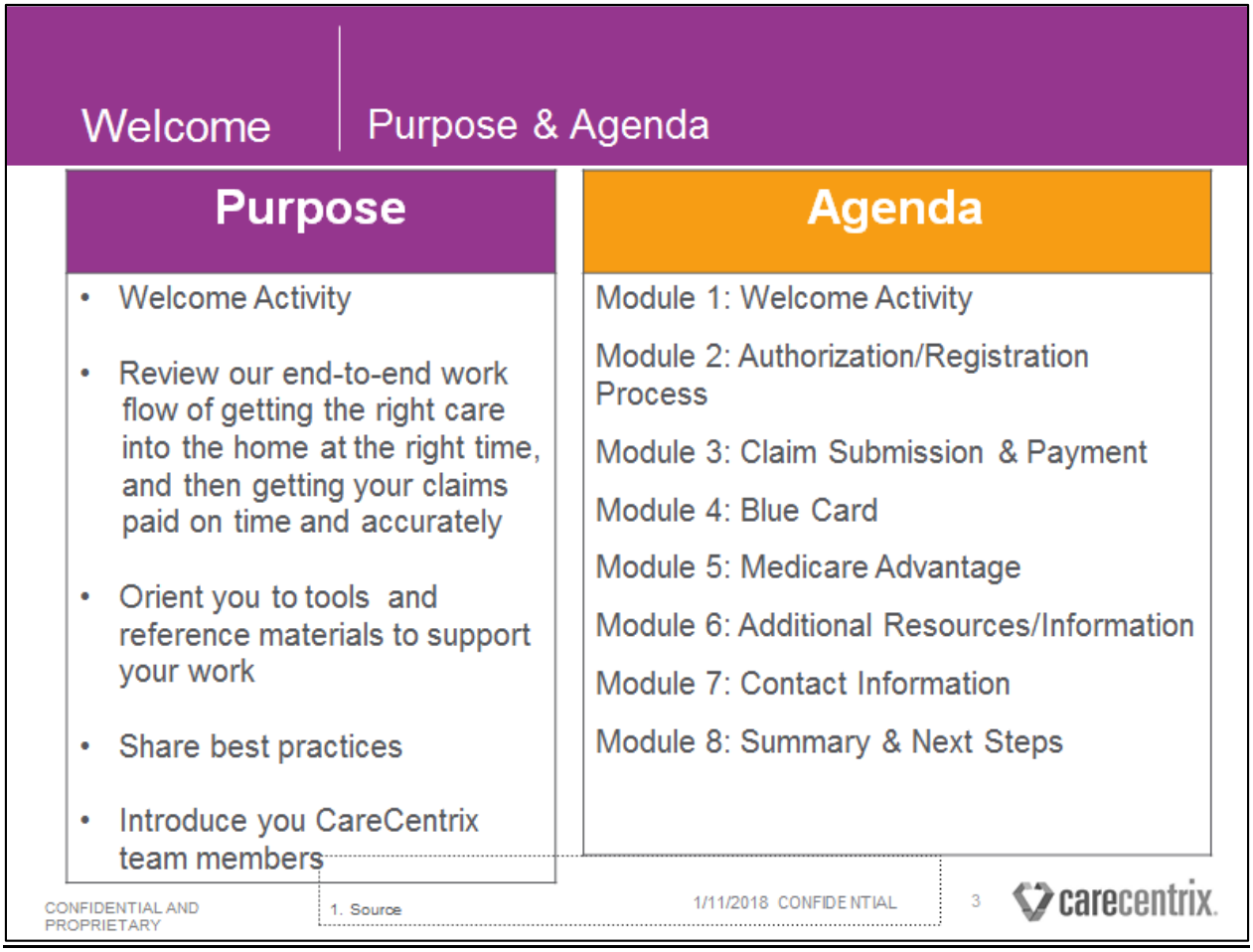
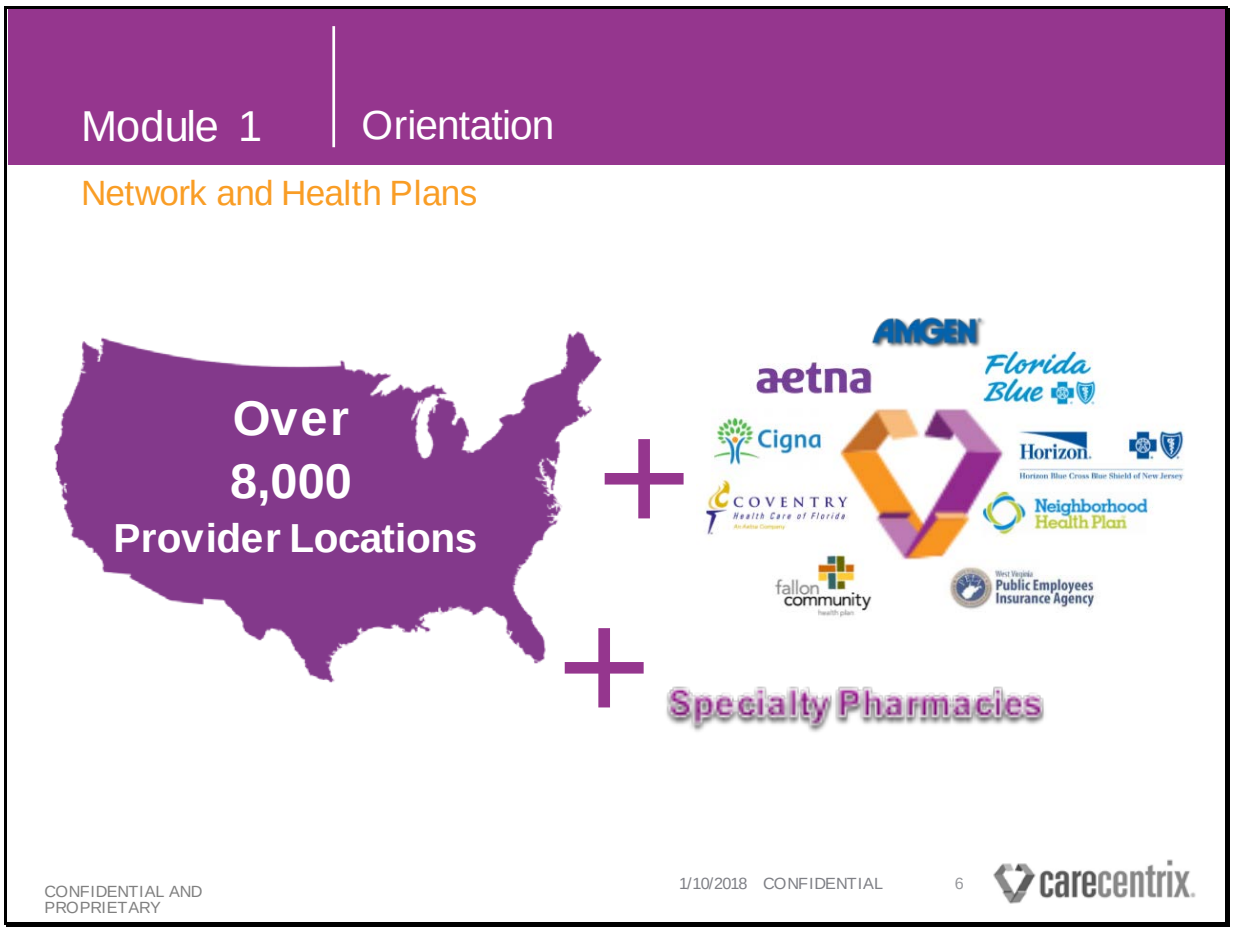


Module 1: Orientation

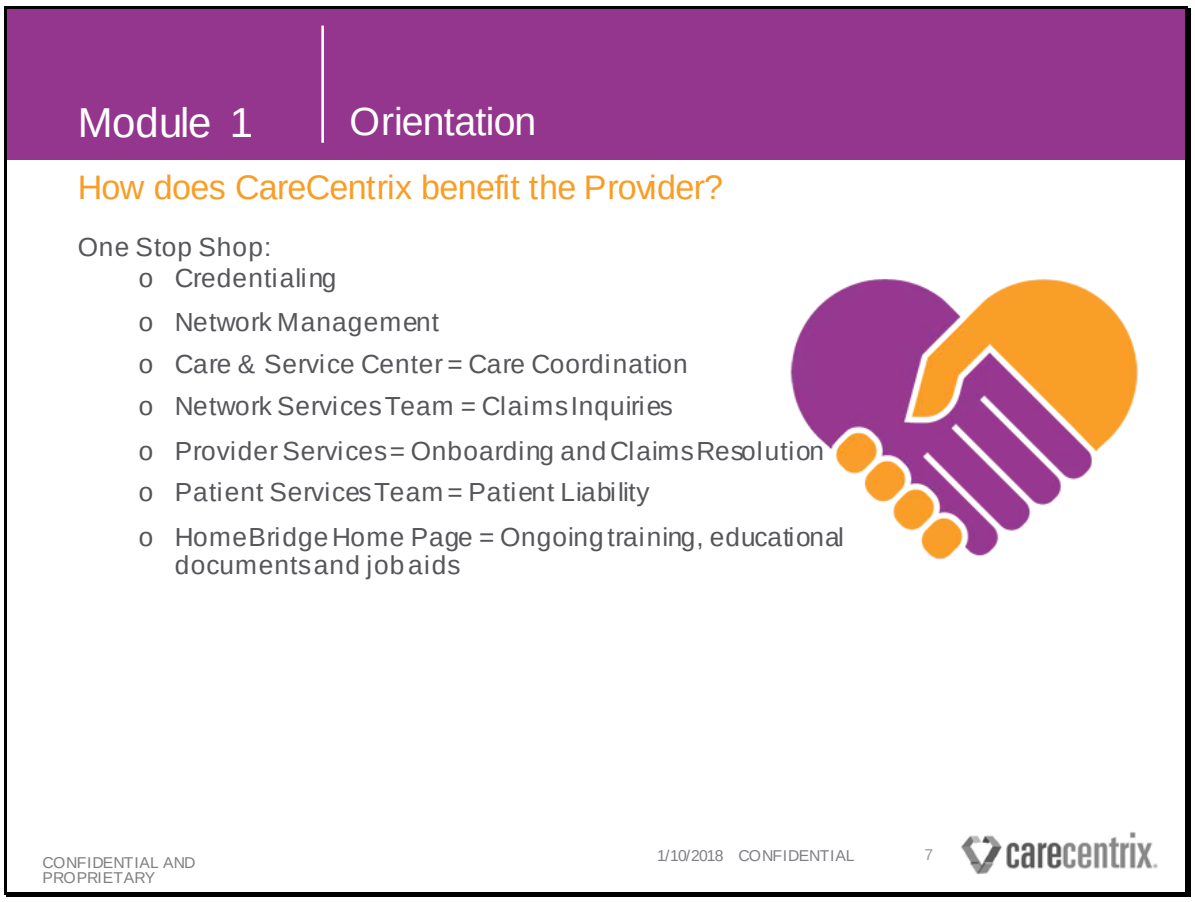
To know who CareCentrix is, you need to understand our Mission, Vision, and our core Values.
Our Vision is to create a world where anyone can age or heal at home.
To achieve such an important vision we developed a mission for ourselves that highlights the need for good partnerships with high performing providers and a growing variety of payors.
How do we deliver on our mission?

- By keeping our core values in sight at all times.
- These values guide all of the actions we take when working inside the four walls of CareCentrix and with our external partners like you.



CareCentrix is the nation's leading home care network.

- CareCentrix is not a Health Plan; we manage a network of providers for our contracted Health Plans.
- Our Health Plan contracts are often state specific.
- Contact your Contract Manager if you have any questions about any contract related/ fee schedule related issues.
- We have over 8000 credentialed provider locations servicing traditional home health, sleep benefits management, durable medical equipment, infusion, and O&P.
- Some of our major partners are Cigna, Florida Blue, Horizon Blue Cross Blue Shield of New Jersey, Aetna, and Amgen.
- CareCentrix is a 24/7 servicing network outreaching to each of the 50 states.

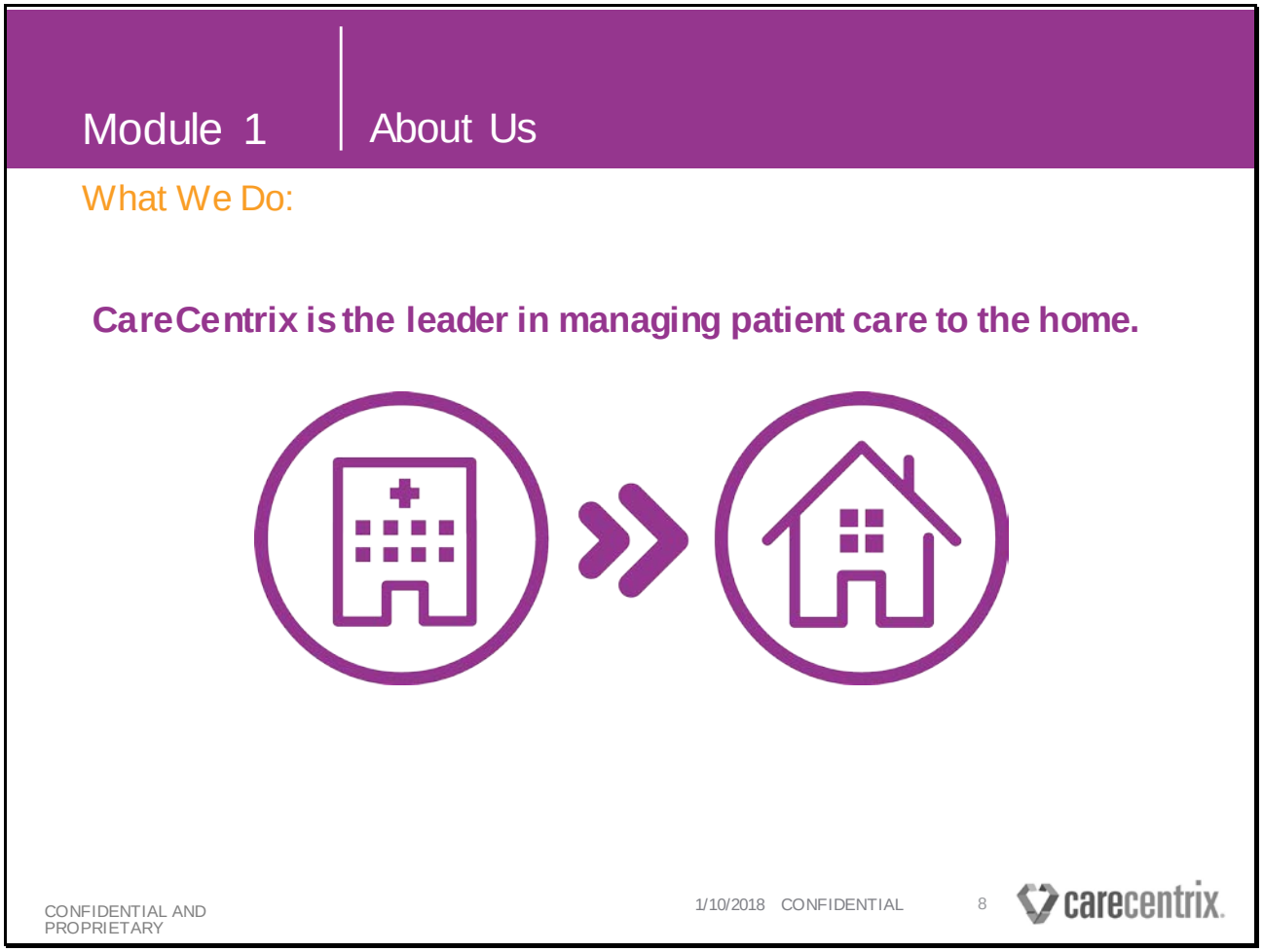


Why should you be excited to be in our Network?

CareCentrix takes care of every need you have beginning with credentialing through claims payment.

- The **Network Management Team** will work with you through the credentialing process and on all contract-related issues.
- The **Care & Service Center** will support you on all aspects of the Care Coordination process to ensure that the right care gets to the patient at the right time.
- The **Network Services Team** will work with you on any claims inquiries.
- The **Provider Services Team** supports you through the first 120 days of working with CareCentrix and supports the Network Services Team in any claims related needs.
- The **Patient Services Team** collects the patient liability. This is one less administrative burden on you!

(See Contact Information for phone numbers)



CareCentrix is the leader in managing patient care to the home.

We have nearly 20 years of experience working with payors and providers to create programs that improve quality and lower costs by managing patient care to the home.

We are passionate about making care at home safe, high quality, accessible, and low cost.

Module 1 | Orientation

How We Do It

- We manage the services, therapies, and resources.
- We reduce over utilization and the dependency on high-cost settings.
- We provide value-based solutions.

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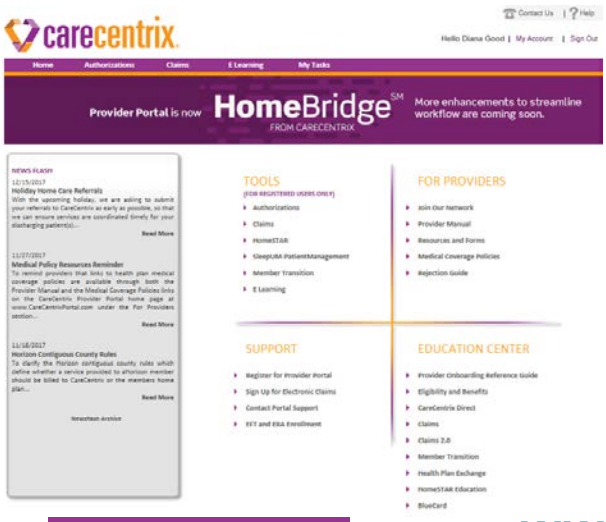
- CareCentrix is making the home the center of patient care by managing the services, therapies, and resources that enable patients to get care at home.
- By making the home a reliable and accountable alternative for care, we reduce over utilization and the dependency on high-cost settings.
- Our value-based solutions lower cost, improve outcomes, and provide customized and comprehensive care for each patient.

Module 1 | Orientation

CareCentrix Support Teams



- Contract Manager
- Credentialing Department
- Care & Service Center
- Specialty Nursing Team
- Transition Team
- Netw ork Services Team
- EDI Support Team
- Provider Services
- Patient Services Team
- Compliance Hotline

Refer to Module **7** for contact information

www.carecentrixportal.com

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There are many teams at CareCentrix here to support you.

- In addition to the live team members, you will be working with HomeBridge to request authorizations and check the status of your claims.
- Module **7** has a chart of what all these teams do to support the network and the best way to reach them.

Module 1 | Patient Membership

25M Members Across All Health Plans

Health Plan	State(s)	Line of Business	Plan Type
Aetna	Georgia and Florida	THH	Commercial, Medicare Advantage
Amgen	National	Diagnostic HST, Sleep	Commercial
Beech Street	Nevada	THH, HME, HIT	Commercial
Cigna/Great West	National	THH, HME, HIT, Sleep	Commercial
Coventry	Florida	THH	Commercial, Medicare Advantage
Fallon	Massachusetts	Diagnostic HST, Sleep	Commercial, Medicare, Medicaid
Florida Blue	Florida	THH, HME, HIT, O&P, Sleep	Commercial, Medicare Advantage, BlueCard, FEP
Horizon	New Jersey	HME, HIT, O&P	Commercial, Medicare Advantage, BlueCard, FEP, SHBP
Neighborhood Health Plan (NHP)	Massachusetts	Diagnostic HST, Sleep	Commercial, Medicaid
Public Employees Insurance Agency (PEIA)	West Virginia	Diagnostic HST, Sleep	Commercial

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The membership of all the Health Plans we support is over **25 million** across all **50 states**. This chart outlines all the Health Plans we serve, the states in which we operate, the type of services we are contracted for and the type of plan.

As a provider, you may have the opportunity to be in-network with these Health Plans through your contract with CareCentrix. If you would like to discuss becoming in-network with any of the Health Plans that CareCentrix supports in your service area, please contact your assigned Contract Manager to discuss.

If you currently hold a contract with a Health Plan in a state for the listed service type, you will now work with CareCentrix to provide the service.

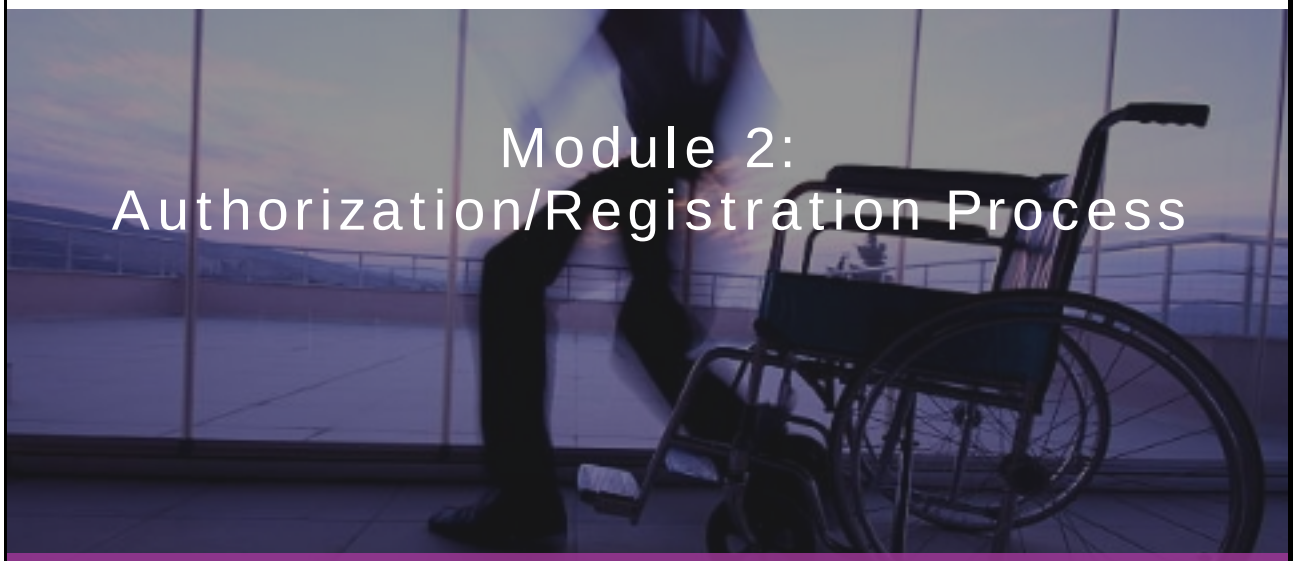
You will not need to make any changes if you are contracted with a Health Plan in a different state or for a service we are not contracted for.

