New Provider Orientation

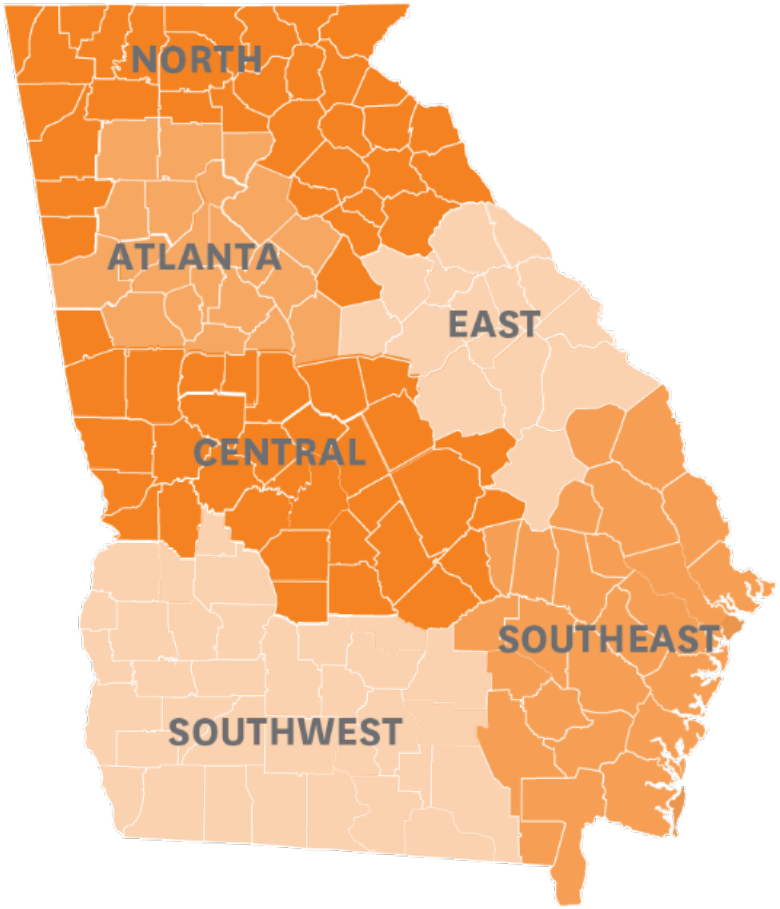
Provider Relations Department

2026

peach state health plan

Agenda

- Peach State Health Plan Overview
- Peach State Health Plan Service Model
- Provider Resources
- Provider Responsibilities
- Verification of Member Eligibility
- Utilization Management/Prior Authorization
- Authorization Appeal Process
- Claim Submission & Payment
- Claim Reconsideration/Appeal Process
- Specialty Companies/Vendors
- Behavioral Health Clinical Training
- Contact Information



Care Management Organization (CMO) since 2006

Subsidiary of CENTENE® Corporation

Georgia Families Program

What is Georgia Families?

Georgia Families® is a program that delivers health care services to members of Medicaid and PeachCare for Kids®. The program is a partnership between the Department of Community Health (DCH).

Planning for Healthy Babies®

Planning for Healthy Babies® is a program from Georgia Department of Community Health.

Planning for Healthy Babies® offers no cost family planning services. The Planning for Healthy Babies program consists of three services:

- Family Planning (FP)
  - Only includes family planning services.
- Inter-pregnancy Care (IPC)
  - Inter-pregnancy includes family planning and additional services for women who have delivered a very low birth weight (VLBW) baby.
- Resource Mother
  - Resource Mother is a case management service for women who have delivered a VLBW baby.

Members can apply online at www.gateway.ga.gov or pick up an application at their local:

- Public Health Department
- Division of Family and Children Services (DFCS) office
- Applications are also available at Federally Qualified Health Centers

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Provider Resources

What Resources are Available to our Providers?

- Dedicated Provider Engagement Administrator Contact
- Provider Servicing
- Provider Secure Portal (Availity – web portal of choice)
- Online Provider Training Library
- Provider Communications
- Clinical Teams
- Community Health Services Team
- Quality Practice Advisor - HEDIS Education
- Provider Practice Risk Adjustment Education Team
- Pharmacy Provider Liasion

Provider Engagement Administrator

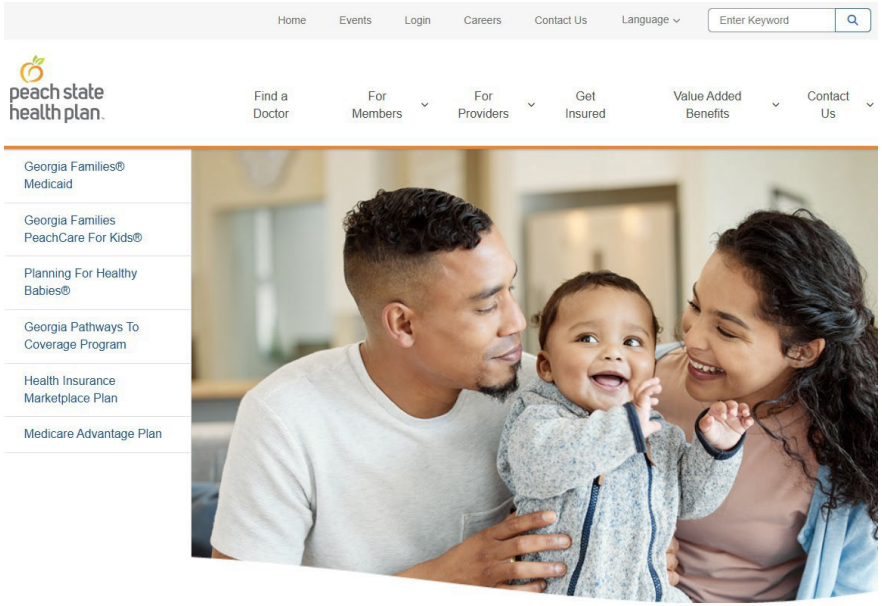
- Serves as the primary liaison between the Plan and our provider network
- Coordinate and conduct ongoing provider education, updates and training
- Clarify plan reimbursement and operational policies
- Demographic Information Update
- Member/Provider roster questions
- Assist in Provider Portal registration and education
- Appointment Agenda Education/Support