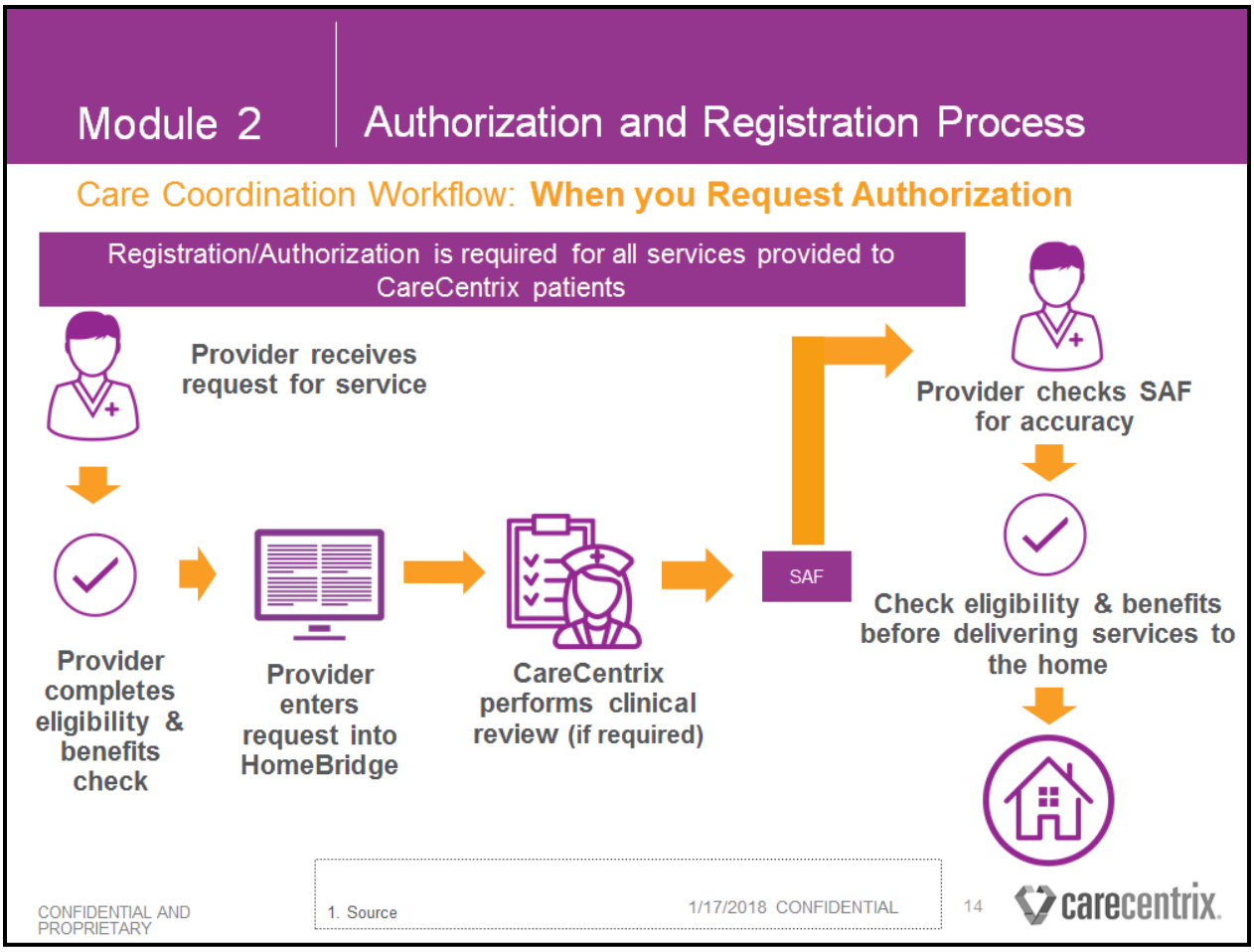
Example:

Provider currently holds a contract with Aetna in Georgia for THH. The provider will no longer work directly with Aetna. You will now work with CareCentrix to provide those services. The provider also services DME in Georgia for Aetna. For the DME service type they would work directly with Aetna since CareCentrix is only contracted for THH.

In the case where you do not hold a contract with a Health Plan; your contract with CareCentrix could possible give you access through the contracts we hold with those particular Health Plans.

Module 2: Authorization/Registration





The CareCentrix workflow for Coordination of Care begins with a request for service from a referral source and ends when the right care gets to the home at the right time.

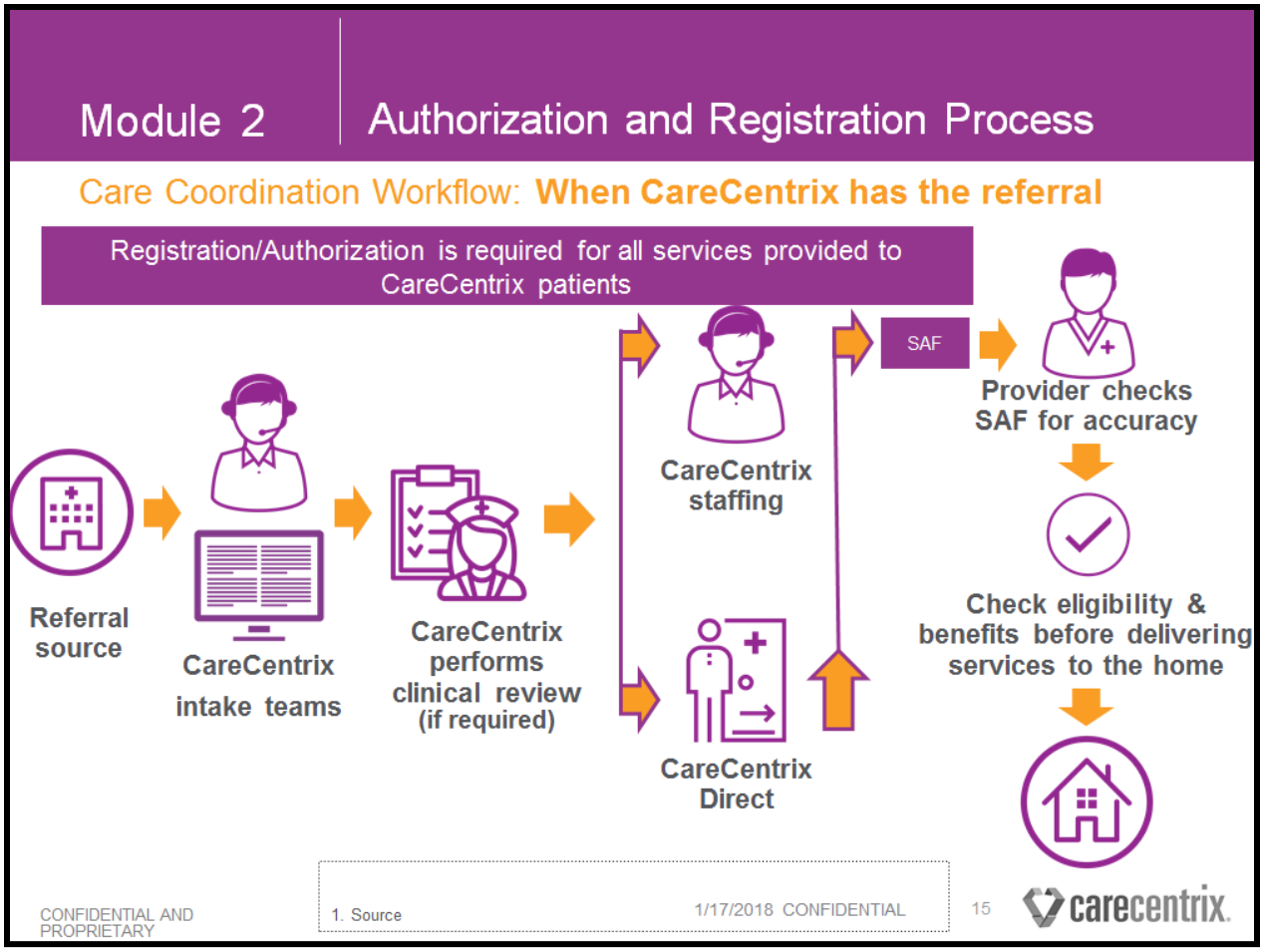
Registration/authorization is required for all services provided to CareCentrix patients. Services may not be reimbursable and are not billable to the patient without a registration/authorization. NOTE: In instances where the patient accepts financial responsibility to receive the services when the Health Plan does not authorize them, prior authorization is not needed to deliver the services.

This is the Care Coordination Workflow when YOU bring us a referral and you need authorization.

- Once you have the case, you must check the eligibility and benefits with the Health Plan to ensure the services are covered.
- Upon confirming coverage, enter a request in HomeBridge .

- CareCentrix will issue you a Service Authorization Form (SAF)
  - If the service requires a **Clinical Review** and we are delegated to perform Utilization Management, our clinical team will review the case and will make a medical necessity determination. For services where we are not delegated for UM, our clinical team will submit the request to the Health Plan for a decision. Once the medical necessity review is complete, or we receive approval from the Health Plan, CareCentrix will provide your Service Authorization Form (SAF).
  - If the service does NOT require additional processing, we will issue the SAF immediately.

Make sure the SAF matches the referral. This will help to ensure the right care gets to the patient at the right time AND that your claim moves through our system without disruption. **The SAF must match the claims exactly.**



CareCentrix receives referrals from patients, Primary Care Physicians, and hospital or Skilled Nursing Facility discharge planners.

CareCentrix receives referrals by phone, fax, and other secured electronic means.

The CareCentrix **Intake Team** gathers all of the relevant information from the referral source on the patient, what care is needed, and when the care should start.

If the service requires a **Clinical Review** and we are delegated to perform Utilization Management, our clinical team will review the case and will make a medical necessity determination. For services where we are not delegated for UM, our clinical team will submit the request to the Health Plan for a decision.

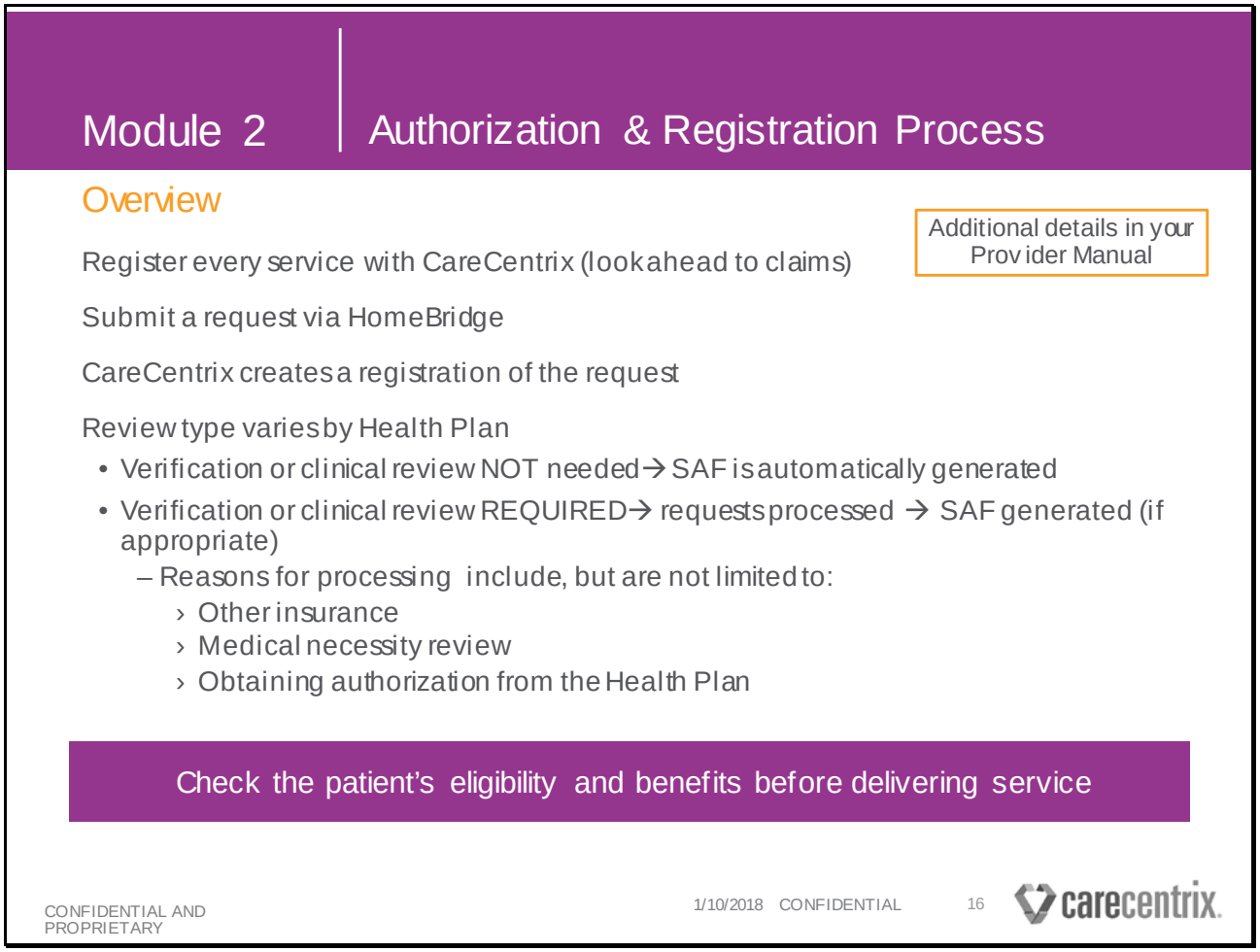
If the patient has the necessary coverage for the service and it is approved, we begin **Staffing**.

We staff a case in 2 ways:

- CareCentrix Direct is an automated staffing tool that allows providers to receive an email notification and accept our cases via HomeBridge.
- We also staff cases by calling providers directly.

Once the Provider accepts the case, a Service Authorization Form (SAF) is sent to the Provider.

The **Provider should always check Eligibility & Benefits** at the time of the request to ensure the patient is covered for all requested services. You are responsible for checking eligibility and benefits prior to delivering services.



The following is an overview of the Registration/Authorization process.

- You are required to register every service with CareCentrix by submitting a request via HomeBridge, unless otherwise directed. Look ahead to claims: this will help you get paid on time and accurately.
- HomeBridge identifies the information necessary to complete a request.
- CareCentrix will then create a registration of the requested service in our system.
- The type of review applied to a request depends on the patient's Health Plan.
    - If the Health Plan **does not require** a verification of administrative information or clinical review the Services Authorization Form (SAF) is automatically generated and faxed to the provider or posted to HomeBridge. In this instance the service has a valid

registration by CareCentrix, but does not require an authorization from the Health Plan.

- Only when the requests **require** verification of administrative information or clinical review will the requests be routed to a CareCentrix associate for processing. Reasons for routing include, but are not limited to:
  - 1. Other insurance
  - 2. Medical necessity review
  - 3. **Obtaining authorization from the Health Plan;** The SAF will be generated and faxed to the provider or posted to HomeBridge and will have been authorized by the Health Plan

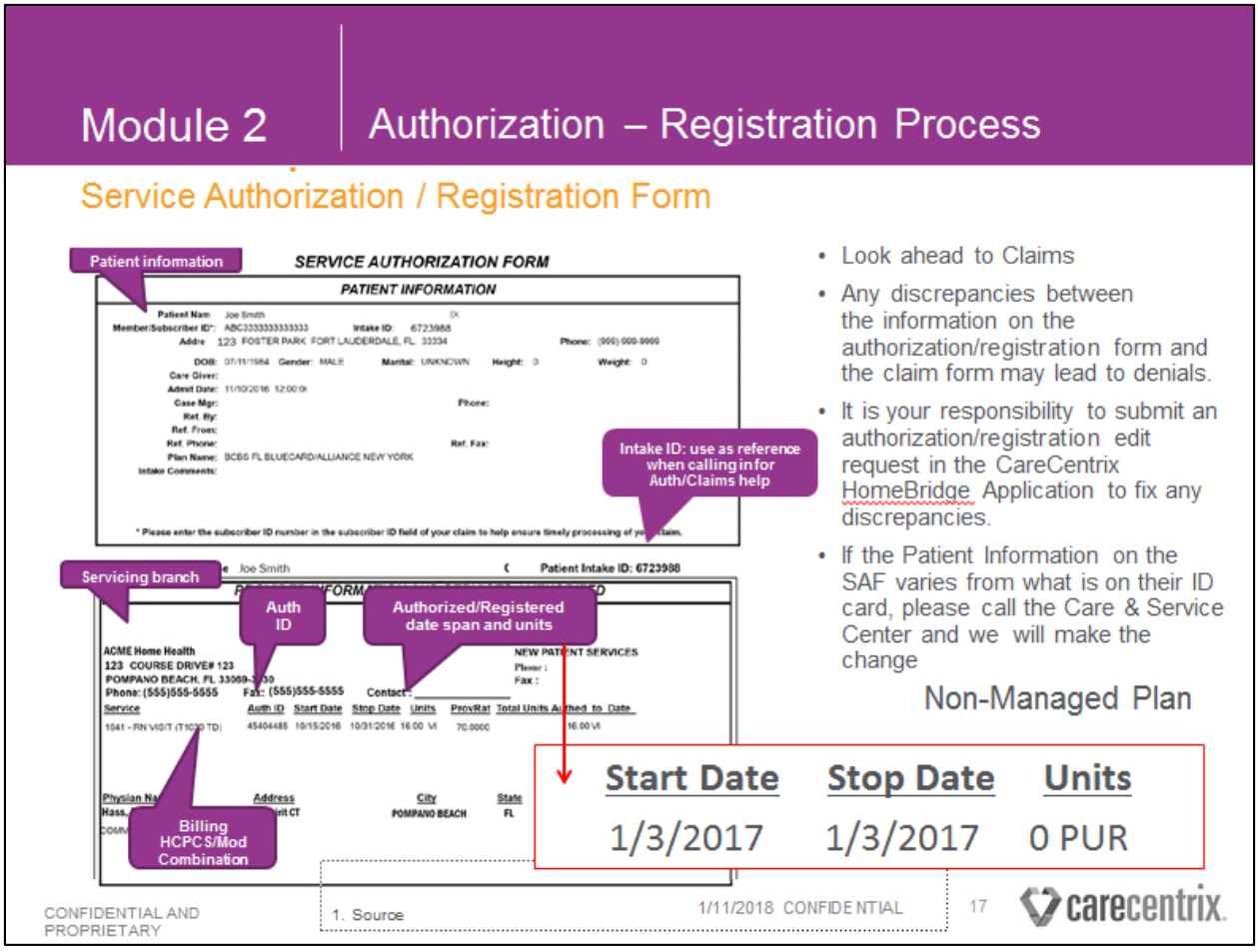
Because the SAF is generated with similar information and will not indicate if the referred service was reviewed for medical necessity, **we recommend that for all services the provider check the patient's eligibility and benefits before delivering service.**

Retro-Authorization:
It is CareCentrix's policy that we do not allow retro-registrations/authorizations unless required by state law. We must have a registration/authorization for every service; in certain medically necessary cases you can make an **Urgent** request when submitting in HomeBridge. We will discuss this in detail later in the training.

Definitions:

- *Registration*: When a provider notifies CareCentrix of a request for a service, CareCentrix registers the service in the CareCentrix system to facilitate service validation with the patient and claims processing, but CareCentrix does not perform a utilization review of the service.

- *Authorization*: When a provider notifies CareCentrix of a request for a service, CareCentrix performs a utilization review of the service, and CareCentrix determines that the service is medically necessary as defined under the patient's Health Plan.



The Service Authorization Form and is the key to getting the right care to the patient at the right time and getting your claim paid timely and accurately.

This is an example of a Service Authorization Form.

- All relevant patient information is noted at the top of the form. Make sure the patient information is correct. For example, perhaps this patient should be Joe Smith Jr. In this case, an authorization edit would need to be submitted to correct the name on the SAF.

- An intake ID has a one to one correlation with the authorization and the patient's account in our system. So if you are ever calling in regards to claim questions, the intake ID does tie the authorization to the specific patient and will make it easier internally to work to solve any issues that stem from it. The intake ID does not need to be on the claim and is strictly for your reference.

- Another important aspect of the form is the servicing branch. It will be in the upper left hand corner. If your agency has multiple locations please make sure the servicing branch matches the address on the auth form and claim.

- Note the Authorization ID. Forgetting to list the Auth ID is one of the top reasons we reject claims.

- Next, you will see the HCPCS modifier. Forms will always have a HCPCS listed. When billing claims please make sure the HCPCS and Modifier is the same as what appears on the authorization form. If you need to downgrade a service (PT to PTA), please use the Billing Crosswalk in HomeBridge to locate the correct HCPCS and modifier combination for the downgraded service.

- You will see a start date and end date as well as units allowed. The date of service must fall between this date span and cannot exceed the units listed. If more units are needed a reauthorization/registration request must be submitted. Always bill to the authorized units.

Any discrepancies between the information on the authorization/registration form and the claim form may lead to denials. It is your responsibility to submit an authorization/registration edit request in CareCentrix's HomeBridge to fix any discrepancies.

The SAF will always indicate the start of care date, end date, and the units.

With some Health Plans there are situations where you could receive a SAF with a start of care and end date that are the same, and the units will indicate a "0."

This is not an indication of a denial. It is an indication that you are servicing a NON MANAGED PLAN. (Only for Cigna)

This type of registration is generated for billing purposes only. The date listed will be your start of care and the registration is good for a longer period of time.

You do not need to contact CareCentrix to request additional authorizations for re-authorization or add on services. The authorization number assigned during the initial referral process will be used and you can leverage it to bill for the services as long as you adhere to the patient's Health Plan guidelines.
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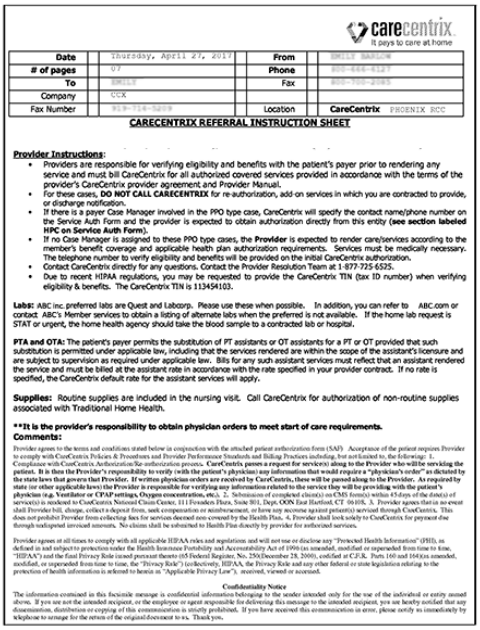
Module 2 | Service Authorization / Registration Form

Sample FAX Cover Sheet



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It pays to care at home

Date	Thursday, April 27, 2017	From	EMILY BARLOW
# of pages	07	Phone	800-444-4127
To	EMILY	Fax	800-700-2085
Company	CCX		
Fax Number	813-558-5808	Location	CareCentrix PHOENIX RCC

CARECENTRIX REFERRAL INSTRUCTION SHEET

Provider Instructions:

- Providers are responsible for verifying eligibility and benefits with the patient's payer prior to rendering any service and must bill CareCentrix for all authorized covered services provided in accordance with the terms of the provider's CareCentrix provider agreement and Provider Manual.
- For these cases, **DO NOT CALL CARECENTRIX** for re-authorization, add-on services in which you are contracted to provide, or discharge notification.
- If there is a payer Case Manager involved in the PPO type case, CareCentrix will specify the contact name/phone number on the Service Auth Form and the provider is expected to obtain authorization directly from this entity (**see section labeled HPC on Service Auth Form**).
- If no Case Manager is assigned to these PPO type cases, the **Provider** is expected to render care/services according to the member's benefit coverage and applicable health plan authorization requirements. Services must be medically necessary. The telephone number to verify eligibility and benefits will be provided on the initial CareCentrix authorization.
- Contact CareCentrix directly for any questions. Contact the Provider Resolution Team at 1-877-725-6525.
- Due to recent HIPAA regulations, you may be requested to provide the CareCentrix TIN (tax ID number) when verifying eligibility & benefits. The CareCentrix TIN is 113454103.

Labs: ABC Inc. preferred labs are Quest and Labcorp. Please use these when possible. In addition, you can refer to ABC.com or contact ABC's Member services to obtain a listing of alternate labs when the preferred is not available. If the home lab request is STAT or urgent, the home health agency should take the blood sample to a contracted lab or hospital.

PTA and OTA: The patient's payer permits the substitution of PT assistants or OT assistants for a PT or OT provided that such substitution is permitted under applicable law, including that the services rendered are within the scope of the assistant's licensure and are subject to supervision as required under applicable law. Bills for any such assistant services must reflect that an assistant rendered the service and must be billed at the assistant rate in accordance with the rate specified in your provider contract. If no rate is specified, the CareCentrix default rate for the assistant services will apply.

Supplies: Routine supplies are included in the nursing visit. Call CareCentrix for authorization of non-routine supplies associated with Traditional Home Health.

****It is the provider's responsibility to obtain physician orders to meet start of care requirements.**

Comments:

Provider agrees to the terms and conditions stated below in conjunction with the attached patient authorization form (SAF). Acceptance of the patient requires Provider to comply with CareCentrix Policies & Procedures and Provider Performance Standards and Billing Practices including, but not limited to, the following: 1. Compliance with CareCentrix Authorization/Re-authorization process. **CareCentrix passes a request for service(s) along to the Provider who will be servicing the patient. It is then the Provider's responsibility to verify (with the patient's physician) any information that would require a "physician's order" as dictated by the state laws that govern that Provider. If written physician orders are received by CareCentrix, these will be passed along to the Provider. As required by state (or other applicable laws) the Provider is responsible for verifying any information related to the service they will be providing with the patient's physician (e.g. Ventilator or CPAP settings, Oxygen concentration, etc.).** 2. Submission of completed claim(s) on CMS form(s) within 45 days of the date(s) of service(s) is rendered to CareCentrix National Claim Center, 111 Founders Plaza, Suite 801, Dept. OON East Hartford, CT 06108. 3. Provider agrees that in no event shall Provider bill, charge, collect a deposit from, seek compensation or reimbursement, or have any recourse against patient(s) serviced through CareCentrix. This does not prohibit Provider from collecting fees for services deemed non-covered by the Health Plan. 4. Provider shall look solely to CareCentrix for payment due through undisputed invoiced amounts. No claims shall be submitted to Health Plan directly by provider for authorized services.

Provider agrees at all times to comply with all applicable HIPAA rules and regulations and will not use or disclose any "Protected Health Information" (PHI), as defined in and subject to protection under the Health Insurance Portability and Accountability Act of 1996 (as amended, modified or superseded from time to time, "HIPAA") and the final Privacy Rule issued pursuant thereto (65 Federal Register, No. 250 (December 28, 2000), codified at C.F.R. Parts 160 and 164 (as amended, modified, or superseded from time to time, the "Privacy Rule") (collectively, HIPAA, the Privacy Rule and any other federal or state legislation relating to the protection of health information is referred to herein as "Applicable Privacy Law"), received, viewed or accessed.

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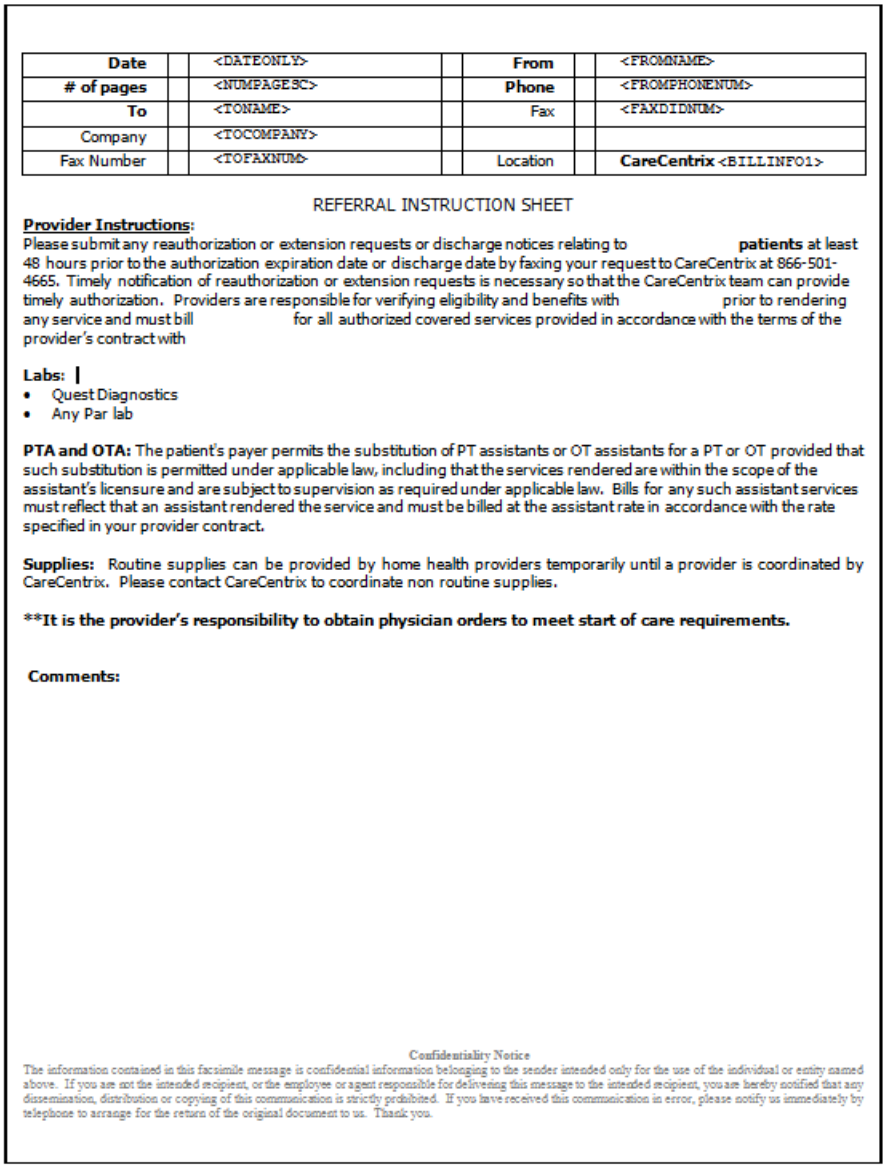
- FAX cover sheets contain critical information about the services, including, but not limited to:
- Information on Labs and Suppliers
- When Substitution is Allowed
- How to Order Non-Routine Supplies



Date	<DATEONLY>		**From**		<FROMNAME>
# of pages	<NUMPAGESC>		**Phone**		<FROMPHONENUM>
To	<TONAME>		Fax		<FAXDIDNUM>
Company	<TOCOMPANY>				
Fax Number	<TOFAXNUM>		Location		**CareCentrix** <BILLINFO1>

REFERRAL INSTRUCTION SHEET

Provider Instructions:
Please submit any reauthorization or extension requests or discharge notices relating to **patients** at least 48 hours prior to the authorization expiration date or discharge date by faxing your request to CareCentrix at 866-501-4665. Timely notification of reauthorization or extension requests is necessary so that the CareCentrix team can provide timely authorization. Providers are responsible for verifying eligibility and benefits with prior to rendering any service and must bill for all authorized covered services provided in accordance with the terms of the provider's contract with

Labs:
- Quest Diagnostics
- Any Par lab

PTA and OTA: The patient's payer permits the substitution of PT assistants or OT assistants for a PT or OT provided that such substitution is permitted under applicable law, including that the services rendered are within the scope of the assistant's licensure and are subject to supervision as required under applicable law. Bills for any such assistant services must reflect that an assistant rendered the service and must be billed at the assistant rate in accordance with the rate specified in your provider contract.

Supplies: Routine supplies can be provided by home health providers temporarily until a provider is coordinated by CareCentrix. Please contact CareCentrix to coordinate non routine supplies.

****It is the provider's responsibility to obtain physician orders to meet start of care requirements.**

Comments:

Confidentiality Notice
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This is an example of FAX cover sheet.
Cover sheets and the information listed will vary depending on the Health Plan. It is vital to review all of the important information it contains.

Important information about the services, included but not limited to:
Information on Labs and Suppliers
When Substitution is Allowed
How to Order Non-Routine Supplies

Module 2

Authorization & Registration Process

Tips

	THH	DME/O&P	HIT
Initial Registration Required?	Yes		
Re-Registration Required?	Plan Dependent		
Start of Care (SOC) Changes	Changes must be approved by referring physician and patient		

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There are a few tips we'd like to share for requests that will help you get your registration/authorization and support timely and accurate payment of your claim:

- An Initial Registration is required for all service types.
- Re-registration of services will vary by plans.
- Start of Care (SOC) changes MUST be approved by referral source and the patient for all three service types.

You can make updates to any registration request in HomeBridge.

Module 2 | Authorization & Registration Process

Service Request Types (Use of "Urgent")

- Only mark "Urgent" if it meets the criteria
- You will need to attest that your request meets this criteria
- CareCentrix audits for compliance
- Contractual obligation to meet the Start of Care. Only accept when you are confident that you can meet the patient's needs.
- Non adherence puts patients at risk and may result in corrective action

Criteria for an Urgent Request

1. A request where the application of time periods for making non-urgent care determinations could:
    a. Seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function
    b. Subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request
2. A request that meets the urgent care definition mandated under applicable law or accrediting body requirements.

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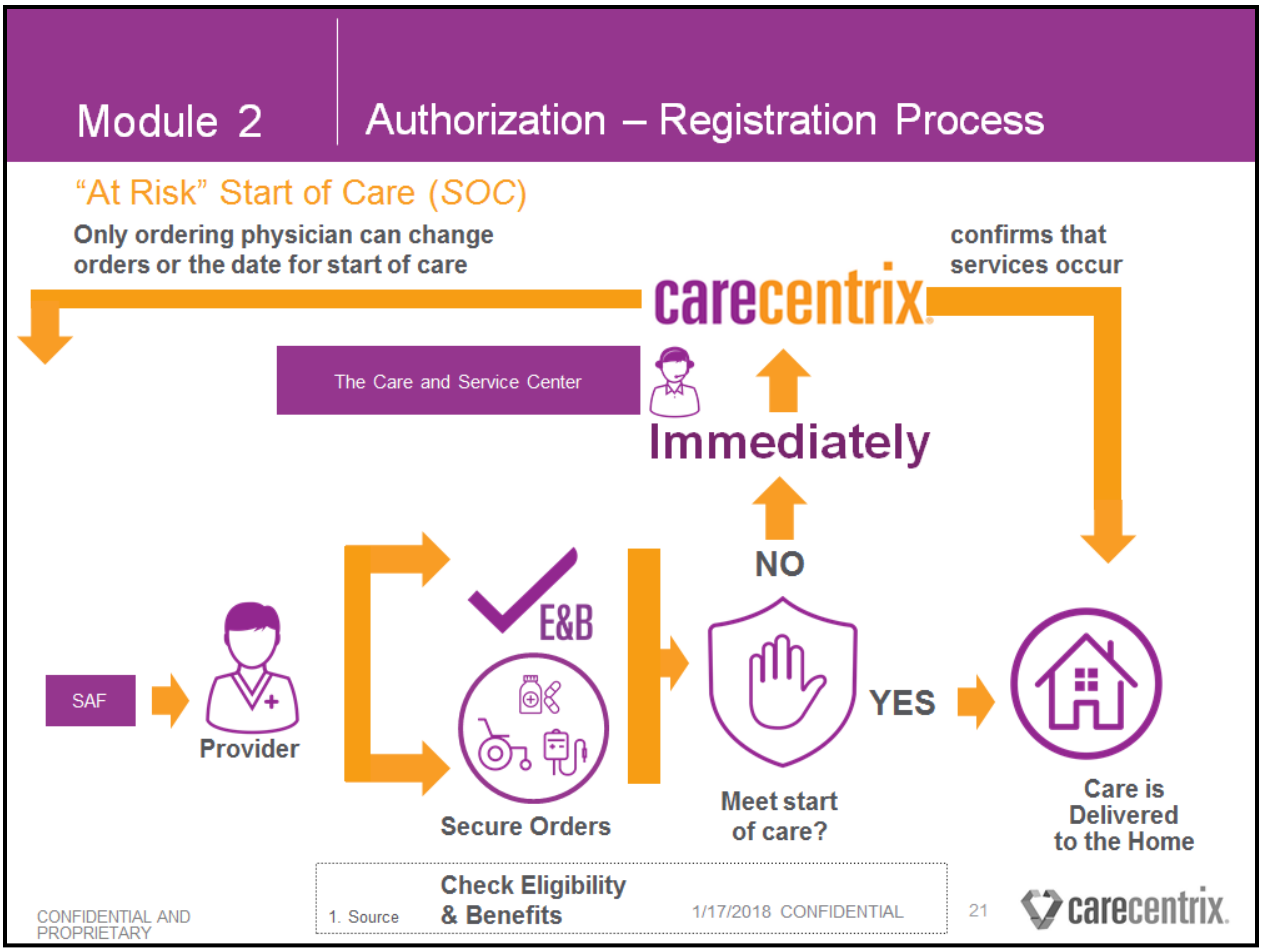
When you resister a request for services in HomeBridge, you will have the choice of two types: Routine and Urgent. **It is critical that you only select urgent if it meets that criteria.** Unless otherwise required by applicable by law or accrediting body requirements, urgent or expedited care requests must meet the criteria noted above.

- Service requests should be categorized as urgent ***based on the circumstance of the patient.***
- Orders are prioritized by SOC date to ensure all patient needs are met. It is extremely important to categorize the requests appropriately so truly urgent cases can be processed in a time fashion.
- CareCentrix reserves the right to audit urgent requests for compliance with the above criteria.

- Non adherence may result in corrective action.
- You have a contractual obligation to meet the Start of Care. Carefully consider your ability to accept every case. Only accept when you are confident that you can meet the patient's needs.
- After you have registered the service in HomeBridge and feel there is a need for an expedited turnaround time, but your service does not meet the **urgent request** criteria, you should contact the Care and Service Center for assistance.



We partner with you to help patients receive reliable and timely care and want to do everything we can to avoid any situation where they do not receive the care they need.

Here are a few key points that you will want to keep in mind when accepting a request for service:

- The Start of Care (SOC) is set by the ordering physician or discharge planner.
- Changes must be appropriate and approved by the referring physician and patient.

- You are expected to secure any needed orders to prevent delays in start of care.

- Carefully consider your ability to accept every case. Only accept when you are confident that you can meet the patient's needs.

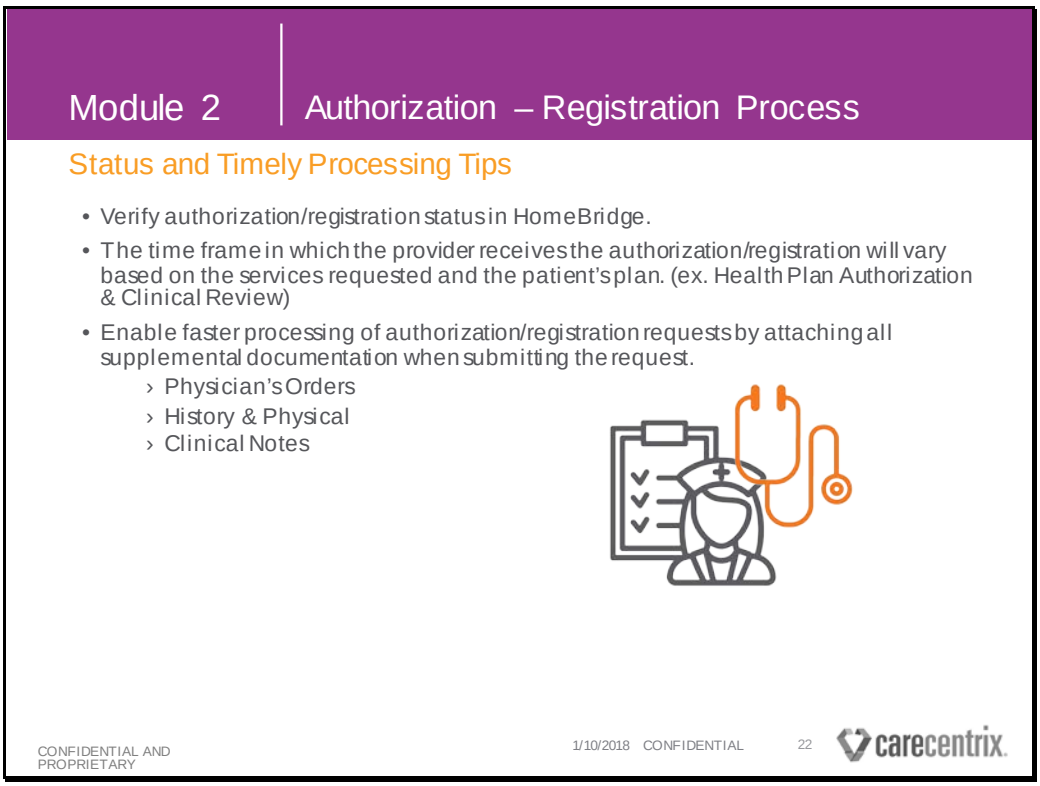
<u>If you are unable to service patient</u> and an Alternate Start of Care <u>IS</u> APPROPRIATE and APPROVED by the referring physician and patient and **NOT** same day of service:

- ❑ Submit an authorization/registration **edit** to notify CareCentrix of changes to the start of care

If you are unable to service patient and an Alternate Start of Care is **NOT** APPROPRIATE and/or **NOT** APPROVED by the referring physician and patient:

- ❑ Notify the **Care and Service Center** and the ordering physician **by phone** as soon as you determine that you are unable to meet start of care. (Refer to the Module 7 for the phone numbers for the Care and Service Center for all Health Plans)

- To confirm that the service actually occurs by the SOC date, CareCentrix Quality representatives make phone calls to a sample of approximately 50% of patients.
- Provider performance is measured on various metrics, one of which is that there are no missed starts of care.
- The CareCentrix Service Validation team completes outbound phone calls to patients to verify the start of care date is met.
- CareCentrix closely tracks turn-backs and missed starts of care to ensure quality patient care and measure provider performance.
- If we are notified of a Missed Start of Care (MSOC), we will outreach to provider to address contractual obligation to meet the Start of Care (SOC).

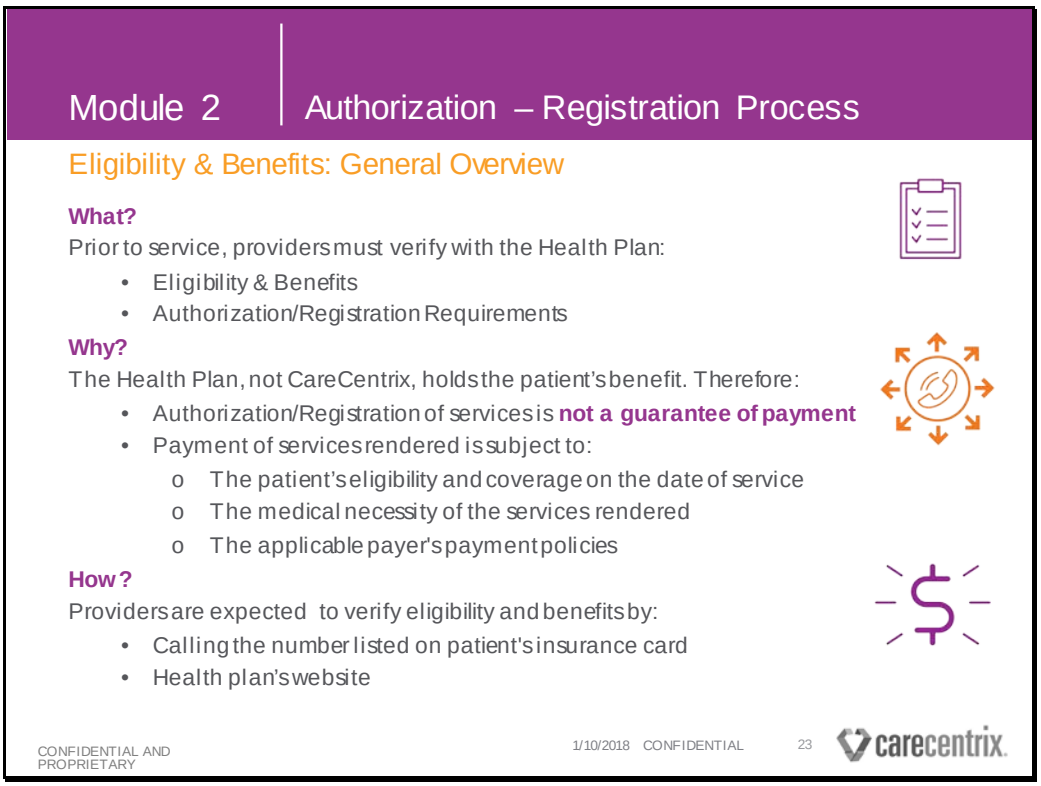


You can help us process your request timely.

- The status of all service requests can be viewed in HomeBridge. **Please review the status in HomeBridge before calling CareCentrix.**

- Some services require prior authorization from the Health Plan and/or clinical review. CareCentrix is delegated to perform clinical review functions by Health Plans for some services. If not delegated, CareCentrix sends the service request to the Health Plan for a decision. This could result in additional time for you to receive your service authorization form

- You are responsible for providing the necessary documentation to help make a clinical decision. When submitting a request, please make sure you attach all required clinical documentation. This information is critical for reviewing the request to make a pre-service or concurrent medical necessity decision. Submitting the correct documentation at the time of the request will help to avoid any delays in receiving the authorization/registration.



Verification of the patient's eligibility and benefits is a key part of your role and can impact your ability to receive payment.

- You must verify eligibility, benefits, and the Health Plan's authorization* requirements prior to providing any service, equipment, or supply item.