Quality Practice Advisors

- The Quality Practice Advisors will assist with:
- HEDIS measure education
- Resources available to support HEDIS gap closure in your office
- Education on the improved reporting and accessibility of data through new reporting tools. (i.e., Provider Analytics, Patient Analytics, Availity)
- Incentive Programs

Public Website

- Located at www.pshp.com
- Find-A-Provider Directory
- Quick Reference Materials
- Provider Relations Territory List
- Reimbursement Policies
- Provider Training Materials
- Preferred Drug List
- Pharmacy Forms & Notifications
- Provider Manual
- Provider Newsletters
- Quality Improvement Program



Secure Portal Features

- Multi-product line and tax id support
- Member Eligibility Check
- Authorization Submission and Authorization Status Check
- Claim Submission and Claim Status Check
- Claim Dispute Submission
- View Explanation of Payment and Payment History
- PCP Patient List
- Care Gap, Disease Management and Case Management Reporting
- Access to CCA Tool
- Comprehensive Member Health Record
- Claim Audit Tool
- Secure Messaging to the Provider Services Team

It's all part of the Members plan

Coverage that covers more

Vision & Pharmacy

Adult Vision
Eligible members 21 and over qualify for one FREE eye exam and $100 to choose glasses outside of your Medicaid coverage, including upgrades.

Over the Counter Medicine (OTC)
Receive up to $240 in health items mailed to your home or schedule for pick-up at participating CVS stores.

Healthy Moms & Babies

FREE Electric Breast Pump for breastfeeding moms.

Eligible members can receive a car seat and diapers after completing both their prenatal and postpartum visits.

Mom's Meals® Delivery Program
Mom's Meals® is a home-delivered meals program for members enrolled in care management programs* and who qualify for Drivers of Health.

Baby Showers
Community showers are held quarterly throughout the state to provide members with information on prenatal and post-delivery care. These events also offer members a chance to participate in a raffle and win prizes.

Healthy Adults

Members ages 21 and older can receive a membership to Costco or Sam's Club.

Gym Membership
Members ages 13 and older have the option to choose an annual gym membership or an at-home fitness program.

Healthy Rewards

Wellness Wins Rewards Program
Eligible members can earn rewards by completing wellness activities.

Quarterly Raffle
Eligible members ages 3 to 21 who recently completed their well visit will be entered into our quarterly raffle for a chance to win the latest iPad®, Apple Watch®, PlayStation® 5, Nintendo Switch™, or Xbox One®

It’s all part of the Members plan

Coverage that covers more

Healthy & Active Children Programs

Boys & Girls Clubs® Membership*
Enjoy youth development programs, and fun activities during the school year at participating clubs. Qualified members grades K to 12 are eligible for annual membership fees.

Girl Scouts® Membership*
Qualified members grades K to 12 are eligible for annual memberships fees, including badge and patch supply fees.

Scouting America® Membership*
Qualified members ages 5 to 17 are eligible for annual memberships fees, includes *Scouts Life Magazine*.

Youth Activities*
This program covers arts, swimming lessons, sports, or STEAM after-school activities for qualified members ages 6 to 18, with up to $100 provided for uniforms and registration fees.

YMCA® Family Membership*
Eligible members can receive a six-month membership at participating YMCA® locations.

Childcare Support
Qualified members can receive emergency childcare support for children ages 0–11.

School Break Grocery Support
Eligible households can receive up to $75 for one child between the ages of 4 and 18 who is an active PSHP member and has completed their annual wellness exam.

Steps to Success

GED Benefits
GED vouchers are available for all eligible members ages 16 and older. Vouchers cover all four (4) GED tests.

Educational & Job Training Scholarships
Qualified members interested in attending a 2-year or 4-year college, vocational, technical, or trade program can apply for a $10,000 educational scholarship. The submission deadline is May 1, 2026 , and winners will be announced in July 2026.

College Bound Dorm Room Supplies
Qualified members considered college freshmen are eligible for a $300 gift card for their dorm room supplies. The submission deadline is May 1, 2026, and winners will be announced in July 2026.

Goodwill Industries Work-Ready Scholarships
Eligible members ages 18 and older may qualify for a Work-Ready Scholarship to help cover the cost of job training and employment certifications through Goodwill Industries. The submission deadline is November 1, 2025.

It’s all part of the Members plan

Coverage that covers more

And much more

Mental Health Support

Peach State Health Plan has partnered with Pyx Health, a digital app that provides mental health support to members ages 19 and older.

Hypoallergenic Bedding

Members with asthma or breathing issues can receive up to $100 per year for hypoallergenic bedding.

Visit **PickPeachState.com** to learn more. If you have any questions, please contact us at **1-800-704-1484** (TTY **1-800-255-0056**).

Clinical Care Management Services

Care Coordination/Care Management

- High Risk OB
- Adult/Pediatric Complex (Face to Face)
- ER
- Lead
- Sickle Cell Center of Excellence
- Behavioral Health
- Planning for Healthy Babies / Resource Mothers
- Transition of Care

Education & Disease Management

- Asthma
- Diabetes
- Hypertension
- Depression
- Substance Abuse

Innovative Programs/Services

- Start Smart for Your Baby
- Community Health Services
- Suicide Prevention Program
- Substance Abuse Program
- Perinatal Substance Abuse
- Social Determinants of Health Program

How to Contact Case/Disease Management

How can someone contact the Case Management Department?

- Case Management Contact Telephone Number: **1-800-504-8573**
- Case Management Email: **pshpcmdmreferrals@centene.com**
- Peach State Health Plan Website
- Case Management Fax: **1-866-532-8835**
- Peach State Health Plan Provider Portal

What are the Case Management Department Normal Business Hours?

- Monday through Friday **8:00AM-5:30PM EST**

How to Contact SDoH Department

How can I make a referral to the SDOH Department?

- SDOH Contact Telephone Number: **1-800-504-8573**
- Peach State Health Plan Web Portal
- Provider Referral Form: https://www.pshpgeorgia.com/providers/resources/forms-resources/chs-provider-referral-form.html

What is the Community Connection Helpline?

- A national, toll-free helpline for members, non-members and providers to access community resources across the state of Georgia by contacting them directly at 1-866-775-2192

What is the Peach State Health Plan Serves by FindHelp?

- A free Social Determinants of Health data base to find free and reduced cost services by zip code.
- https://peachstatehealthplan.findhelp.com/

What are the Social Determinants of Health Normal Business Hours?

- Monday through Friday **8:00AM-5:30PM EST**

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Provider Responsibilities

Provider Responsibilities

- **Peach State Health Plan's Provider Manual:** Review the manual and comply with the policies outlined in the manual.
- Provider accepts Members for treatment, unless they have a full panel and are accepting no new Georgia Families or commercial patients. Providers do not intentionally segregate Members in any way from other persons receiving services.
- Ensure Members are provided services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, health status, income status, or physical or mental disability.
- PCPs and Physicians delivering care to Peach State Health Plan members must ensure adult members 18 years of age and older receive information on advance directives and are informed of their right to execute advance directives.

Provider Responsibilities (cont'd)

- Prior-authorization requests may be submitted a maximum of thirty (30) days prior to the service/admission.
- Retroactive authorization request may be submitted for urgent services/admissions.
- Prior-Authorization requirements did not change with the implementation of the Centralized PA Portal. Providers are responsible for determining each CMO's prior-authorization requirements.
- Non-participating providers are eligible to submit authorization requests using the centralized portal.
- Peach State Health Plan has a Waste, Abuse and Fraud program that complies with state and federal laws. Peach State Health Plan, in conjunction with it's management company, Centene Corporation, operates a billing errors/waste, abuse and fraud unit. The confidential hotline is 1-866-685-8664

Appointment Availability Standards

Provider Type	Waiting Time
PCPs – Routine/Regular visit (Adult and Pediatric)	Not to exceed fourteen (14) calendar days
PCPs – Sick/Urgent (Adult)	Not to exceed twenty-four (24) clock hours
PCPs – Sick/Urgent (Pediatric)	Not to exceed twenty-four (24) hours
PCPs – Initial Pediatric health/screening check	Not to exceed ninety (90) calendar days of eligibility or within twenty-four (24) hours of birth (in the hospital) for all Newborns
Maternity care – • Pregnant Women- Initial visit • First Trimester • Second Trimester • Third Trimester	 • Not to exceed fourteen (14) calendar days from enrollment • Not to exceed fourteen (14) calendar days • Not to exceed seven (7) calendar days • Not to exceed three (3) business days

Appointment Availability Standards (cont'd)

Provider Type	Waiting Time
Specialists	Not to exceed thirty (30) calendar days
Therapy: Physical, Occupational, Speech, and Aquatic Therapists	Not to exceed thirty (30) calendar days
Vision (Delegated Vendor)	Not to exceed thirty (30) calendar days
Dental Providers Routine visit-(Delegated Vendor)	Not to exceed twenty-one (21) calendar days
Dental Providers-Urgent visit-(Delegated Vendor)	Not to exceed forty-eight (48) clock hours
Elective Hospitalizations	Thirty (30) calendar days

Appointment Availability Standards (cont'd)

Provider Type	Waiting Time
Mental Health Providers • Care is available for a non-life-threatening appointment • Urgent care appointment available for a patient • Initial visit for routine care • Follow-up Routine Care	 • Within six (6) hours • Within forty-eight (48) hours • Within ten (10) business days • Within ten (10) business days
Urgent Care provider	Not to exceed twenty-four (24) clock hours
Emergency provider	Immediately (twenty-four (24) clock hours a day/seven (7) days a week) without prior authorization
High Volume specialist: Ob/ Gyn (excludes Ob/Maternity care visit requirement) Urgent	• Not to exceed thirty (30) calendar days • Within seventy-two (72) hours
High Impact specialist: Oncology Urgent	• Not to exceed thirty (30) calendar days • Within seventy-two (72) hours

Appointment Availability Standards (cont'd)

Provider Type	Waiting Time
Scheduled Appointments	Waiting times shall not exceed 60 minutes. After 30 minutes, patient must be given an update on waiting time with an option of waiting or rescheduling appointment.
Walk-In Appointments	Waiting time shall not exceed 90 minutes. After 45 minutes, patient must be given an update on waiting time with an option of waiting or rescheduling appointment.

Provider Response Time For After Hour Calls

- Urgent Calls: Shall not exceed twenty (20) minutes
- Other Calls: Shall not exceed one (1) hour.

Providers must provide one of the following after-hours options:

- An Auto Attendant/Answering system that advises the member that urgent calls will be returned within 20 minutes and all other calls will be returned within one hour and the option to page the physician; or

- A live attendant/Advice nurse and/or answering service that advises the member that urgent calls will be returned within 20 minutes and all other calls will be returned within one hour and the option to page the physician.

Cultural Competency

- Cultural competency within Peach State Health Plan is defined as the willingness and ability of the organization to value the importance of culture in the delivery of services to all segments of the population. It is the use of a systems perspective which values differences and is responsive to diversity at all levels.

- Information on Peach State Health Plan's Cultural Competency Plan can be found on our website, www.pshp.com.

- Peach State Health Plan offers Interpreter and Translation services both onsite and via telephone. Provider should call Member Services for assistance with interpreters at 1-800-704-1484.

- Language Line services are available in 140 languages to assist providers and enrollees in communicating with each other when there are no other translators available for the language.

- TTY access is available for enrollees who are hearing impaired through 1-800-255-0056.

Authorizations Overview

How can I determine if a service requires prior authorization?

- Pre-Auth Check Tool: https://www.pshpgeorgia.com/providers/preauth-check.html
- Peach State Health Plan Prior Authorization Guidelines (PSHP website)

What channels are available for prior authorization request submission?

- DCH Centralized Prior Authorization Portal: https://www.mmis.georgia.gov
- Peach State Health Plan Provider Secure Portal: https://provider.pshpgeorgia.com/
- Fax
- Pharmacy authorizations for retail or specialty medications can be submitted via CoverMyMeds: https://oidc.covermymeds.com/login

What is the turnaround time to process an authorization request?

- Standard – Up to 3 business days
- Expedited – Within 24 hours

What is required for an authorization request to be considered expedited?