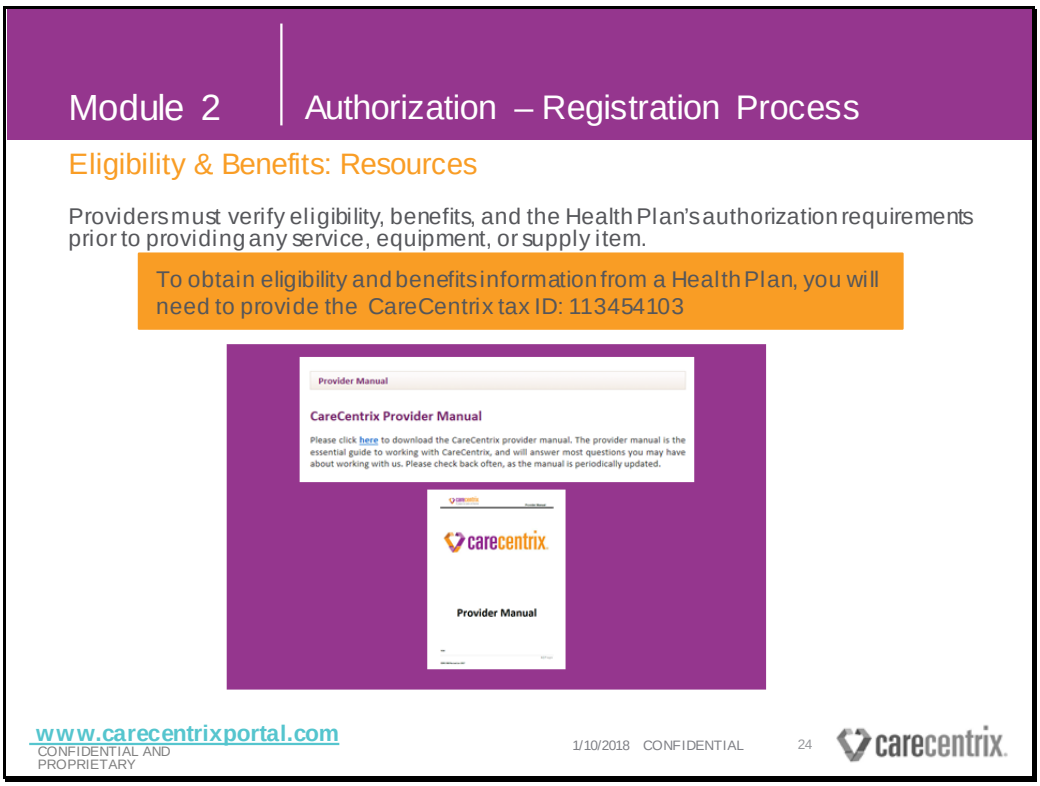
This is critical because **the Health Plan, not CareCentrix, holds the patient's benefit**. For this reason, you must verify this information directly with the Health Plan. The Health Plan is the entity that would ultimately deny payment for lack of eligibility or benefits.

- Authorization/Registration of services is **not a guarantee of payment.**

- Payment of services rendered is subject to the patient's eligibility and coverage on the date of service, the medical necessity of the services rendered, the applicable payer's payment policies, including but not limited to, applicable the payer's claim coding and bundling rules, and compliance with the Provider's contract with CareCentrix.

- Management entities include Care Allies, BlueCard, and TPAs

To verify eligibility and benefits, call the Health Plan's phone number listed on the patient's **insurance card** or **as noted on the plan website.**

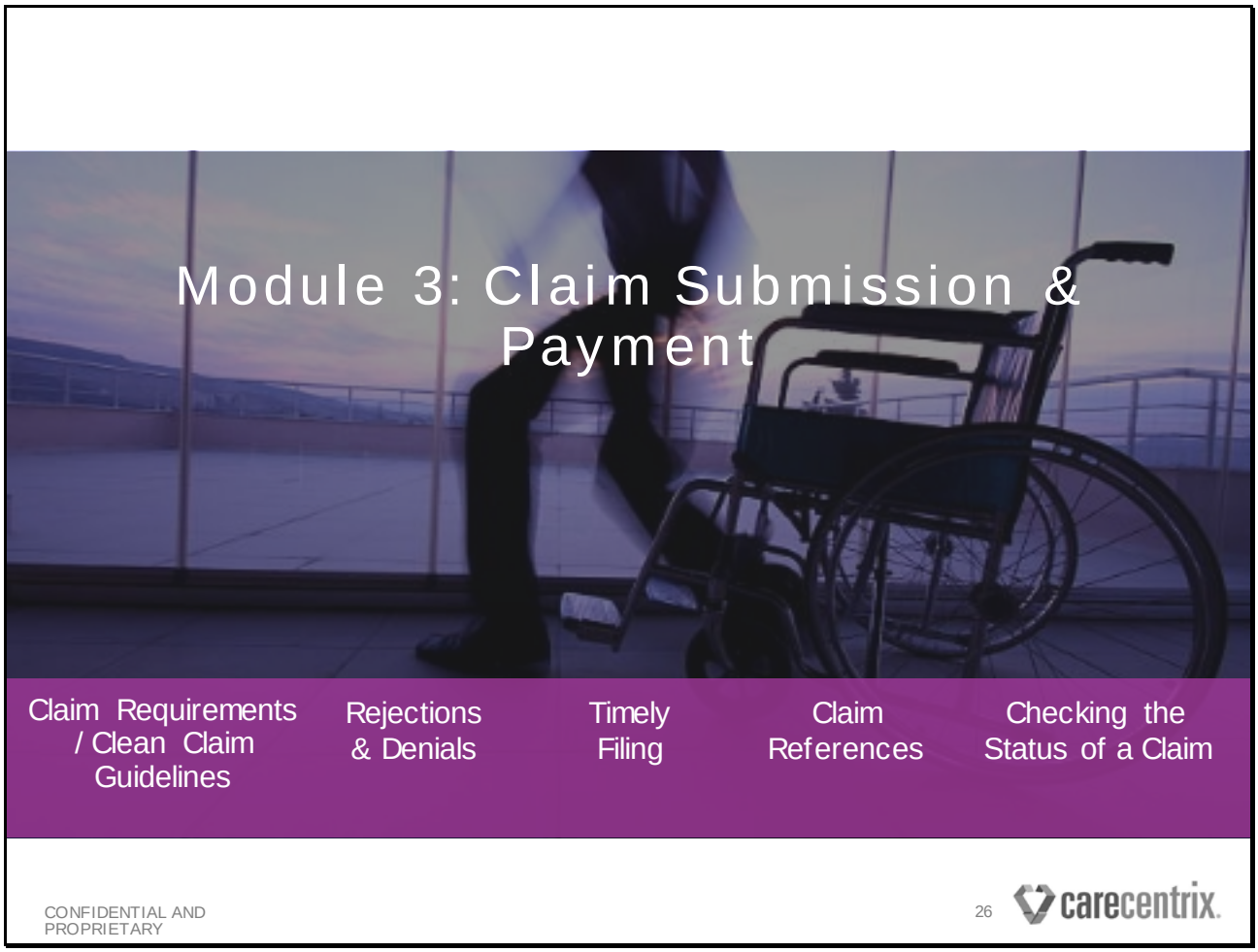


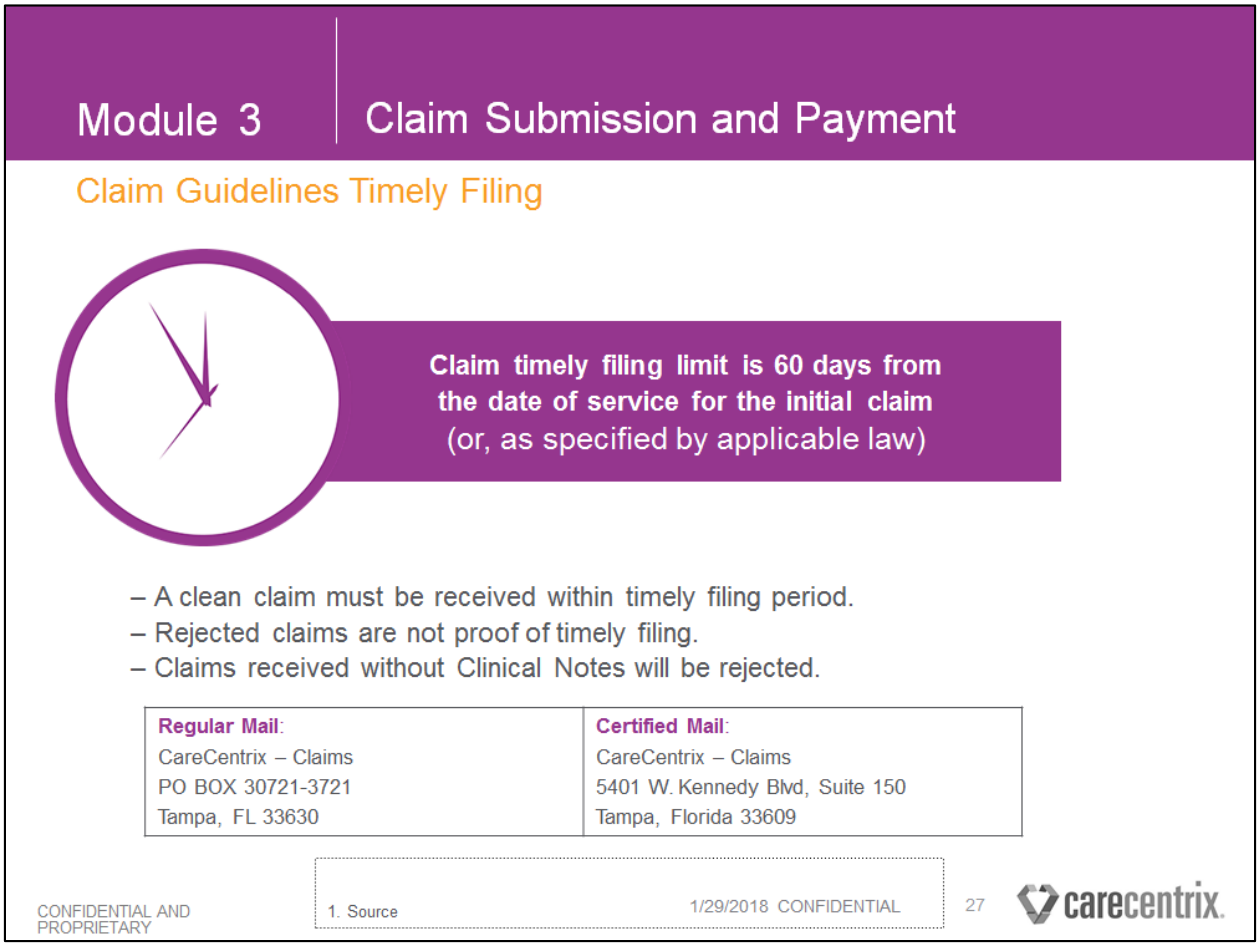
When calling the Health Plan, you may be asked to provide the CareCentrix tax ID.

- For Horizon and Florida Blue patients, providers can provide their own tax ID and do not need to provide the CareCentrix ID.
- For Cigna patients, providers need to provide the CareCentrix tax ID.

- When required, use CareCentrix's Tax ID because you are in-network with the Health Plan insofar as you are in-network with CareCentrix.
- If you provide your own tax ID, you will most likely be informed that you are out of network and be quoted with the patient's out of network benefits.

Module 3: Claim Submission and Payment





When you are ready to submit your claim to CareCentrix, you must adhere to the proper Timely Filing guidelines.

Claim timely filing limit is 60 days from the date of service for the initial claim (or, as specified by applicable law or plan mandate).

- A clean claim must be received within timely filing period. We will review the clean claims requirements later in this training.
- Rejected claims are not proof of timely filing. If you submit a claim and it is rejected, you must re-submit it within 60 days of time of service.

- Print and send all Service Authorization Forms and Clinical Notes **with** your claim to the following address:

CareCentrix – Claims
PO BOX 30721-3721
Tampa, FL 33630

- Claims received without Clinical Notes will be rejected.

Claims must match SAF exactly

Module 3 | Claim Submission and Payment

Clean Claims Requirements include but are not limited to:

1. Patient name, Subscriber ID number (including any prefix and/or suffix as appropriate), address, relationship to subscriber, gender, and date of birth
2. Insurance name, group name and group number
3. Subscriber name, address, and gender
4. Place of service code
5. Primary diagnosis code(s) V codes will not be accepted as the primary diagnosis code and Provider is expected to follow all ICD coding rules
6. Rendering Provider name, service location, and billing address
7. Rendering Provider National Provider Identifier (NPI) number, Federal Tax ID number, Medicaid ID number (Medicaid network Providers only), and Taxonomy Code
8. Referring Provider/physician name and NPI number (837P)
9. Attending Provider/physician name and NPI number (837I)
10. Individual line level charge for each service
11. Number of invoiced units for each claim line
12. CareCentrix HCPCS/ CPT code(s) and modifier combination
13. NDC codes, NDC description, NDC unit of measure, and NDC units (i.e. prescription drugs)
14. Date of service (FROM and TO required; FROM date must be before the claim receipt date and before or equal to the TO date)
15. Whether the patient's condition is related to employment, auto accident or other accident
16. Other insurance information (if other insurance, include other insured's name, date of birth, other insurer's name, group or policy number)
17. Coordination of benefits information for secondary claims (explanation of payment from primary carrier)
18. Service authorization number
19. Revenue Code (institutional claims)
20. HIPPS code on all home health claims submitted for Medicare Advantage members
21. Treatment Authorization Code (TAC) on all home health claims submitted for Medicare Advantage members
22. Description of miscellaneous code

1. Source

See the Provider Manual for full list

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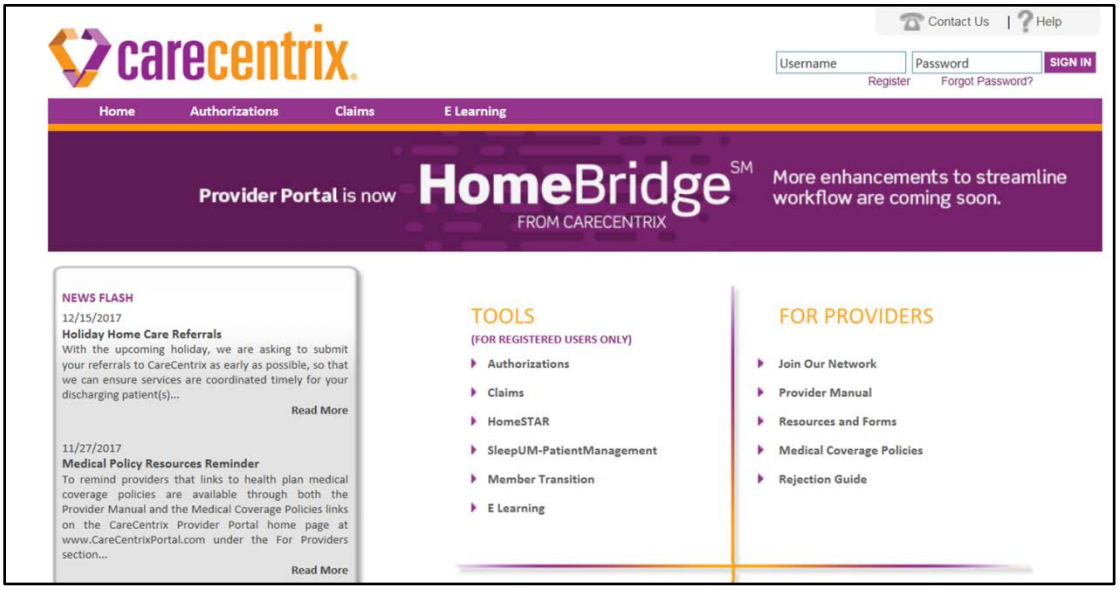

Module 3 | Claim Submission & Payment

Claim Guidelines

Ensure you are billing on the correct claim form. Use the chart below for reference.

Line of Business	All Other Health Plans	Horizon
HIT	CMS-1500	Claims for factor drugs: UB-04 All other claims: CMS-1500
THH	UB-04 or CMS-1500	
PDN		
DME	CMS-1500	
O&P		

Covered services provided in accordance with your provider contract are reimbursed at 100% of the contracted rate

- Services performed on the same day with the same HCPCS modifier combination must be billed on the same claim line.
  - Example:
    - INFUSION- Two nursing visits were performed on the same day – both units must be billed on one claim line
    - PDN- all hours on that day need to be on the same line.
  - If you split it to 2 claims lines, it will reject/deny

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- Covered services provided in accordance with your provider contract are reimbursed at 100% of the contracted rate in your fee schedule.
- If you would like a copy of your fee schedule or have any questions on your reimbursement, then please contact your Contract Manager.
- Two services performed on the same day with the same HCPCS, must be billed on one line.

Module 3 | Claim Submission and Payment

Claim Guidelines Substitution of Services

Refer to your Provider Manual for Health Plan substitution requirements

Substitution of Services

- Must be approved by the ordering physician.
- Must be allowed by the patient's plan and applicable law.
- When billing CareCentrix, you must have the lower skilled service in your contract with CareCentrix in order to substitute services.
- Billing for the higher skilled services is considered fraud, waste, or abuse.

Example: If an authorization is provided for a Physical Therapist, a provider may service the patient with a PTA without requesting an authorization edit or a new authorization for the PTA services.

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Refer to your Provider Manual for all Health Plan substitution requirements.

Key highlights are as follows:

- Substitutions must be approved by the ordering physician.
- Substitutions must be allowed by the patient's plan and applicable law.
- When billing hourly nursing, you must have the lower skilled service in your contract with CareCentrix in order to substitute services.
- If you substitute services, then you must bill CareCentrix for the lower skilled service.

- Billing for the higher skilled services **is considered fraud, waste, or abuse.**

Module 3 | Claim Submission and Payment

Claim Guidelines Fractional Billing

Fractional Billing

- HCPCS codes must be billed in whole units of 1 or greater.
- Any partial units billed must be rounded up or down to the nearest whole number. **Partial units will not be accepted**!
- NDC quantities may be submitted in fractional units up to 2 decimal points.

Single unit =1 hour

↓

Nurse Spends 8 hours and 38 mins

↓

Bill for 9 units

*Clean Claims Requirements can be found in your Provider Manual.
The Provider Manual is located in HomeBridge.
www.carecentrixportal.com

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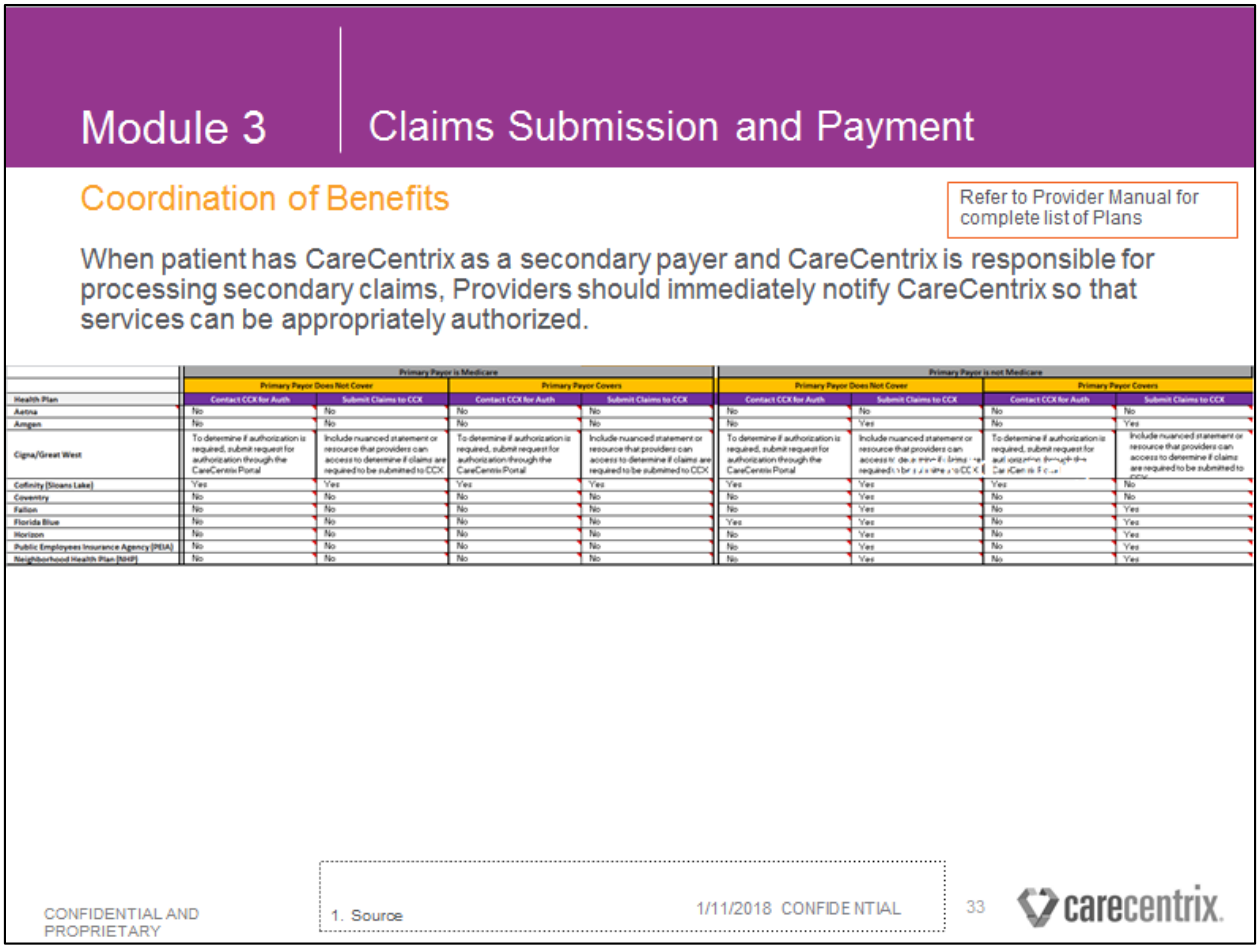
Please note the additional considerations for Fractional Billing:

- HCPCS codes must be billed in whole units of 1 or greater.
- Any partial units billed must be rounded up or down to the nearest whole number. Partial units will not be accepted!
- NDC quantities may be submitted in fractional units up to 2 decimal points.

For example if a single unit is equal to 1 hour and a nurse spends 8 hour and 38 minutes with a member, you will round up and bill 9 units.



Module 3 | Claims Submission and Payment

Coordination of Benefits

Refer to Provider Manual for complete list of Plans

When patient has CareCentrix as a secondary payer and CareCentrix is responsible for processing secondary claims, Providers should immediately notify CareCentrix so that services can be appropriately authorized.

	Primary Payor is Medicare				Primary Payor is not Medicare			
	Primary Payor Does Not Cover		Primary Payor Covers		Primary Payor Does Not Cover		Primary Payor Covers	
Health Plan	Contact CCX for Auth	Submit Claims to CCX	Contact CCX for Auth	Submit Claims to CCX	Contact CCX for Auth	Submit Claims to CCX	Contact CCX for Auth	Submit Claims to CCX
Aetna	No	No	No	No	No	No	No	No
Amgen	No	No	No	No	No	Yes	No	Yes
Cigna/Great West	To determine if authorization is required, submit request for authorization through the CareCentrix Portal	Include nuanced statement or resource that providers can access to determine if claims are required to be submitted to CCX	To determine if authorization is required, submit request for authorization through the CareCentrix Portal	Include nuanced statement or resource that providers can access to determine if claims are required to be submitted to CCX	To determine if authorization is required, submit request for authorization through the CareCentrix Portal	Include nuanced statement or resource that providers can access to determine if claims are required to be submitted to CCX	To determine if authorization is required, submit request for authorization through the CareCentrix Portal	Include nuanced statement or resource that providers can access to determine if claims are required to be submitted to CCX
Cofinity (Sloans Lake)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Coventry	No	No	No	No	No	Yes	No	No
Fallon	No	No	No	No	No	Yes	No	Yes
Florida Blue	No	No	No	No	Yes	Yes	No	Yes
Horizon	No	No	No	No	No	Yes	No	Yes
Public Employees Insurance Agency (PEIA)	No	No	No	No	No	Yes	No	Yes
Neighborhood Health Plan (NHP)	No	No	No	No	No	Yes	No	Yes

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1. Source

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For secondary claims, you will want to make sure that you bill your claim correctly to prevent delays in your claim payment.