The provider must indicate, or Peach State Health Plan must determine, that following the standard review timeframe could seriously jeopardize the Member's life, health or ability to attain, maintain or regain maximum function.

Prior Authorization

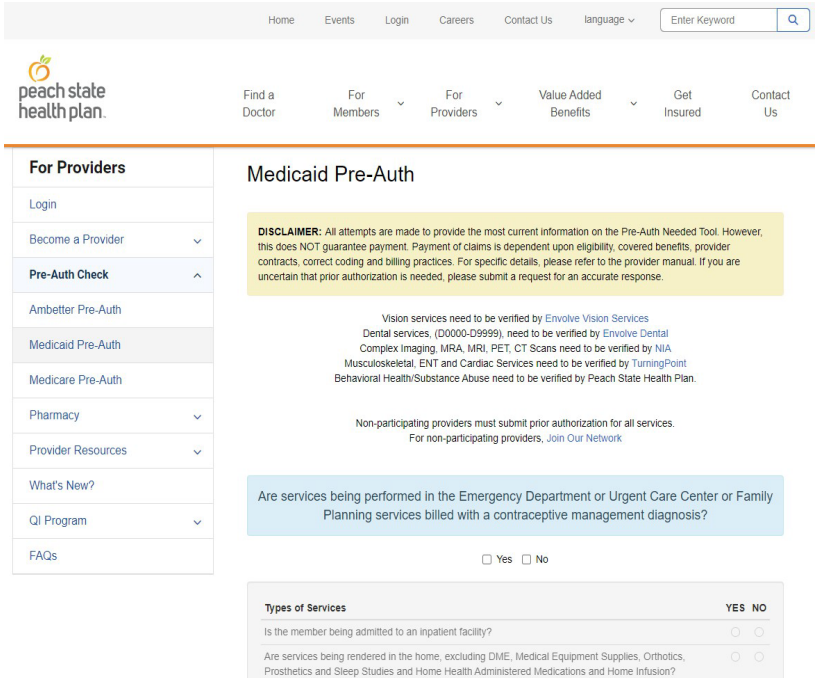
>93% of Services Do Not Require Prior Approval

- Peach State Health Plan is an open access health plan; no initial specialist referral needed
- Annual review of prior authorization requirements
- At least annually, Peach State Health Plan updates authorization requirements to ease administrative burden

PRIOR AUTHORIZATION SUMMARY
Place of Service
Office – POS 11
Inpatient – POS 21
Outpatient – POS 19 and 22
Ambulatory Surgery Center – POS 24

Pre-Authorization Tool

- The **Pre-Auth Tool** may be used to identify the prior authorization requirement of a service or procedure.
- A search may be conducted by CPT code or HCPCS code.
- The Pre-Auth Check Tool is located on the Peach State Health Plan website at: https://www.pshpgeorgia.com/providers/preauth-check.html
- Tool available for Medicaid, Medicare and Ambetter product lines.



Centralized PA Portal

The Centralized Prior-Authorization (PA) Portal was implemented by the Department of Community Health to streamline the prior authorization process for Georgia Medicaid providers by allowing providers to submit CMO and FFS authorizations in a centralized location.

Newborn delivery notification	In-state transplants
Inpatient hospital admissions and outpatient hospital or ambulatory surgical center procedures	Durable Medical Equipment
Hospital outpatient therapy (includes ambulatory surgical centers)	Children's Intervention Services
Outpatient Behavioral Health	Exclusions: Dental, vision, radiology and oncology treatment plans which include chemotherapy or radiation are processed by third party vendors
Pregnancy notification	

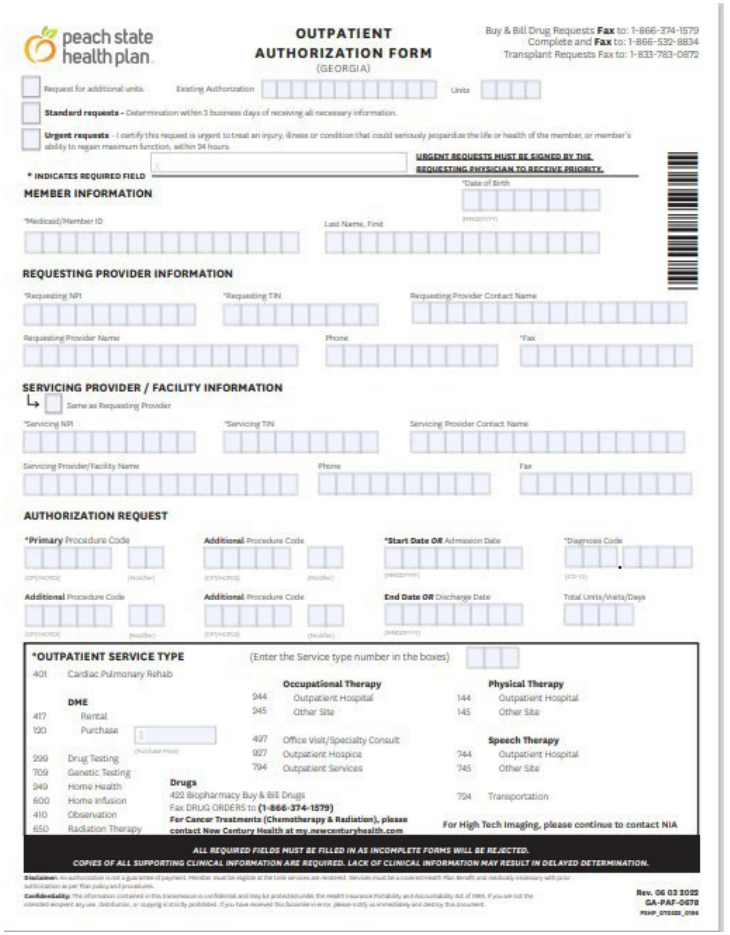
- How can a provider access the Centralized PA Portal? www.mmis.georgia.gov
- Where can Centralized PA Portal training be obtained? The Provider Education section of the GAMMIS website (www.mmis.georgia.gov)

Centralized PA Portal Facts

- Both standard and expedited prior authorization requests may be submitted using the centralized portal. Requests will be subject to traditional processing times.
- Prior-authorization requests may be submitted a maximum of thirty (30) days prior to the service/admission.
- Providers are responsible for determining each CMO's prior authorization requirements.
- Non-participating providers are eligible to submit authorization requests using the centralized portal.