- CareCentrix processes secondary claims for some payors. For these payors, you will want to send your claims directly to CareCentrix for processing within the 60-day timely filing period.

- If the payor is not contracted with CareCentrix, you will bill the payor directly.

Module 3 | Claim Submission and Payment

Eligibility & Benefits: Coordination of Benefits

When patient has CareCentrix as a secondary payer and CareCentrix is responsible for processing secondary claims, Providers should immediately notify CareCentrix so that services can be appropriately authorized.

	Primary Payor is Medicare			
	Primary Payor Does Not Cover		Primary Payor Covers	
Health Plan	Contact CCX for Auth	Submit Claims to CCX	Contact CCX for Auth	Submit Claims to CCX
Aetna	No	No	No	No
Amgen	No	No	No	No
Cigna/Great West	To determine if authorization is required, submit request for authorization through the CareCentrix Portal	Include nuanced statement or resource that providers can access to determine if claims are required to be submitted to CCX	To determine if authorization is required, submit request for authorization through the CareCentrix Portal	Include nuanced statement or resource that providers can access to determine if claims are required to be submitted to CCX
Cofinity (Sloans Lake)	Yes	Yes	Yes	Yes
Coventry	No	No	No	No
Fallon	No	No	No	No
Florida Blue	No	No	No	No
Horizon	No	No	No	No
Public Employees Insurance Agency (PEIA)	No	No	No	No
Neighborhood Health Plan (NHP)	No	No	No	No

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Additional Comments:
The above slide shows the secondary payer grid when the primary payer IS Medicare.

Module 3 | Claim Submission and Payment

Eligibility & Benefits: Coordination of Benefits

When patient has CareCentrix as a secondary payer and CareCentrix is responsible for processing secondary claims, Providers should immediately notify CareCentrix so that services can be appropriately authorized.

	Primary Payor is not Medicare			
	Primary Payor Does Not Cover		Primary Payor Covers	
Health Plan	Contact CCX for Auth	Submit Claims to CCX	Contact CCX for Auth	Submit Claims to CCX
Aetna	No	No	No	No
Amgen	No	Yes	No	Yes
Cigna/Great West	To determine if authorization is required, submit request for authorization through the CareCentrix Portal	Include nuanced statement or resource that providers can access to determine if claims are required to be submitted to CCX	To determine if authorization is required, submit request for authorization through the CareCentrix Portal	Include nuanced statement or resource that providers can access to determine if claims are required to be submitted to CCX
Cofinity (Sloans Lake)	Yes	Yes	Yes	No
Coventry	No	Yes	No	No
Fallon	No	Yes	No	Yes
Florida Blue	Yes	Yes	No	Yes
Horizon	No	Yes	No	Yes
Public Employees Insurance Agency (PEIA)	No	Yes	No	Yes
Neighborhood Health Plan (NHP)	No	Yes	No	Yes

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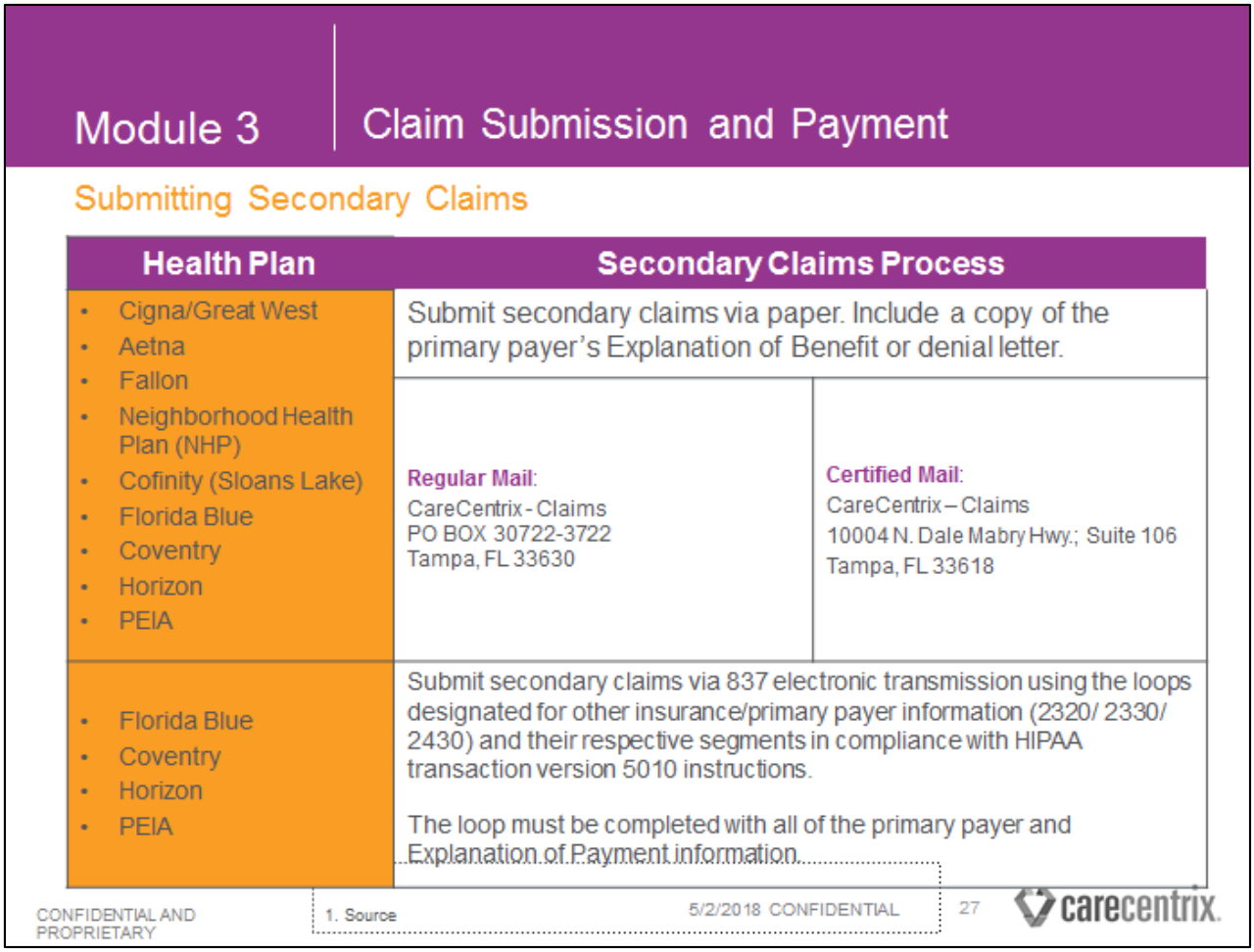
Additional Comments:

The above slide shows the secondary payer grid when the primary payer is NOT Medicare.



You can submit claims by paper for ALL plans.

Electronic Claims submission is available for the following Health Plans.
- Florida Blue
- Coventry
- Horizon
- PEIA

You have the option of submitting the secondary claims by paper, but also have the ability to submit secondary claims electronically for these four plans.

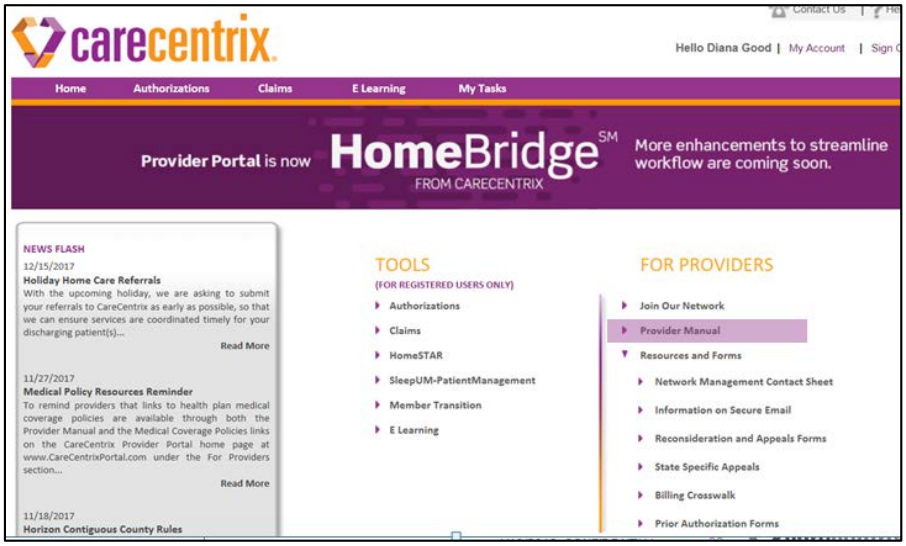
Module 3 | Claim Submission and Payment

Claim Guidelines Timely Filing

Claim timely filing limit is 60 days from the date of service for the initial claim (or, as specified by applicable law)

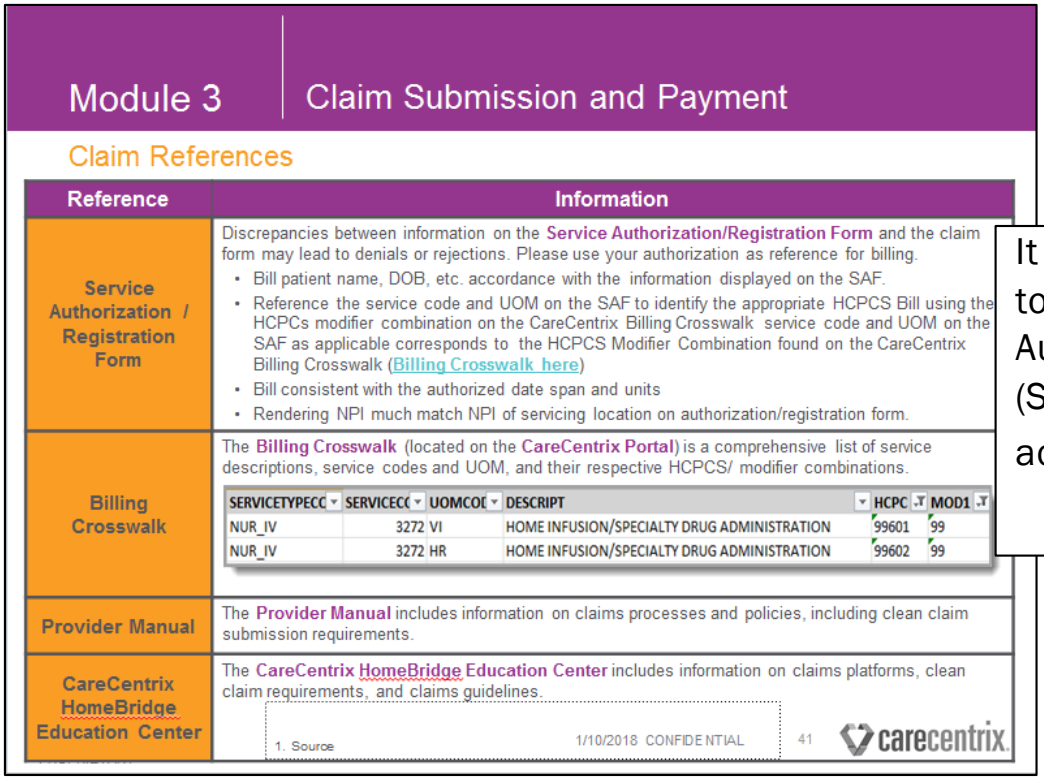
– A clean claim must be received within timely filing period.
– Rejected claims are not proof of timely filing.
– Claims received without Clinical Notes will be rejected.

Regular Mail:	Certified Mail:
CareCentrix – Claims PO BOX 30721-3721 Tampa, FL 33630	CareCentrix – Claims 10004 N. Dale Mabry Hwy.; Suite 106 Tampa, FL 33618



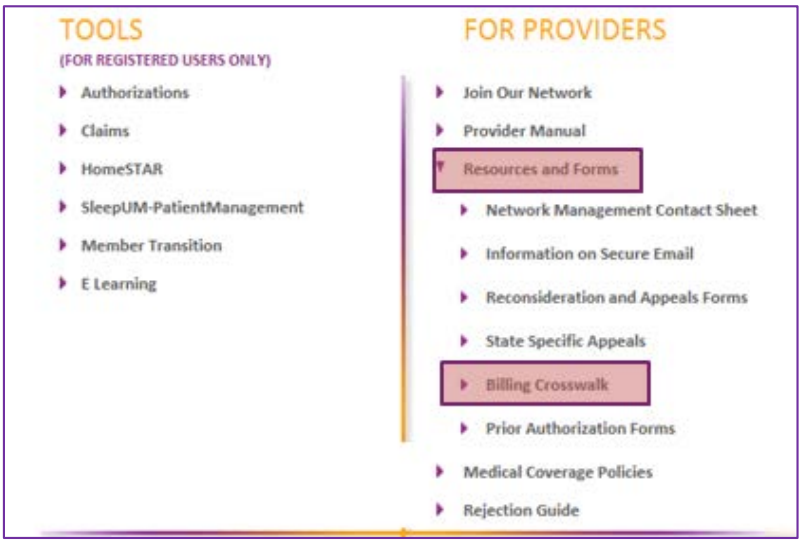
The CareCentrix Provider Manual (pg. 56-57) contains the full list of clean claims requirements for all types of claims submissions.

- In addition to meeting the clean claim requirement for submitting claims, you must also submit the initial claim, reconsideration, and appeal within the appropriate timeframe (if required).
- As a reminder, here are the timeframes that you should follow and the forms that you should use.
- You can find the forms in HomeBridge on the Home Page.
- You can refer to the participant guide for diagrams outlining the work flows for the different claim submission paths.



It is your responsibility to review the Service Authorization Form (SAF) to ensure it is accurate

- Refer to the Provider Manual for a complete list of clean claim submission requirements.
- The "For Providers" section in HomeBridge provides access to the Provider Manual, forms, and other resources.

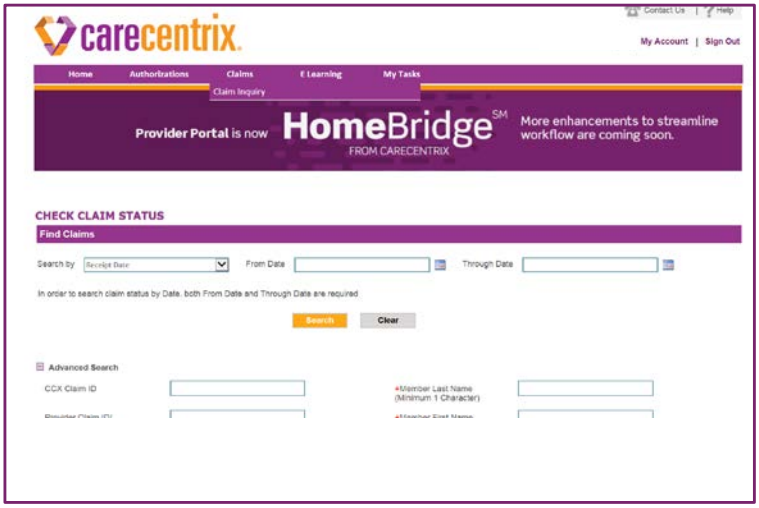


- ❑ If there are any discrepancies with the services displayed on your SAF, call the Care and Service Center and they will make the update.
  - Refer to the Billing Crosswalk in HomeBridge for a comprehensive list of CareCentrix service codes for HCPCS included in your fee schedule. Use the Billing Crosswalk to locate the correct HCPCS/modifier combination to bill on the claim form.

Module 3 | Claim Submission and Payment

Claim Status

https://www.carecentrixportal.com



Status

- Claim Receipt Date
- Pending CareCentrix Review
- Rejected by CareCentrix
- Accepted By CareCentrix
- Submitted to Health Plan
- Reviewing Health Plan 277 Response
- Accepted by the Health Plan for Processing
- Rejected by Health Plan
- Pending Health Plan Review
- Received Health Plan 835 Response
- Reviewing Health Plan 835 Response
- Provider Payment made prior to Health Plan Adjudications
- Preparing Final Claim Determination
- Finalized by CareCentrix
- Additional Information is Required by the Health Plan and CareCentrix has Taken Action on your behalf
- Reversed
- Void

You can check the status of a claim in HomeBridge.

- Once you log in, hover your mouse over the **Claims** tab to display **Claims Inquiry**.
- Click to open.
- **Search** for the claim using the appropriate criteria.
- All of the **Statuses** available to view.

Module 3 | Claim Submission and Payment

Claim HomeBridge Functionality

Health Plan	Functionality
Coventry	• Detailed Claim Status • Submit Claim Inquiries (Check Status) • View Claim History • Find Claim Replica • Submit Reconsiderations and Appeals
Horizon	
PEIA	
Florida Blue	
Amgen	

All other plans can contact
The Network Services Team (877) 725-6525

For providers contracted with CareCentrix for Cigna business, CIGNA Authorizations and Network Services Team 844-457-9969

Providers are also encouraged to supply Cigna members with the dedicated Cigna member toll free number for all CareCentrix inquiries: (844) 457-9810

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You will have the ability to use HomeBridge to perform specific functions for some of our Health Plans.

For Coventry, Horizon, PIEA, Florida Blue, and Amgen you can use HomeBridge to:

- Check detailed claim status (on initial claim status only)
- Submit claim inquiries through HomeBridge
- View claim History in HomeBridge
- Locate and exact copy of your claim

For all other plans you can obtain this information by calling the Network Services Team at 877-725-6525.

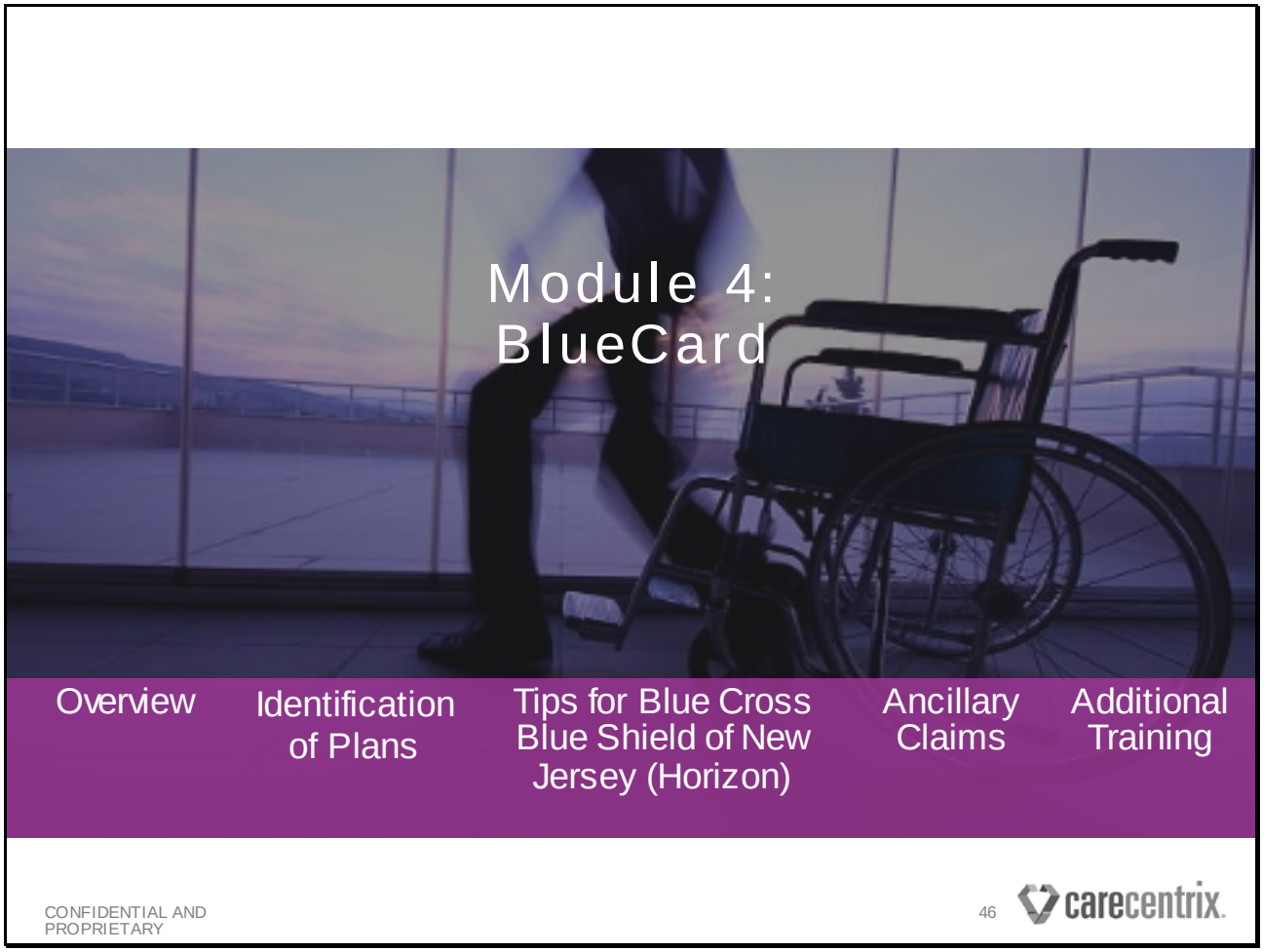
For providers contracted with CareCentrix for Cigna business CIGNA Authorizations and Network Services Team 844-457-9969

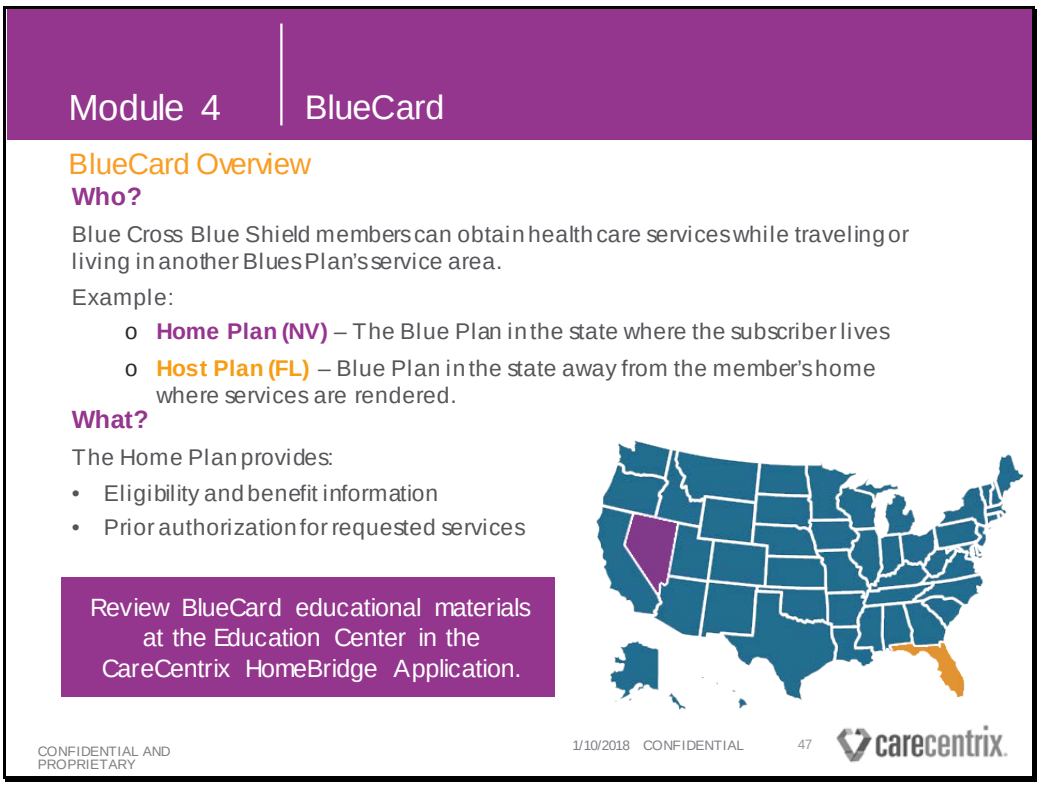
Providers are also encouraged to supply Cigna members with the dedicated Cigna member toll free number for all CareCentrix inquiries: 844-457-9810

We are always striving to improve the provider experience when working with CareCentrix.

We are working hard to ensure that in the future all the Health plans we contract with will have all the same features.

Module 4: BlueCard





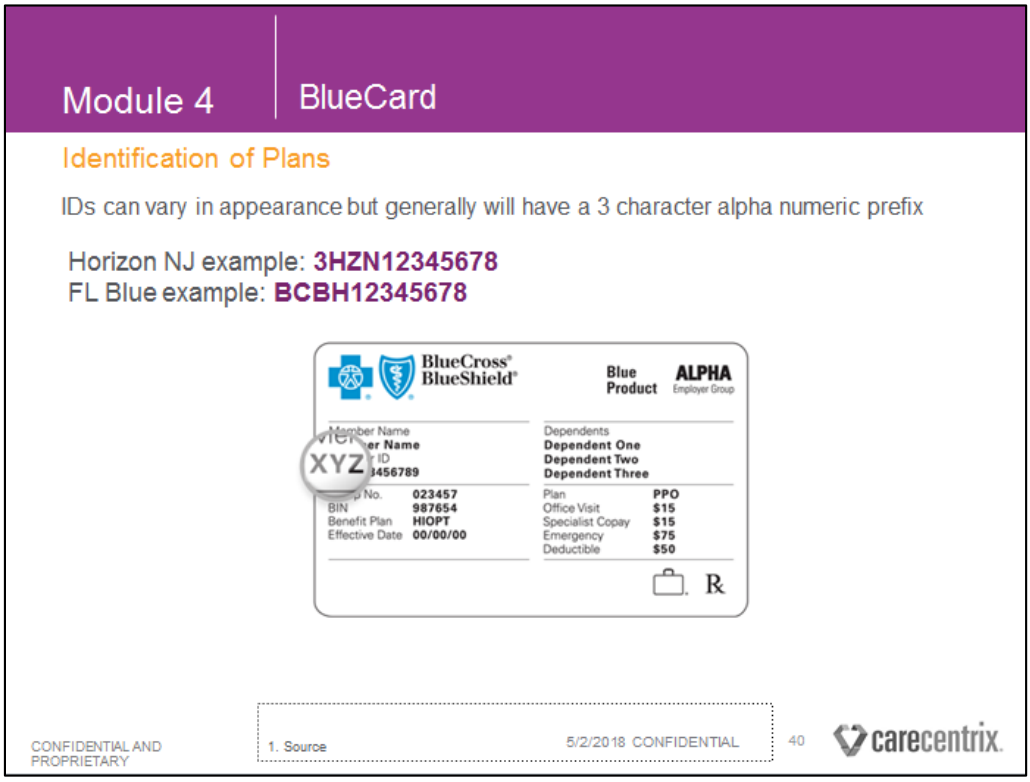
In addition to the general guidelines for checking eligibility and benefits, there are also specific requirements that you must follow when providing service to a BlueCard member.

The **BlueCard** program provides the ability for Blue Cross Blue Shield members to obtain health care services while traveling or living in another Blues Plan's service area.

- Home Plan: Where the Health Plan or policy originated and provides coverage
- Host Plan: Where the subscriber or patient received services

For example, if the patient is covered by Blue Cross Blue Shield of Nevada , but spends a few months out of the year in FL where they sometimes receive health services, you must contact the patient's Home Plan, of Blue Cross Blue Shield of Nevada directly to verify eligibility and benefits and obtain any necessary precertification prior before servicing the patient.

BlueCard precertification requirements vary by Home Plan. Please review the BlueCard educational materials at the Education Center on the **CareCentrix HomeBridge Application Home Page.**



IDs can vary in appearance but generally will have a 3 letter alpha numeric prefix followed by varying alpha prefix numeric digits.

Medicare Advantage or Medicare replacement plans sold in another state other than NJ or FL are identified in the same manner.

<u>Horizon NJ Plans:</u>

- Sold through NJ (Horizon). Plans generally contain the alpha numeric combination "3HZN" in the subscriber ID.
- This includes Medicare Advantage sold in NJ.
- There are some Horizon plans administered by local labor unions that resemble BlueCards. The only way to determine these plans as Horizon is to use the BlueCard Verifications Tool, call or use the Out of Sate Router found on many plan websites.

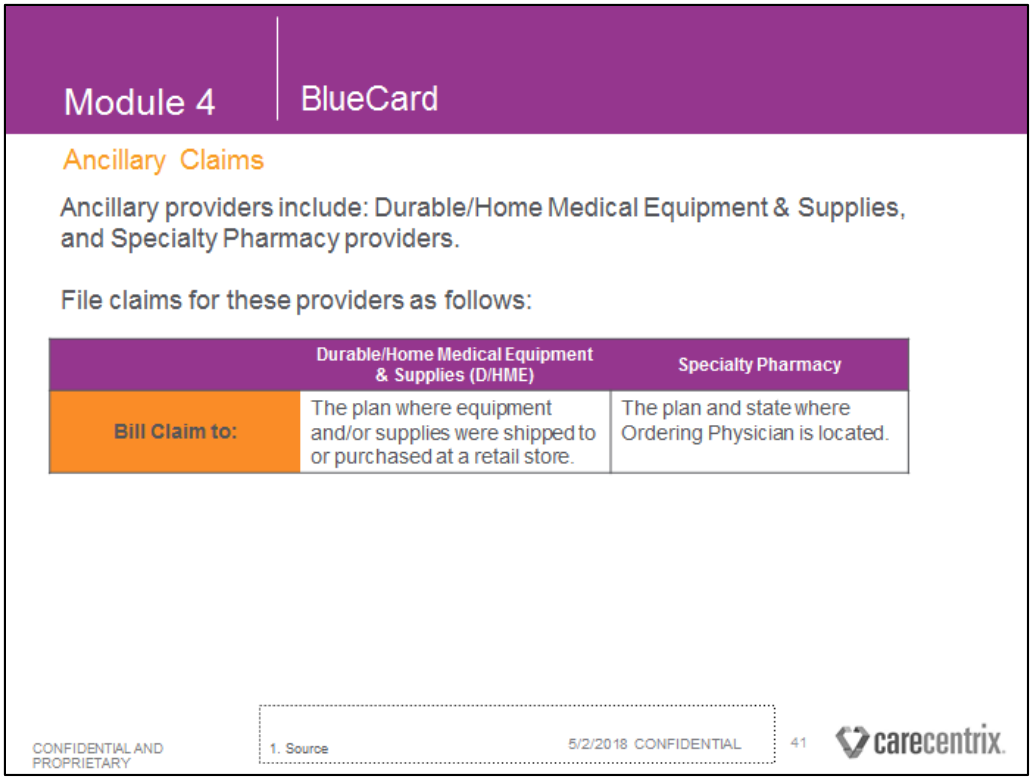
<u>FL Blue:</u>

- Plans sold through FL Blue are typically identified by a 3 letter alpha numeric pre-fix but the 4th character is generally an "H" followed by 8 digits.
- This includes Medicare Advantage sold in FL.

The patient's Home Plan contact information can be found on their insurance identification card, or you can call 1-800-676-2583 and provide the three letter alpha numeric prefix on the insurance card to be transferred to the Home Plan.

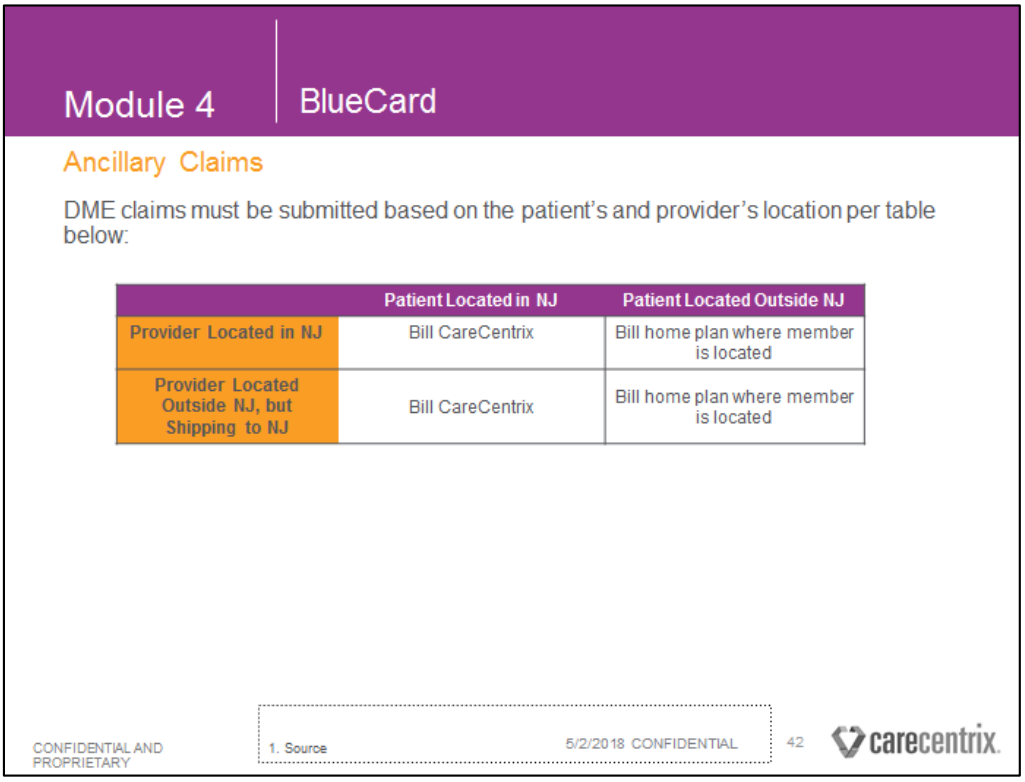
**Note:

- Some FL Blue Commercials & Commercial Medicare plans arrive containing just the single letter H followed by 8 digits.
- FL Blue has since stopped this process of creating these IDs but you may still see them.
- Although rare, a few Anthem plans mimic the FL Blue style of an H in the 4th character.



BlueCard Ancillary providers include, Durable/Home Medical Equipment and Supplies, and Specialty Pharmacy providers.

- When servicing **Durable/Home Medical Equipment and Supplies (D/HME)**, you should bill the plan in whose state the equipment was shipped to or purchased at a retail store.
- When servicing **Specialty Pharmacy**, you should bill the Plan in whose state the Ordering Physician is located.



DME- In the case of durable medical equipment for all plans except FEP, a provider would bill CareCentrix when both that provider and the patient are located in New Jersey. National providers may provide DME services to Horizon subscribers but would bill the Blue plan in the state where that member is located.

O&P- For all plans except FEP, members and providers can be in the state of New Jersey or a contiguous county.

Service Area State Contiguous Counties (O&P Services only for plans except FEP)

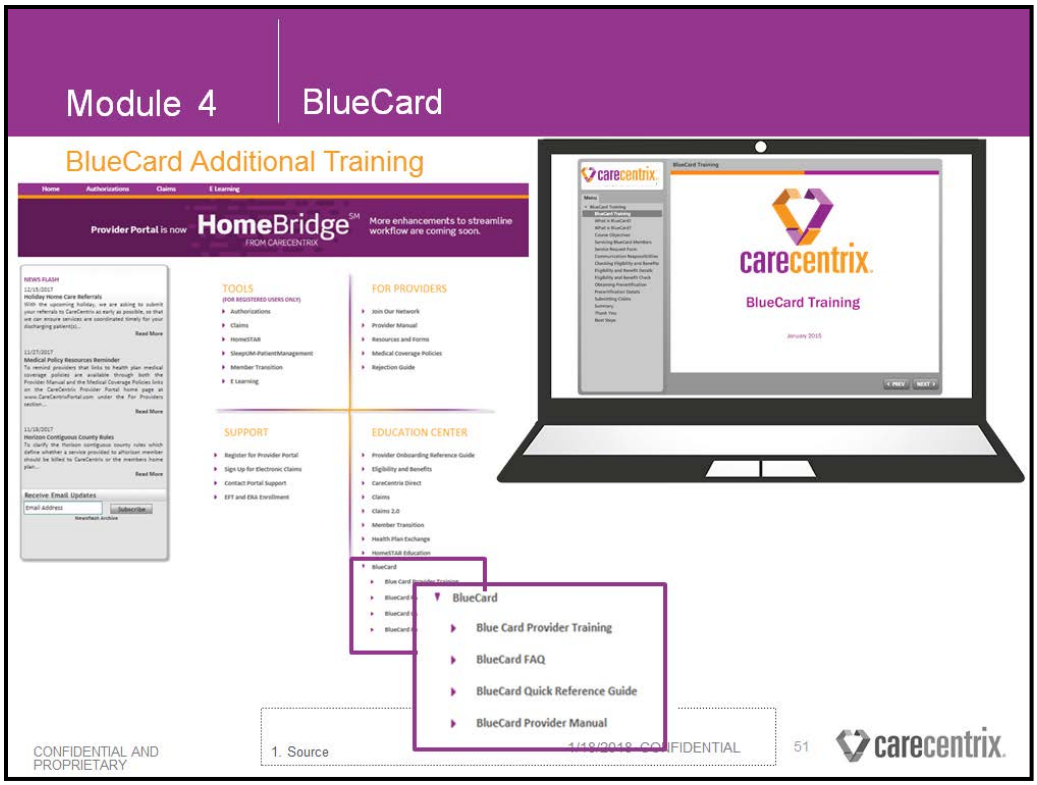
NJ

Delaware: New Castle, Kent and Sussex

New York: Orange, Rockland, Westchester, New York, Bronx, Richmond, and Kings

Pennsylvania: Pike, Monroe, North Hampton, Bucks, Philadelphia and Delaware

FEP- Subscribers with FEP plans can reside outside the state of New Jersey as long as the servicing provider is located in New Jersey. The provider must be in New Jersey and cannot be located in a contiguous county.



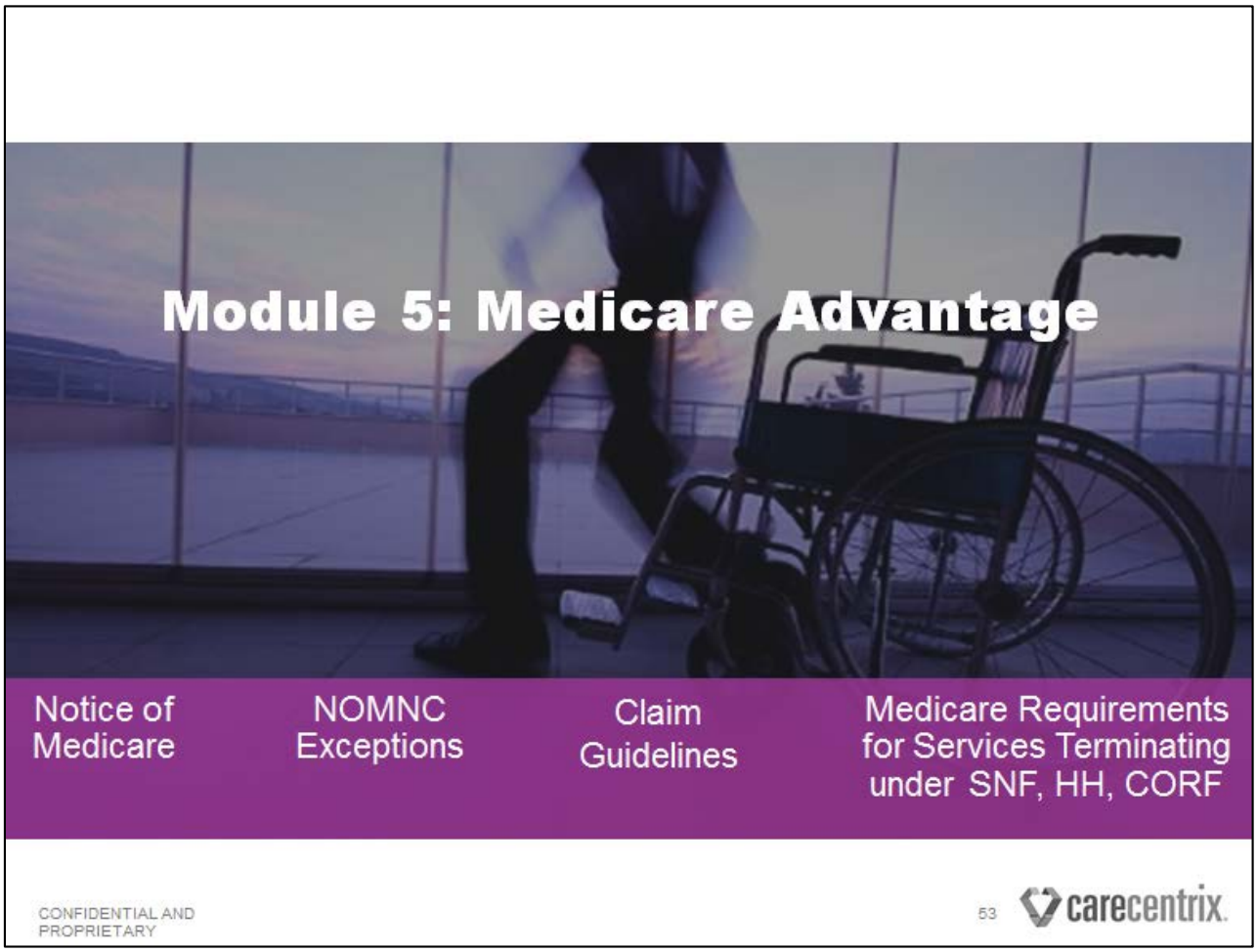
We have covered the important points for what you need to know with BlueCard

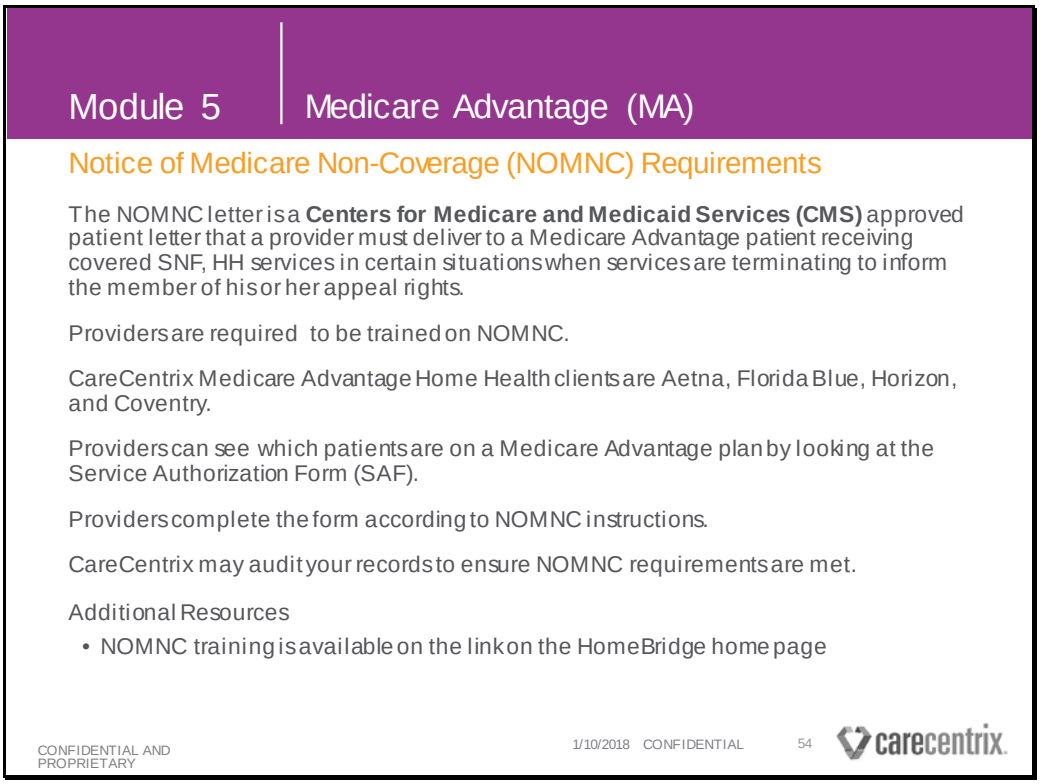
For more information:

- Access HomeBridge for additional educational materials for BlueCard.
- They are located in the education center on the homepage in the Education Center.