PA Request Submission: Fax

- **Faxed authorization requests must be submitted using the Peach State Health Plan Inpatient or Outpatient Fax Forms.**
- Forms may be typed.
- A new copy of the form must be used for each prior authorization request. No photocopies.
- Faxed requests should be submitted to the UM department fax number associated with the product line.
- Faxed requests should only be submitted if the Centralized PA Portal is unavailable.



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OUTPATIENT AUTHORIZATION FORM
(GEORGIA)

Buy & Bill Drug Requests **Fax** to: 1-866-374-1579
Complete and **Fax** to: 1-866-532-8834
Transplant Requests Fax to: 1-833-783-0872

Request for additional units. Existing Authorization Units

Standard requests - Determination within 3 business days of receiving all necessary information.

Urgent requests - I certify this request is urgent to treat an injury, illness or condition that could seriously jeopardize the life or health of the member, or member's ability to regain maximum function, within 24 hours.

* INDICATES REQUIRED FIELD

URGENT REQUESTS MUST BE SIGNED BY THE REQUESTING PHYSICIAN TO RECEIVE PRIORITY.

MEMBER INFORMATION

*Date of Birth (MM/DD/YYYY)

*Medicaid/Member ID

Last Name, First

REQUESTING PROVIDER INFORMATION

*Requesting NPI *Requesting TIN Requesting Provider Contact Name

Requesting Provider Name Phone *Fax

SERVICING PROVIDER / FACILITY INFORMATION

Same as Requesting Provider

*Servicing NPI *Servicing TIN Servicing Provider Contact Name

Servicing Provider/Facility Name Phone Fax

AUTHORIZATION REQUEST

*Primary Procedure Code (CPT/HCPCS) (Modifier)

Additional Procedure Code (CPT/HCPCS) (Modifier)

*Start Date OR Admission Date (MM/DD/YYYY)

*Diagnosis Code (ICD-10)

Additional Procedure Code (CPT/HCPCS) (Modifier)

Additional Procedure Code (CPT/HCPCS) (Modifier)

End Date OR Discharge Date (MM/DD/YYYY)

Total Units/Visits/Days

***OUTPATIENT SERVICE TYPE** (Enter the Service type number in the boxes)

401 Cardiac Pulmonary Rehab

DME
417 Rental
100 Purchase $ (Purchase Price)

299 Drug Testing
709 Genetic Testing
949 Home Health
600 Home Infusion
410 Observation
650 Radiation Therapy

Occupational Therapy
944 Outpatient Hospital
945 Other Site

497 Office Visit/Specialty Consult
927 Outpatient Hospice
794 Outpatient Services

Drugs
420 Biopharmacy Buy & Bill Drugs
Fax DRUG ORDERS to **(1-866-374-1579)**
For Cancer Treatments (Chemotherapy & Radiation), please contact New Century Health at my.newcenturyhealth.com

Physical Therapy
144 Outpatient Hospital
145 Other Site

Speech Therapy
744 Outpatient Hospital
745 Other Site

724 Transportation

For High Tech Imaging, please continue to contact NIA

ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED.
COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION.

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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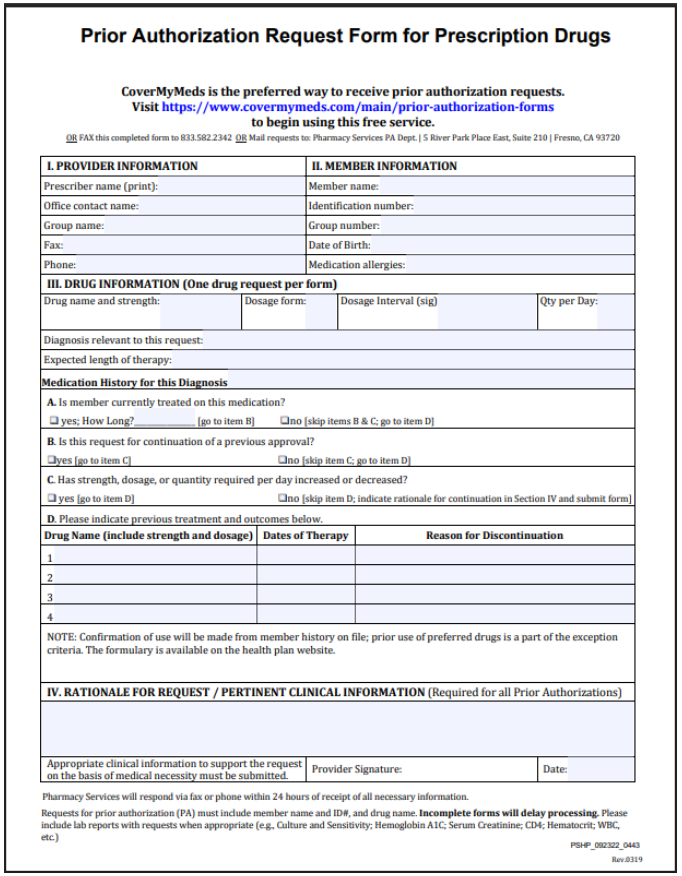
PA Request Submission: Pharmacy Services

- **Pharmacy Retail & Specialty medication** PA requests should be submitted using the **CoverMyMeds.com portal.**
- **Provider Administered Medications** billed on medical claims and requiring PA should be submitted using the standard **process for Outpatient Services**.
- **Oncology Treatment Plans** (chemotherapy and/or radiation) should be submitted directly to **Evolent** (fka New Century Health)
- Faxed requests using the Medication Prior Authorization Request form should be sent to the Pharmacy Services fax number.
- Faxed requests should only be submitted if CoverMyMeds.com is unavailable.



Prior Authorization Request Form for Prescription Drugs

CoverMyMeds is the preferred way to receive prior authorization requests.
Visit https://www.covermymeds.com/main/prior-authorization-forms to begin using this free service.