For additional support, please send a note to ProviderServices@carecentrix.com

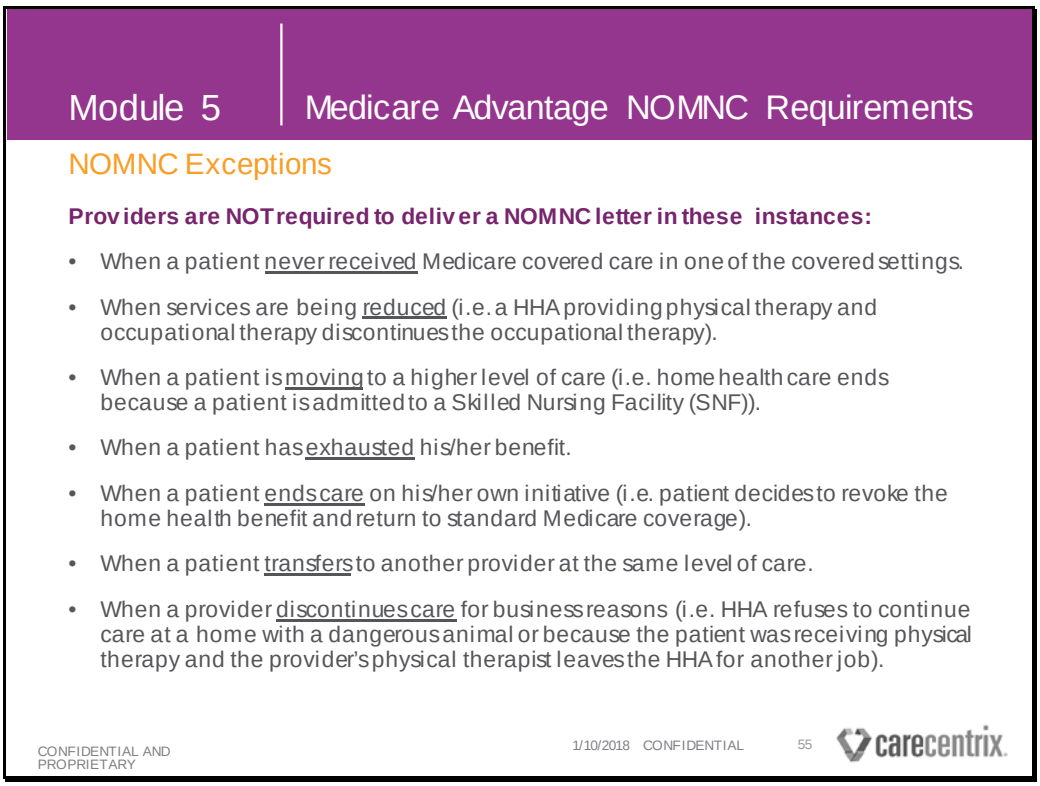
Module 5: Medicare Advantage





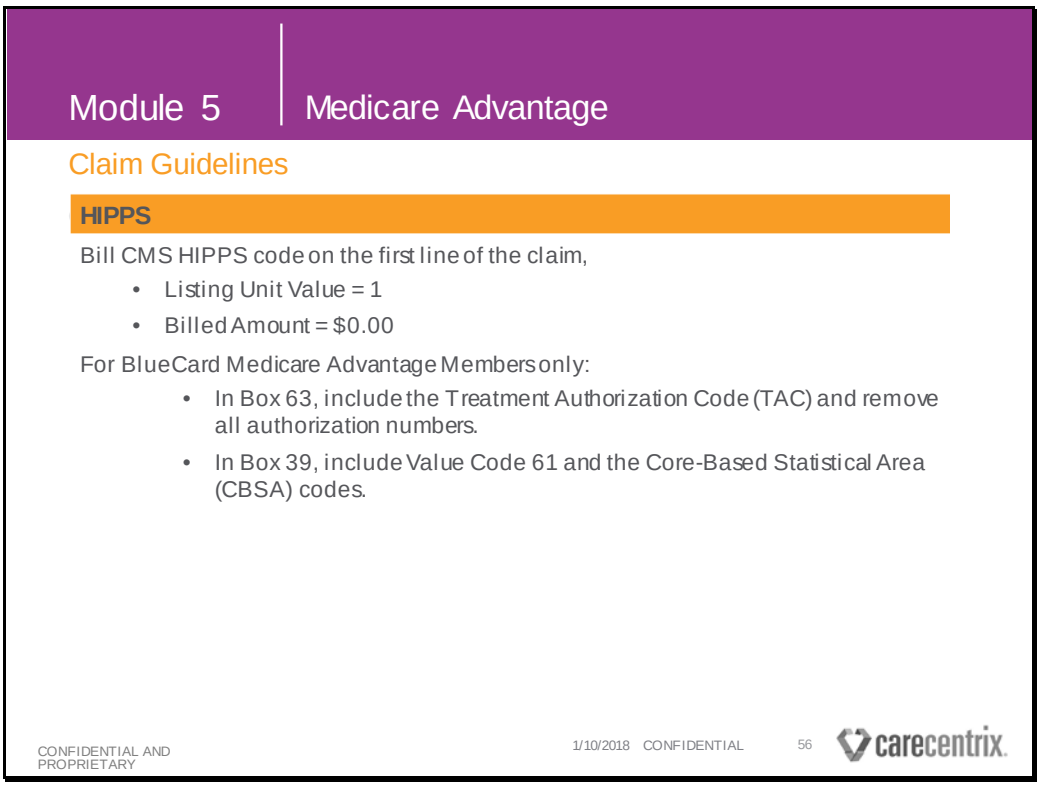
- Providers are trained on NOMNC via the CareCentrix training module in order to provide more information about what a NOMNC is and when a Medicare Advantage patient should receive one and when an exception applies.
- CareCentrix Medicare Advantage Home Health clients are Aetna and Florida Blue.
- Providers can see which patients are on a Medicare Advantage plan by looking at the Service Authorization Form (SAF).
- Providers complete the form according to NOMNC instructions and using the template letter CMS Form 10123 (Approved 12/31/2011) OMB approval (0938-0953) available on CMS' website.

- CMS requires providers to timely issue a Notice of Medicare Non-Coverage (**NOMNC**) to the patient unless an exception to the NOMNC requirement applies.
- Some Medicare Advantage members are exempt from NOMNC requirements:
  - Must receive a CMS NOMNC letter at least **2 calendar days** prior to discharge or the second to the last day of service.
  - Utilize The CMS NOMNC letter template and complete the letter as directed by CMS.
- CareCentrix may audit your records to ensure NOMNC requirements are met.



Providers are NOT required to deliver a NOMNC letter in these instances:

- When a patient never received Medicare covered care in one of the covered settings.
- When services are being reduced (i.e., a HHA providing physical therapy and occupational therapy discontinues the occupational therapy).
- When a patient is moving to a higher level of care (i.e. home health care ends because a patient is admitted to a Skilled Nursing Facility (SNF).
- When a patient has exhausted his/her benefit.
- When a patient ends care on his/her own initiative (i.e. patient decides to revoke the home health benefit and return to standard Medicare coverage).
- When a patient transfers to another provider at the same level of care.
- When a provider discontinues care for business reasons (i.e. HHA refuses to continue care at a home with a dangerous animal or because the patient was receiving physical therapy and the provider's physical therapist leaves the HHA for another job).

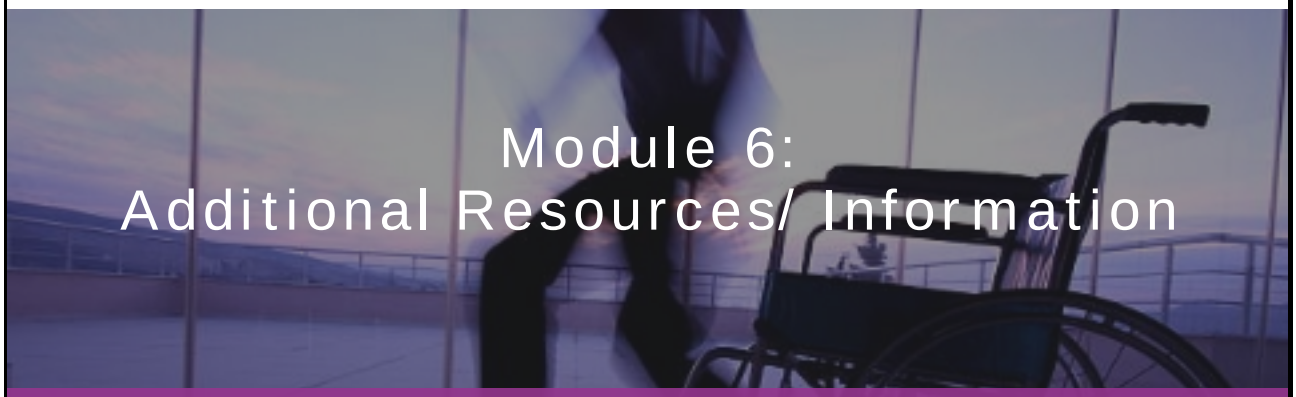


HIPPS Codes
- Do not bill the HIPPS Code with 0 or a value greater than 1
- Refer to Education Center more information.

- All home health claims for services provided to Medicare Advantage Members must include a CMS HIPPS code.
  - Bill CMS HIPPS code on the first line of the claim, listing Unit Value = 1 and Billed Amount = $0.00.
  - Must be billed on 837i/UB-04 Institutional Claim

- For BlueCard Medicare Advantage Members only:
  - In Box 63, include the Treatment Authorization Code (TAC) and remove all authorization numbers.
  - In Box 39, include Value Code 61 and the Core-Based Statistical Area (CBSA) codes.

Module 6: Additional Resources/Information



- Transition of Care
- Patient Adverse Events
- Patient Financial Responsibility
- Information Updates
- HomeBridge Training
- HomeBridge Registration
- EDI Enrollment
- Registering for ERA/EFT
- Provider Newsflashes
- CareCentrix Direct

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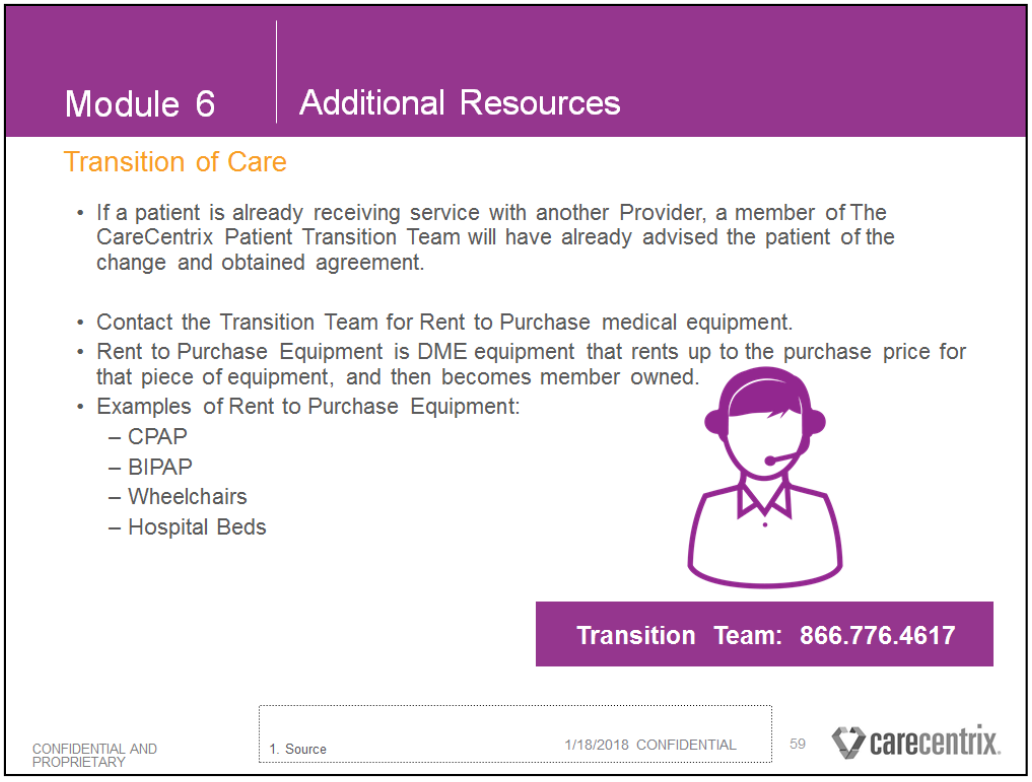
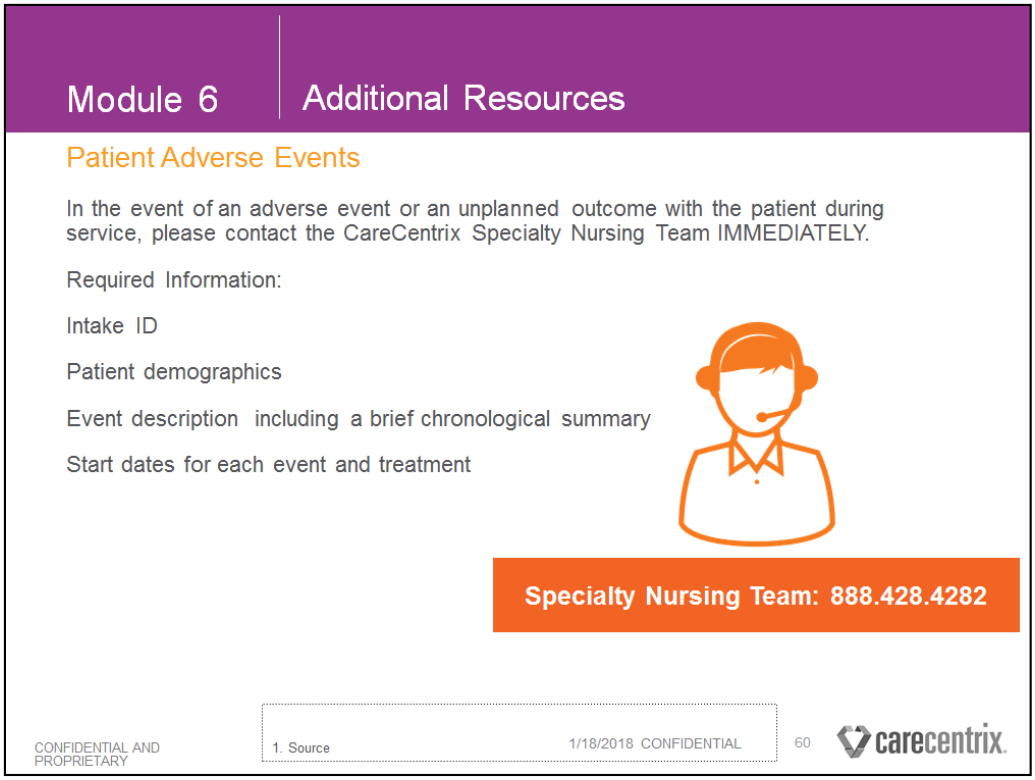


If a patient is already receiving service with another Provider, a member of The CareCentrix Patient Transition Team will have already advised the patient of the change and obtained agreement.

Contact the CareCentrix Transition Team at 1-866-776-4617 with any questions or concerns.

- If a patient changes Health Plans while renting Rent to Purchase medical equipment, please contact the Transition Team to receive assistance facilitating the transition.
    - Do not submit request for authorization/registration through HomeBridge for the remaining units, please contact the Transition Team.
    - Authorization/registration will be issued for the remaining rental units which were not paid by the previous insurer based on your CareCentrix allowable.

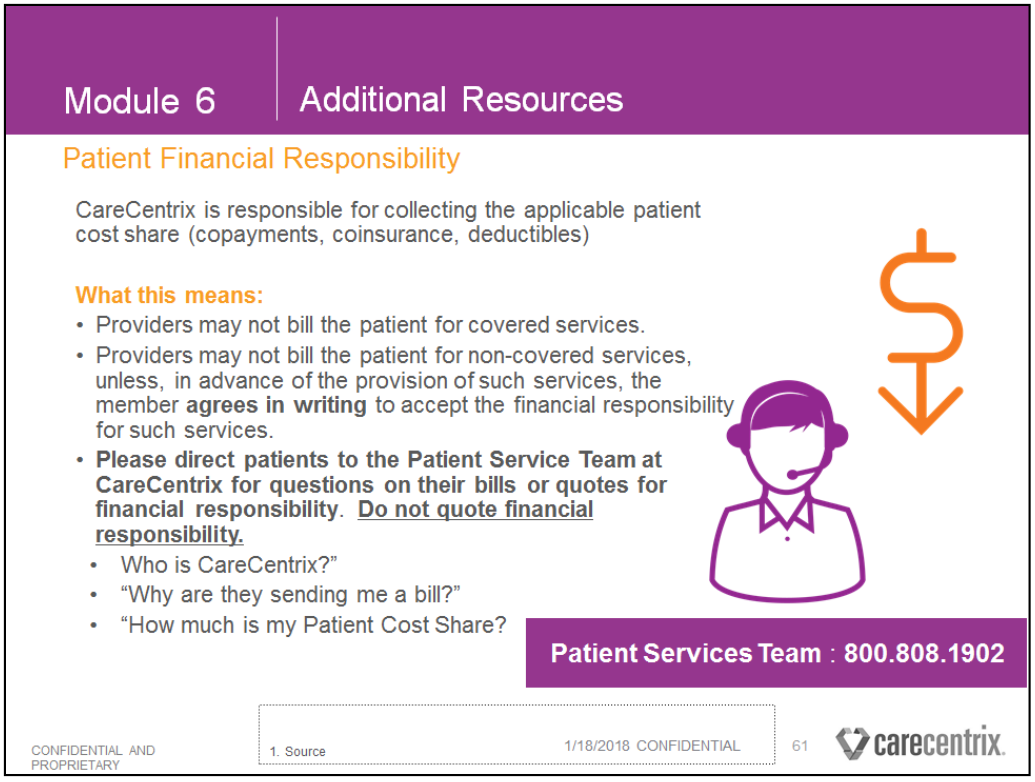


In the event of an adverse event or an unplanned outcome with the patient during service, please contact the CareCentrix Specialty Nursing Team IMMEDIATELY.

Information you will need for the call includes:

- Intake ID
- Patient demographics
- Event description including a brief chronological summary
- Start dates for each event and treatment

You can reach the CareCentrix Specialty Nursing Team at 1-888-428-4282.



CareCentrix assumes responsibility for collecting the applicable patient cost share (co-pays, co-insurances, deductibles). A provider should never tell a patient/member that they are not responsible for any co-pays, coinsurance or deductibles

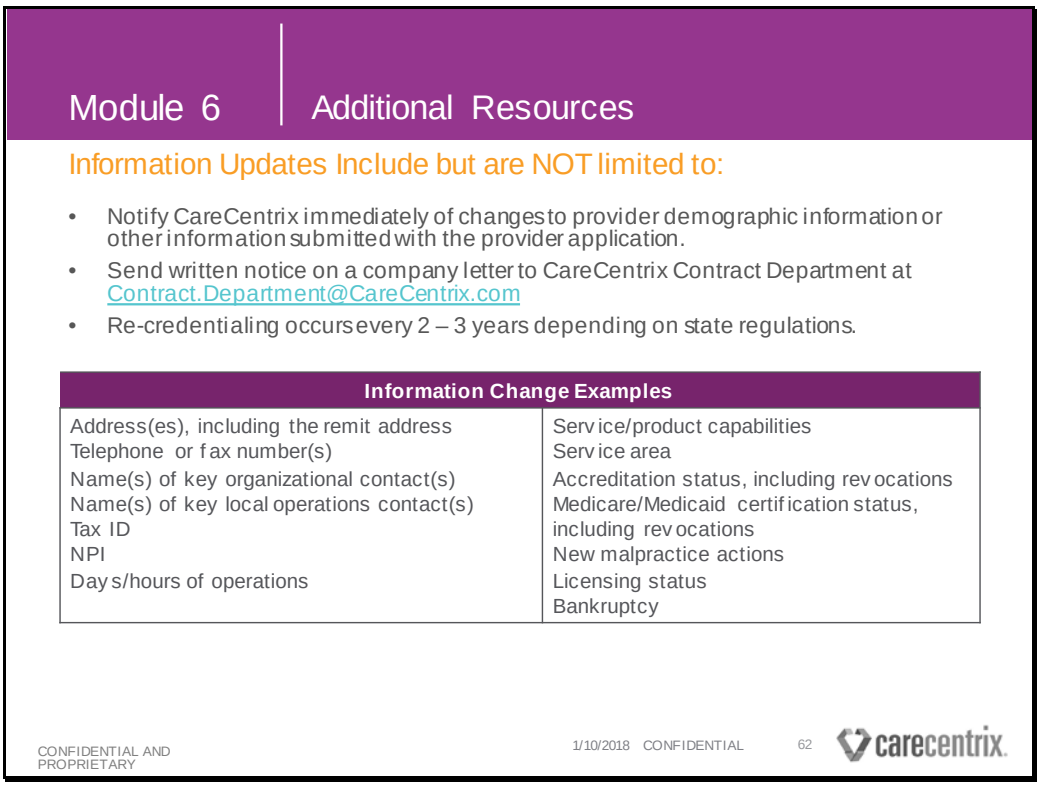
Important:

- Providers may not bill the patient for covered services. If you bill the patient, they will receive two bills and the situation will likely end in an escalation.

- Providers may not bill the patient for non-covered services, unless, in advance of the provision of such services, the member agrees in writing to accept the financial responsibility for such services.

- Providers will not interact with our Patient Services Team, but we want you to know who they are. If a member asks "Who is CareCentrix?" or "Why are they sending me a bill?" please let them know that we are contracted with their Health Plan to coordinate care in the home and the bill is their co-pay.

- Please direct patients to the Patient Service Team at CareCentrix for questions on their bills or quotes for financial responsibility. Do not quote financial responsibility.

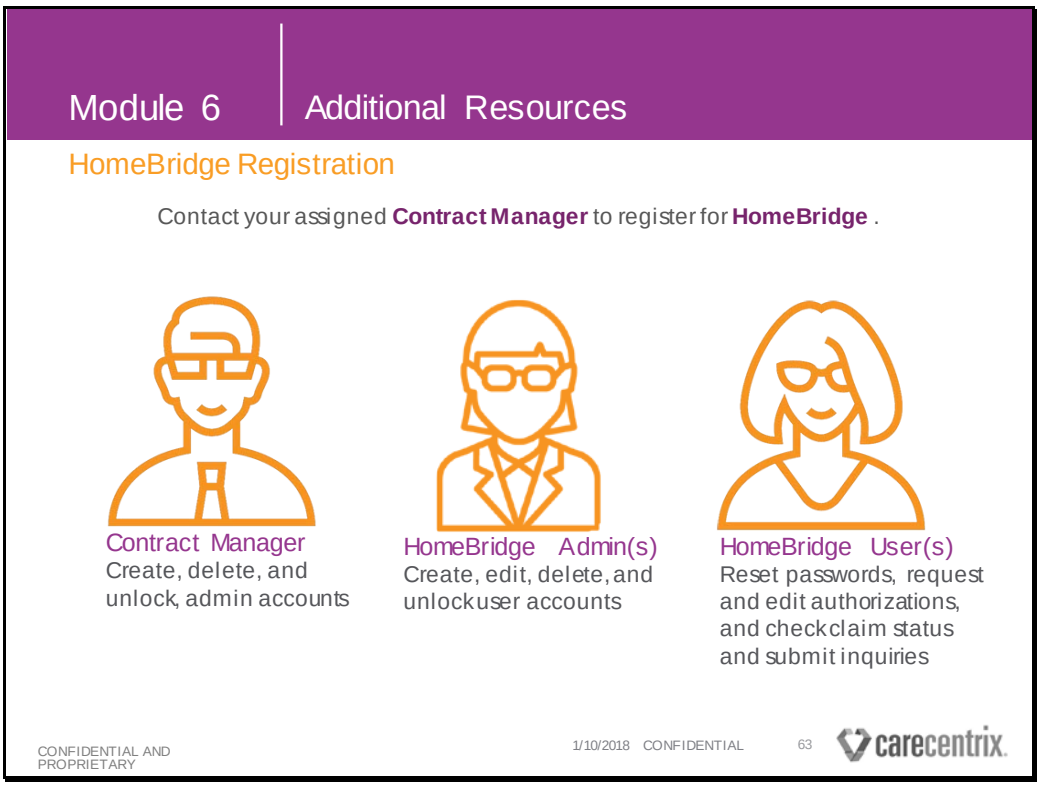


It is very important that you update your demographic information with CareCentrix to ensure we have the most current information for you on file.

Send written notice to Contract.Department@CareCentrix.com.

If you would like to update your contract by:
- Adding or removing codes from your fee schedule
- Add a new location to your contract with CareCentrix
- Expand your service offering to another line of business
- Update your service area
- Or if you are interested in expanding your relationship with CareCentrix in any other way

Contact your assigned Network management representative.