OR FAX this completed form to 833.582.2342 OR Mail requests to: Pharmacy Services PA Dept. | 5 River Park Place East, Suite 210 | Fresno, CA 93720

I. PROVIDER INFORMATION	II. MEMBER INFORMATION
Prescriber name (print):	Member name:
Office contact name:	Identification number:
Group name:	Group number:
Fax:	Date of Birth:
Phone:	Medication allergies:

III. DRUG INFORMATION (One drug request per form)

Drug name and strength:	Dosage form:	Dosage Interval (sig)	Qty per Day:

Diagnosis relevant to this request:

Expected length of therapy:

Medication History for this Diagnosis

A. Is member currently treated on this medication?
❑ yes; How Long? _____ [go to item B] ❑no [skip items B & C; go to item D]

B. Is this request for continuation of a previous approval?
❑yes [go to item C] ❑no [skip item C; go to item D]

C. Has strength, dosage, or quantity required per day increased or decreased?
❑ yes [go to item D] ❑no [skip item D; indicate rationale for continuation in Section IV and submit form]

D. Please indicate previous treatment and outcomes below.

Drug Name (include strength and dosage)	Dates of Therapy	Reason for Discontinuation
1		
2		
3		
4		

NOTE: Confirmation of use will be made from member history on file; prior use of preferred drugs is a part of the exception criteria. The formulary is available on the health plan website.

IV. RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION (Required for all Prior Authorizations)

Appropriate clinical information to support the request on the basis of medical necessity must be submitted.	Provider Signature:	Date:

Pharmacy Services will respond via fax or phone within 24 hours of receipt of all necessary information.

Requests for prior authorization (PA) must include member name and ID#, and drug name. **Incomplete forms will delay processing.** Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)

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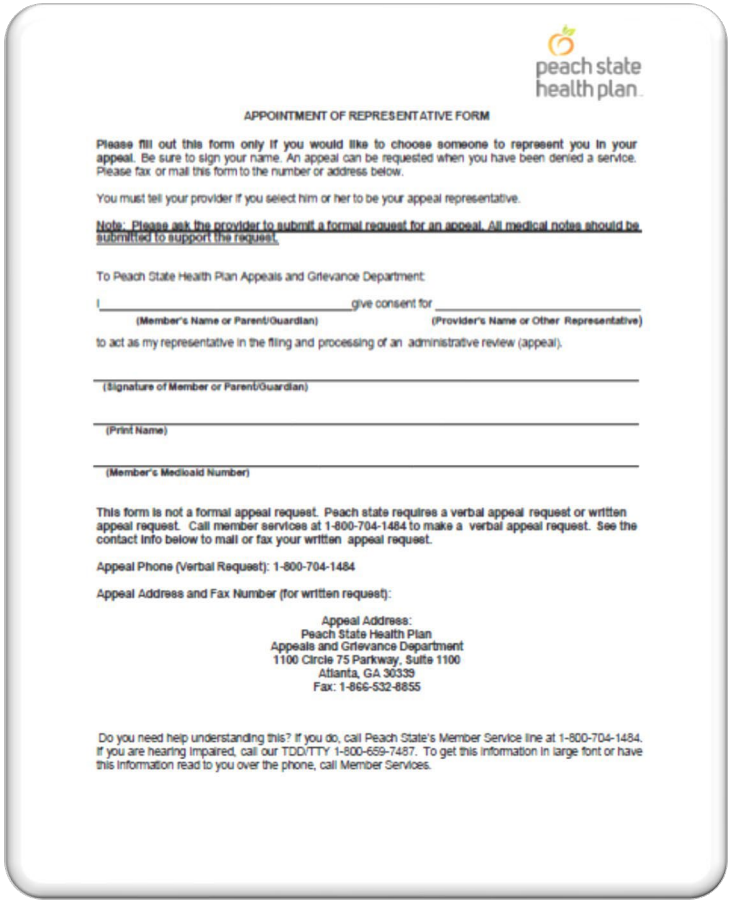
Appeals

- An Appeal is a formal request for the review of an adverse authorization determination.
- An adverse authorization decision is a denied, partially-denied or reduce authorization determination.
- A Notice of Adverse Benefit Determination (letter) is issued to the provider and the member when an adverse authorization determination is received.
- An appeal request must be submitted within sixty (60) calendar days from the date of the Notice of Adverse Benefit Determination to be considered timely.



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APPOINTMENT OF REPRESENTATIVE FORM

Please fill out this form only if you would like to choose someone to represent you in your appeal. Be sure to sign your name. An appeal can be requested when you have been denied a service. Please fax or mail this form to the number or address below.

You must tell your provider if you select him or her to be your appeal representative.

Note: Please ask the provider to submit a formal request for an appeal. All medical notes should be submitted to support the request.

To Peach State Health Plan Appeals and Grievance Department:

I _____ give consent for _____
(Member's Name or Parent/Guardian) (Provider's Name or Other Representative)

to act as my representative in the filing and processing of an administrative review (appeal).

_____
(Signature of Member or Parent/Guardian)

_____
(Print Name)

_____
(Member's Medicaid Number)

This form is not a formal appeal request. Peach state requires a verbal appeal request or written appeal request. Call member services at 1-800-704-1484 to make a verbal appeal request. See the contact info below to mail or fax your written appeal request.

Appeal Phone (Verbal Request): 1-800-704-1484

Appeal Address and Fax Number (for written request):

Appeal Address:
Peach State Health Plan
Appeals and Grievance Department
1100 Circle 75 Parkway, Suite 1100
Atlanta, GA 30339
Fax: 1-866-532-8855

Do you need help understanding this? If you do, call Peach State's Member Service line at 1-800-704-1484. If you are hearing impaired, call our TDD/TTY 1-800-659-7487. To get this information in large font or have this information read to you over the phone, call Member Services.

Appeals (con't)

- An appeal request may be submitted by:
  - Member
  - Authorized Representative of the Member
  - Provider with member's written consent or a completed Appointment of Representative Form
  - A legal entity of a deceased member's estate
- Appeal requests may be submitted via phone, fax or mail.
- Verbal request for an appeal must be followed with a written request from the member or the member's Representative with the member's written consent.
- A signed Appointment of Representative Form must be used by the provider to obtain the member's written consent.
- Faxed requests should be submitted to: 1-866-532-8855

Expedited Appeals

- An expedited appeal request may be submitted if a decision on an appeal is required immediately based on a member's health needs.
- A provider may submit a request for an expedited appeal by calling Peach State Health Plan Provider Services at 1-866-874-0633.
- The expedited review request will be reviewed, and a determination will be provided in writing within 72 hours or as expeditiously as the member's health requires.
- An expedited review may be reclassified as a standard appeal if there is not sufficient evidence that an expedited review is required.
- If the review is reclassified as a standard review the requestor will be notified by telephone immediately and a letter will be sent within two (2) calendar days advising that the appeal will be reviewed through the standard review process.

Administrative Law Hearing

- An **Administrative Law Hearing (ALH)** is the final step in the authorization appeal process. (if the service authorization request continues to be denied)
- If the member is not satisfied with the Adverse Benefit Appeal Review Determination, the member or the Provider with the member's written consent may request an Administrative Law Hearing within 120 days of the date on the Adverse Benefit Determination
- All request for an Administrative Law Hearing must be submitted in writing to:

  Peach State Health Plan
  Attn: Administrative Law Hearing Coordinator
  1100 Circle 75 Parkway, Suite 1100
  Atlanta, GA 30339

Specialty Company/Vendors

Service	Specialty Company/Vendor	Contact Information
High Tech Imaging Services	Evolent (fka National Imaging Associates)	1-888-642-4723 www.radmd.com
Vision Services	Envolve Vision	1-866-458-2139 https://visionbenefits.envolvehealth.com/
Dental Services	Envolve Dental	1-844-464-5632 https://dental.envolvehealth.com/
Retail Pharmacy Services	Pharmacy Services	1-866-399-0928 (PA line) https://www.covermymeds.com
Retail Pharmacy Claims	Express Scripts Inc (ESI)	1-833-750-4403 https://prc.express-scripts.com
Chemotherapy, Radiation	Evolent (fka New Century Health)	1-888-999-7713 https://www.newcenturyhealth.com/

peach state health plan™

Claims

Claim Submission

Peach State Health Plan offers the following claim submission options:

1. Provider Secure Portal: https://provider.pshpgeorgia.com

2. EDI/Clearinghouse: Payor ID 68069*

3. Mail /Paper claim submission:

   Peach State Health Plan
   P.O. Box 3030
   Farmington, MO 63640-3812

Claim Submission Timelines

Claim Type	Timely Submission Deadline
Original Claim	Six (6) months from the date of service
Corrected Claim	Six (6) months from the month in which the service was rendered or three months (3) from the month in which the denial occurred, whichever is later.
Claim Reconsideration	Six (6) months from the month in which the service was rendered or three months (3) from the month in which the denial occurred, whichever is later.
Claim Appeal	30 Days from the Claim Reconsideration Denial Date
Claim Life Cycle	Claims submissions and adjustments to denied claims completed within 365 days.
Administrative Law Hearing (ALH)	15 days from the Claim Appeal Denial
Secondary (COB) Claim	Within one (1) year from date of service

Claim Submission Timelines (cont'd)

"Clean" Claims:

- **Clean Claims** are defined as claims received by Peach State Health Plan for adjudication, in a nationally accepted format in compliance with standard coding guidelines which require no further information, adjustment or alternation to be processed for payment.
- Clean Claims will be adjudicated within 15 business days from the date of receipt.

"Non-clean" Claims

- **Non-clean claims** are submitted claims that required further information or investigation for processing.
- Non-clean claims may be subject to a front-end rejection.
- Non-clean claims will be adjudicated (finalized as paid or denied) within thirty (30) business days from the date of submission.

Claims Payment

PaySpan

- Peach State Health Plan partners with PaySpan for Electronic Remittance Advice (ERA) and Electronic Funds Transfer (EFT).

- The following options are available for PaySpan registration:
  - Phone: 1-877-331-7154
  - Web: https://www.payspanhealth.com/

Claim Submission Policies

- **CLIA Requirement:** Peach State Health Plan requires that a valid and appropriate CLIA certification or waiver number be included on all professional claims that contain laboratory services.

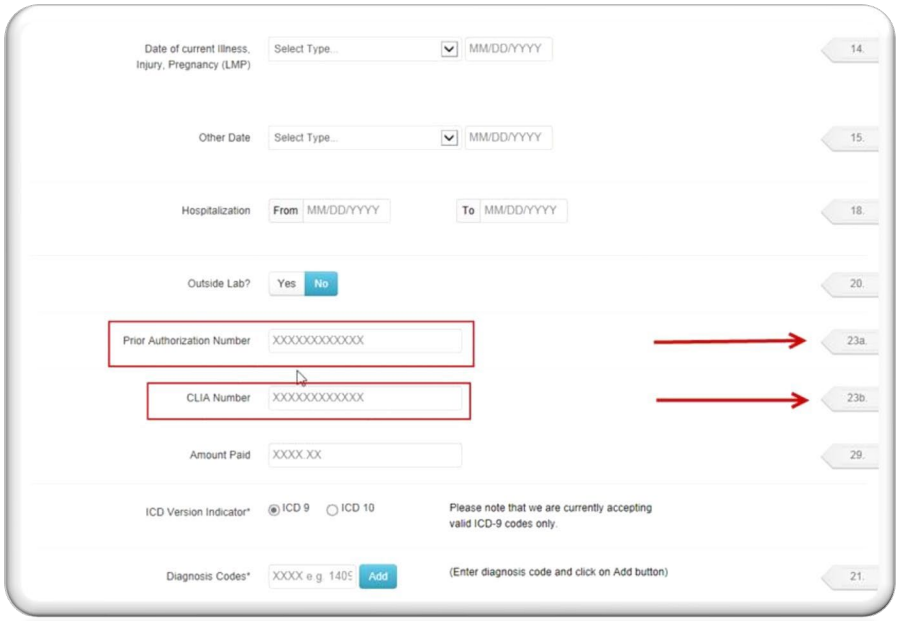
- **Ordering, Prescribing & Referring (OPR) Requirement:** In accordance with the Affordable Care Act, Peach State Health Plan currently edits medical claims for the presence of an Ordering, Referring or Prescribing Medicaid provider NPI.

- **Taxonomy Requirement**: Peach State Health Plan requires that all professional and facility claims be submitted with the applicable taxonomy code and qualifier code consistent with the provider's specialty.