Contract Manager

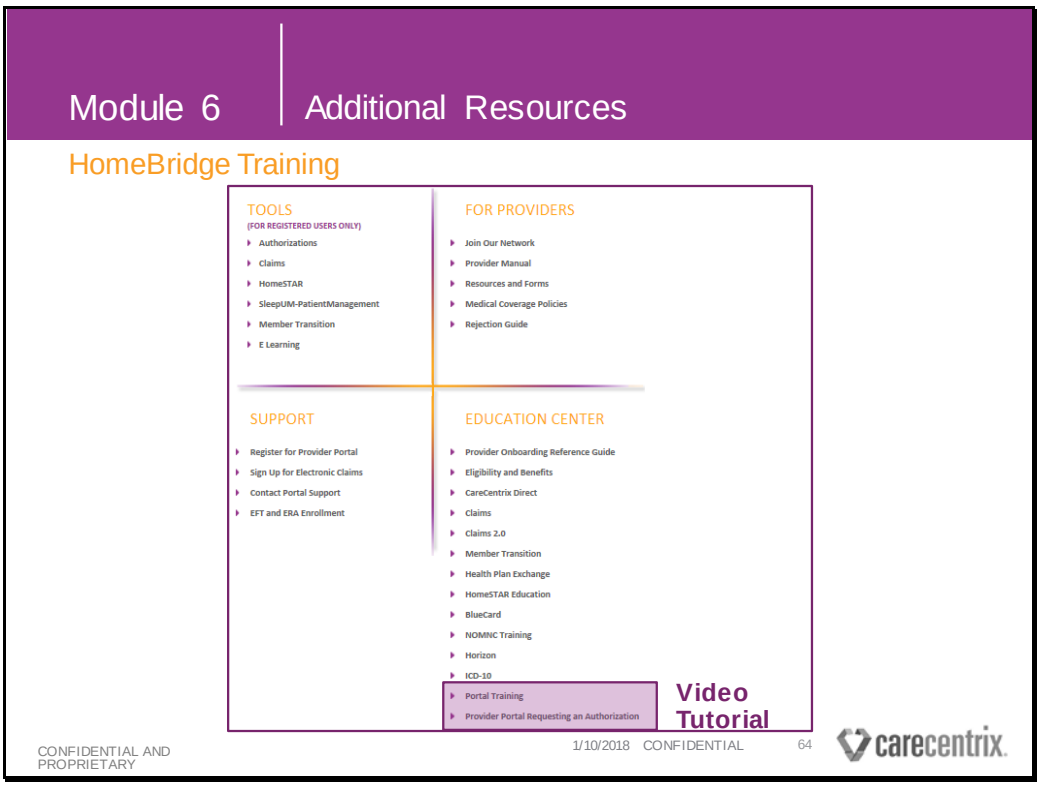
- Your assigned network management representative is able to create, unlock, and manage **admin accounts** for your agency in the CareCentrix HomeBridge Application

HomeBridge Administrator

- Accounts Administrators are able to:
    - Create, edit and delete users
    - Unlock user accounts and reset user passwords
    - Add and delete CareCentrix Direct contacts
- If you are an administrator, it is important that you communicate this information throughout your agency so that the users know who to contact with questions or concerns.

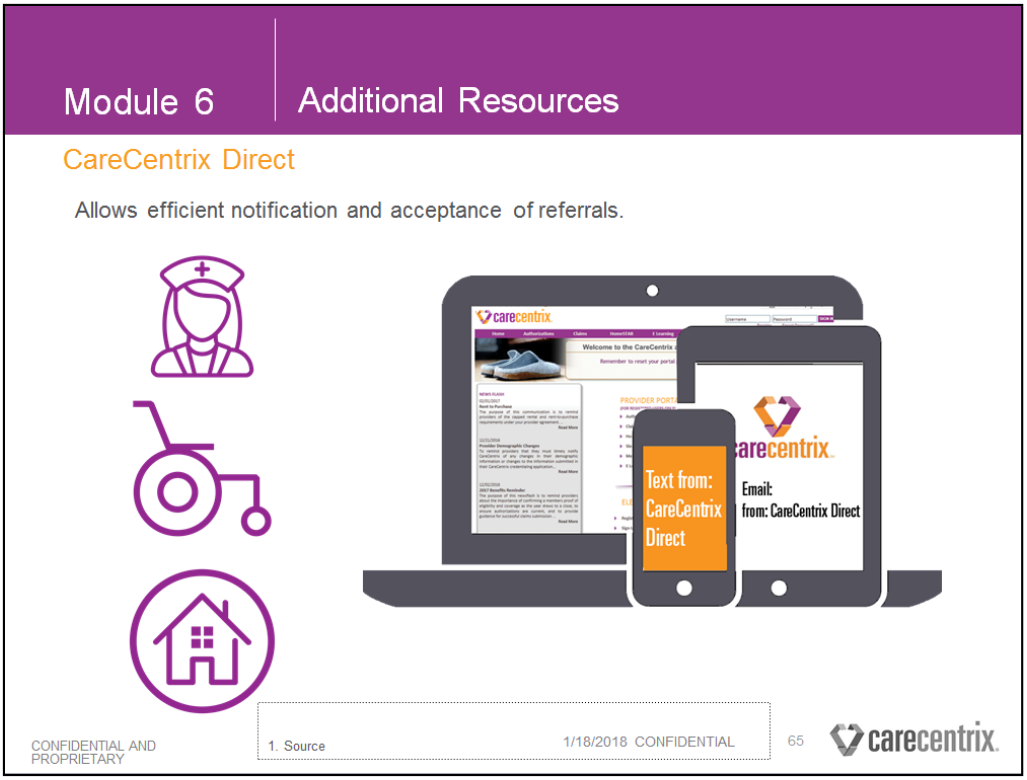
HomeBridge User

- As a User you can reset your password, complete intake functions, including request for initial authorization/registration, add-on service, re-authorization/registration, authorization/registration edit, checking authorization/registration status, complete claims functions, including checking claim status.



- In this orientation, you have already heard a lot about HomeBridge.
- Your next step after this session will be to learn how to use HomeBridge.

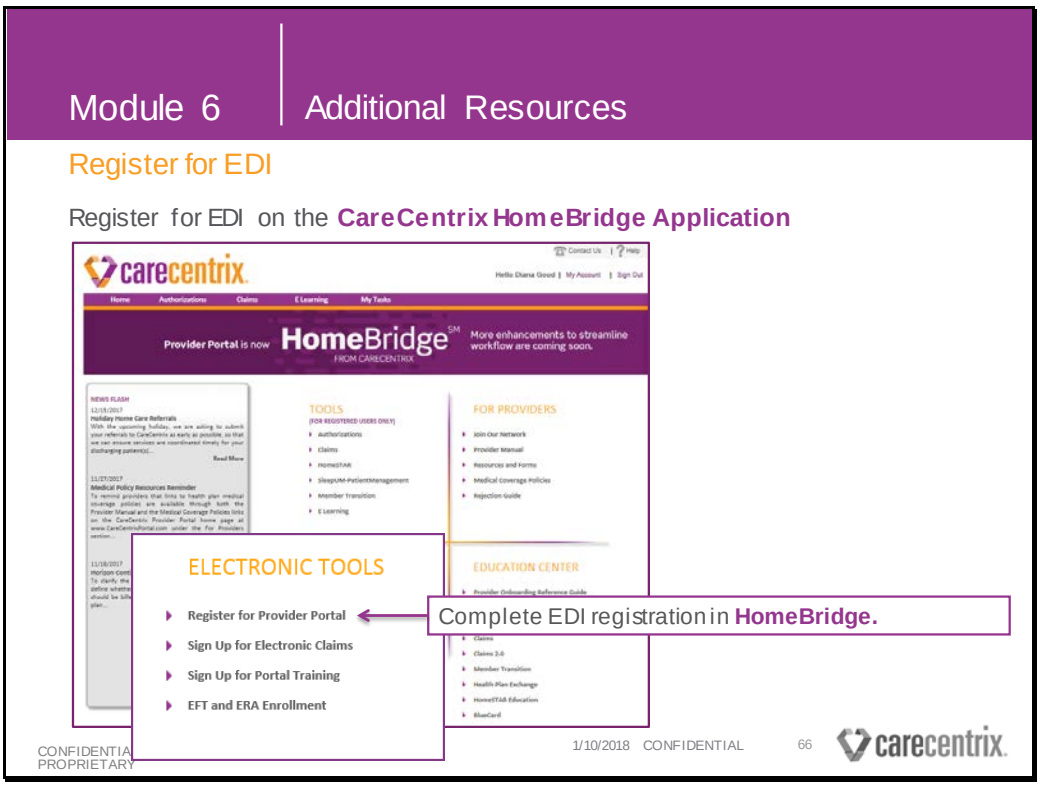
  ❑ Play the VIDEO TUTORIALS
  ❑ Participate in the initial authorization simulation



CareCentrix Direct leverages technology to more quickly and efficiently offer referrals and allow you to accept them.

- Referral notifications are sent via email and text message
- Notifications are automated from the time of receipt allowing more lead time before the start of care date
- Accepting a referral is done quickly by logging into HomeBridge
- Signing up for notifications is a simple online process

Training on how to enroll in CareCentrix Direct is found in HomeBridge.

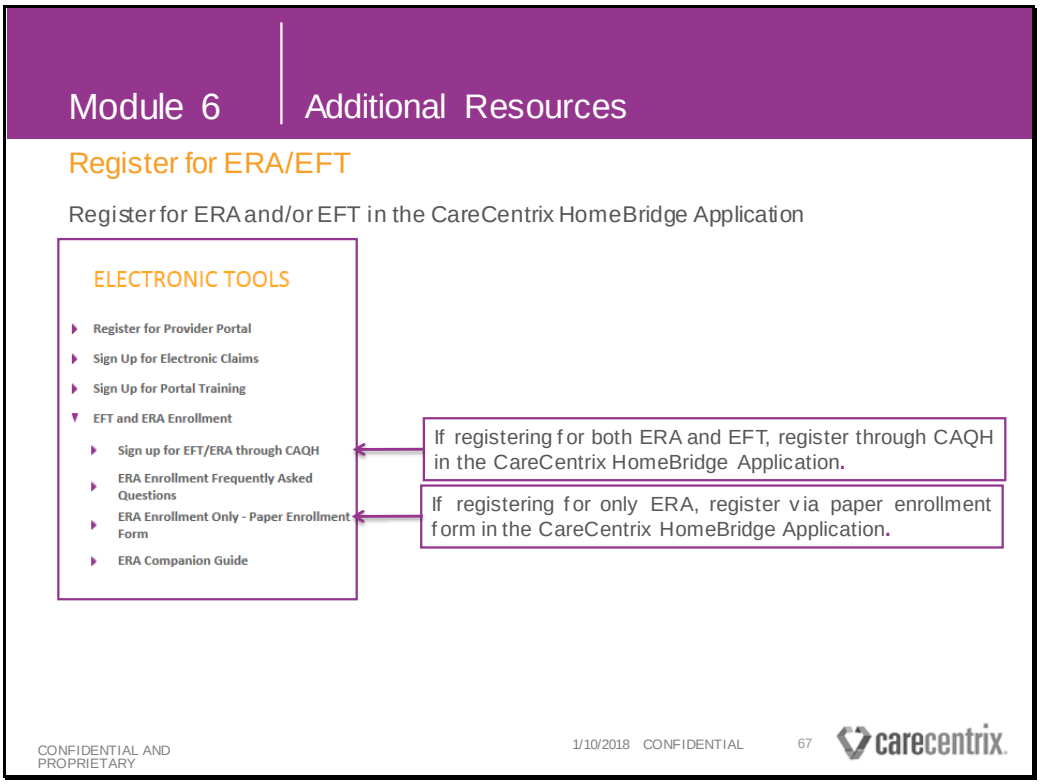


CareCentrix offers you the convenience of electronic claims submission to increase the efficiency and speed of the claims adjudication process.

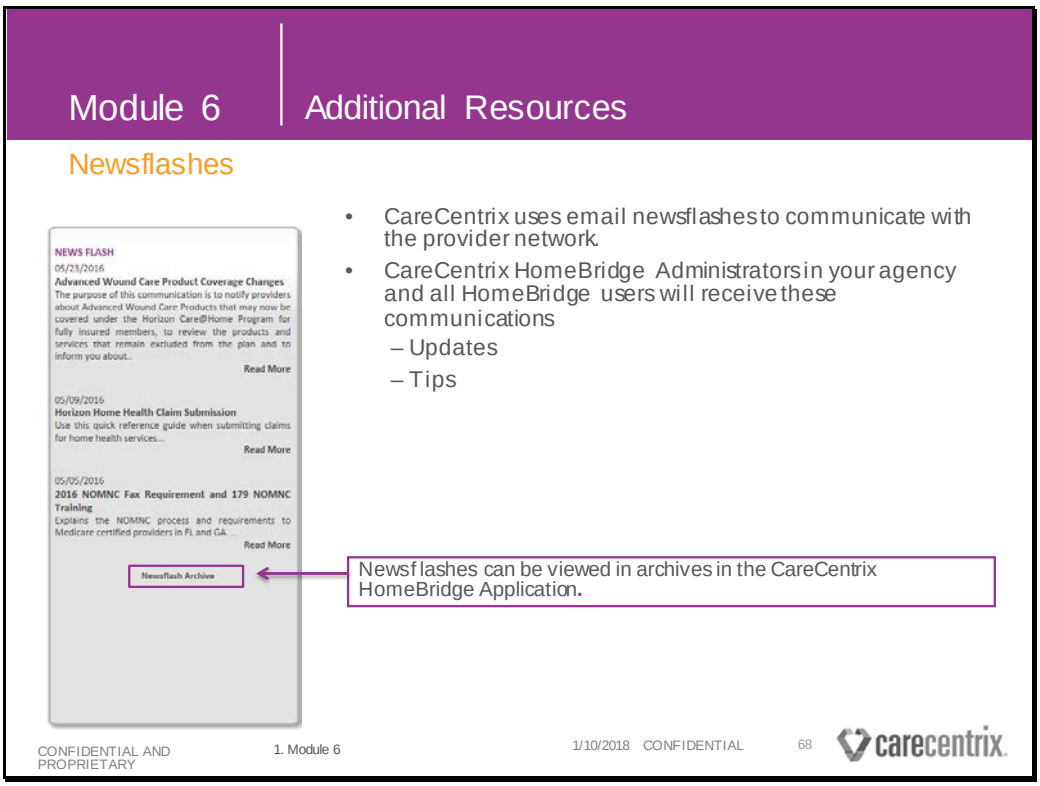
Registering for electronic claims submission is not required, but is highly recommended.

To register for EDI:

- Login into HomeBridge
- Under "Electronic tools" find the link titled "Sign Up for Electronic Claims"
- You will be brought to a new page with the EDI form
- Read all the directions and fill out all the required fields



- ERA enrollment cannot be completed until at least one check has been cut, however, it is preferred that three checks are cut prior to enrollment for testing purposes.
- Enrollment may take up to 45 days.
- Once enrolled in ERA with CareCentrix, it may also be necessary to enroll in ERA with your clearinghouse.
- Please contact your clearinghouse to enroll for ERA.
- Currently CareCentrix only sends ERA to Change Healthcare (Emdeon) and Availability, but we do work with multiple clearing houses.
- CareCentrix ERA enrollment process is different than that of most Health Plans.
  - You may be used to enrolling through clearinghouse only.
- CareCentrix prefers that you register for ERA and EFT at the same time.



Staying connected and providing you with important updates is a necessity.

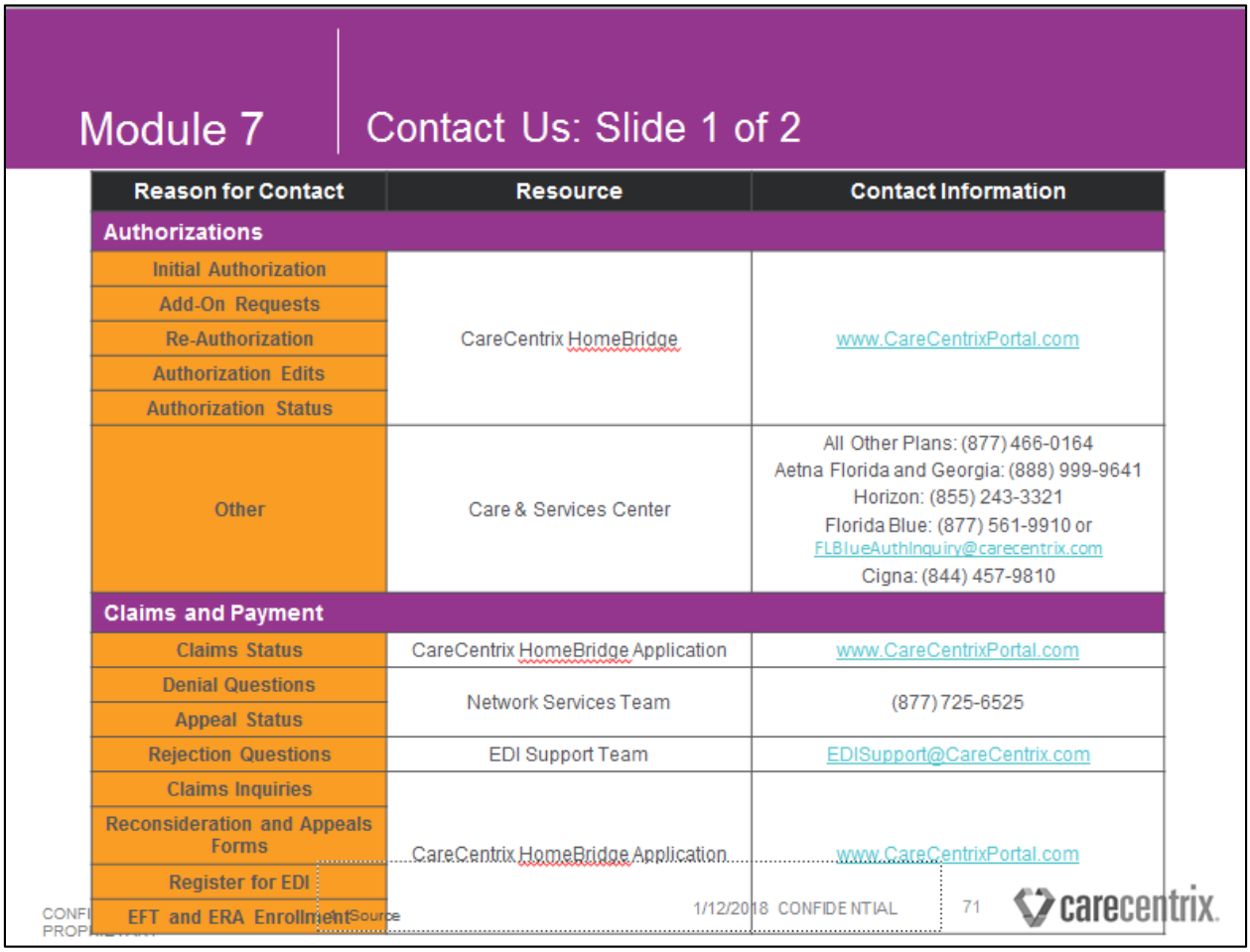
We first and foremost use newsflashes to provide additional information on policy and/or process changes. We also use newsflashes to communicate best practices and other pertinent information. This is information you want to receive, as it will inform your daily operations. All HomeBridge users will receive these communications about updates and tips. CareCentrix uses email Newsflashes to communicate with the provider network.

You can sign up for Newflashes by adding your email address and click **Subscribe.**

CareCentrix HomeBridge Administrators and users will receive newsflashes. Please ensure that you read them when they reach your inbox.

Some Newsflashes can be viewed in archives in the CareCentrix HomeBridge Application. To see an archive of the news, you can click Newsflash archive

Module 7: Contact Us



Module 7 | Contact Us: Slide 1 of 2

Reason for Contact	Resource	Contact Information
Authorizations		
Initial Authorization	CareCentrix HomeBridge	www.CareCentrixPortal.com
Add-On Requests		
Re-Authorization		
Authorization Edits		
Authorization Status		
Other	Care & Services Center	All Other Plans: (877) 466-0164 Aetna Florida and Georgia: (888) 999-9641 Horizon: (855) 243-3321 Florida Blue: (877) 561-9910 or FLBlueAuthInquiry@carecentrix.com Cigna: (844) 457-9810
Claims and Payment		
Claims Status	CareCentrix HomeBridge Application	www.CareCentrixPortal.com
Denial Questions	Network Services Team	(877) 725-6525
Appeal Status		
Rejection Questions	EDI Support Team	EDISupport@CareCentrix.com
Claims Inquiries	CareCentrix HomeBridge Application	www.CareCentrixPortal.com
Reconsideration and Appeals Forms		
Register for EDI		
EFT and ERA Enrollment		

These are the contacts and resources available to you at CareCentrix.
Please ensure that you are contacting the appropriate contacts for the right reasons!

Many of your questions can be answered by navigating to HomeBridge and reviewing the resources documents available to you.
CareCentrix recommends that for most inquiries accessing the HomeBridge resources should be your first action to find answers.

Module 7 | Contact Us: Slide 2 of 2

Reason for Contact	Resource	Contact Information
CareCentrix HomeBridge Application		
Admin Accounts: Create or Unlock	Network Management	Click here for Network Management Contacts
User Accounts: Create , Reset, or Unlock	HomeBridge Admin at your agency	HomeBridge Admin at your agency
HomeBridge Questions	HomeBridge Info Box	Portalinfo@CareCentrix.com
Other		
Transition of Care	Transition Team	1 -866- 776-4617
CareCentrix Direct	HomeBridge	www.carecentrixportal.com
Provider Information Updates	Credentialing Department	Contract.Department@CareCentrix.com
Compliance Concerns	Compliance Hotline	(877) 848-8229
Policies and Processes	Provider Manual	Click here to access the Provider Manual
Contractual Questions	Network Management	Click here for Network Management Contacts
Provider Education	HomeBridge	www.carecentrixportal.com
Adverse Events	Specialty Nursing Team	**1- 888-428-4282**

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These are other contacts and resources available to you at CareCentrix.
Please ensure that you are contacting the appropriate contacts for the right reasons!

Module 8: Summary and Next Steps

Module 8 | Summary & Next Steps

Things to Remember

1. Prior authorization/registration is required for services. Authorization/Registration is not a guarantee of payment.
2. Providers must verify eligibility and benefits with the patient's Health Plan prior to rendering services. For Blue Card members, Providers must obtain authorization from the Home Plan when required prior to rendering services.
3. The timely filing limit for an initial clean claim is 60 days from the date of service (or, as required by applicable law).
4. CareCentrix is responsible for collecting all applicable co-pays, co-insurances, and deductibles.
5. Contacts and resources are available to you!

Module 8 | Summary & Next Steps

Things to Do

- Obtain **CareCentrix HomeBridge** access:
  - If you are a HomeBridge user, contact the administrator at your agency to register for an account in the CareCentrix HomeBridge Application
  - If you are a HomeBridge Administrator, contact **Portal Info** box to register for an account in the CareCentrix HomeBridge Application
- Register for **EFT/ERA**
- Register for **CareCentrix Direct**
- Register for **EDI**
- Familiarize yourself with available resources in the CareCentrix HomeBridge Application **Education Center**
- Complete our **Training Survey**

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Module 7 | Thank You!

Questions?

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We are so happy to have you working with us and making our network of Providers even stronger.

We look forward to our partnership as we work together to create “a world where anyone can heal or age at home” a reality.