- **Corrected Claim Submission**: Peach State Health Plan requires that all corrected claims be submitted with the appropriate claim resubmission code "7" and the original claim number. Claims should be free of handwriting.

CLIA Requirement

- The **CLIA Number** is required on the CMS 1500 claim form in all instances in which a CLIA waived or CLIA certified laboratory service is billed.
- The CLIA number should be populated in **Box 23** on a paper CMS 1500 claim.
- The CLIA number should be populated in **Box 23b** of the CMS 1500 claim form on the provider web portal.
- The CLIA number SHOULD supersede the authorization number on a paper claim.
- Failure to populate the CLIA number on the claim will result in a service denial.



Taxonomy: CMS-1500

Taxonomy Requirements:

- All claims are required to be submitted with the appropriate taxonomy code.
- Rendering and billing taxonomy are required on the claim.
- Referring taxonomy is conditionally required on the claim.
- Claims will be subject to a front-end rejection if taxonomy is omitted from the claim.

Rendering Taxonomy (Required)

Box 24i should contain the qualifier of "ZZ." Box 24j (shaded area) should contain the taxonomy code.

Billing Taxonomy (Required)

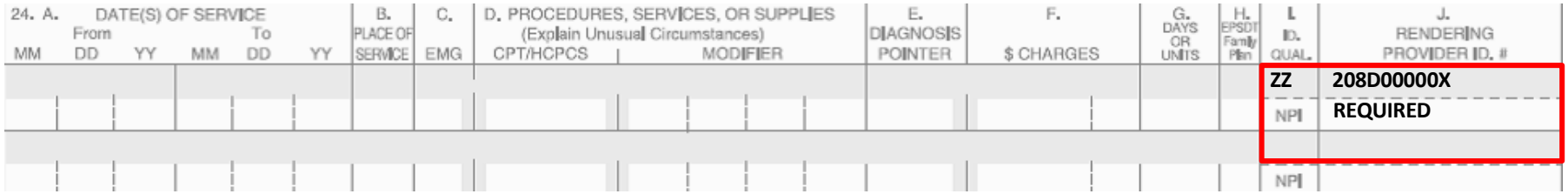
Box 33b should contain the qualifier of ZZ along with the taxonomy code.

Referring Taxonomy (Conditionally Required)

If field 17 is completed, then taxonomy is required in 17a with the "ZZ" qualifier.

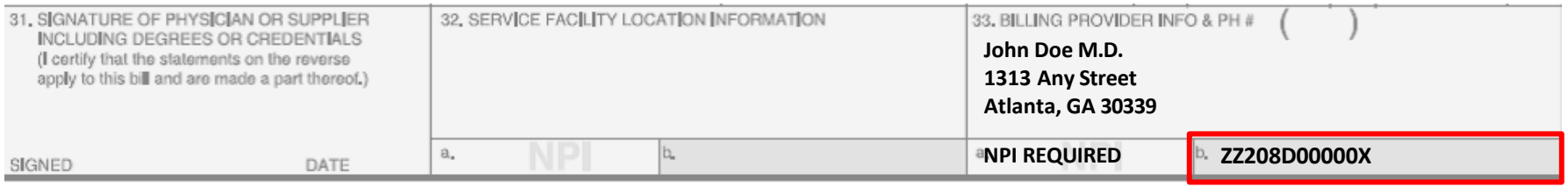
Taxonomy: CMS-1500 (cont'd)

Rendering Provider: Box 24i/24j



24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
														ZZ	208D00000X
														NPI	REQUIRED
														NPI	

Billing Provider: Box 33b



31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH # ( )
			John Doe M.D. 1313 Any Street Atlanta, GA 30339
SIGNED DATE	a. NPI	b.	a. NPI NPI REQUIRED	b. ZZ208D00000X

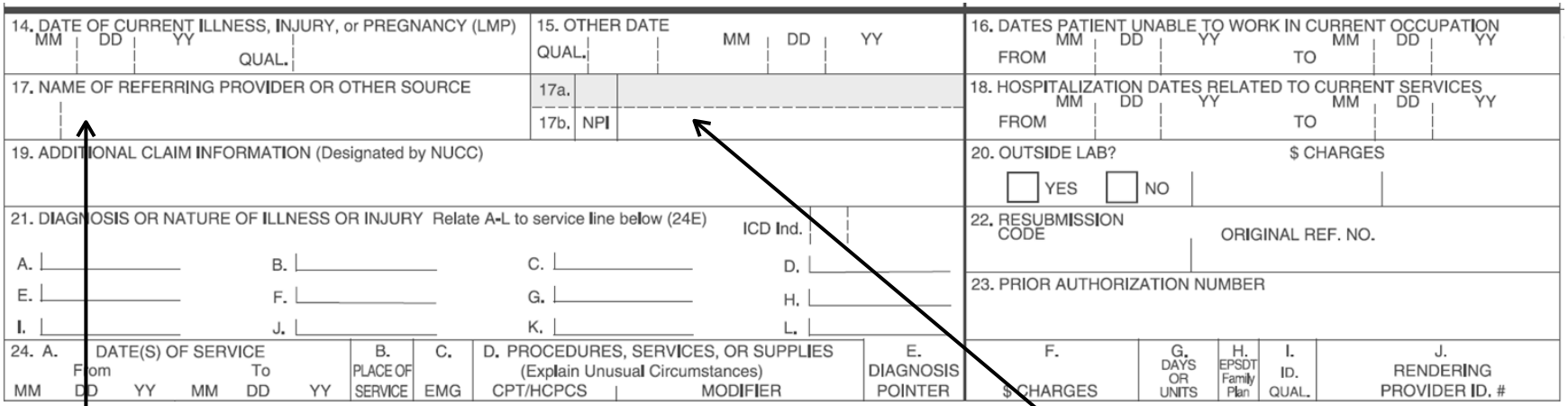
Taxonomy:
CMS-1500 (cont'd)

Referring Provider: Box 17a

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE **Jane Doe MD**	17a. **ZZ** **208D00000X**	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
	17b. NPI **REQUIRED**	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES NO $ CHARGES

OPR Requirement
CMS 1500 Claim Form

Enter the OPR information in Box 17 and Box 17b of the CMS 1500 claim form.



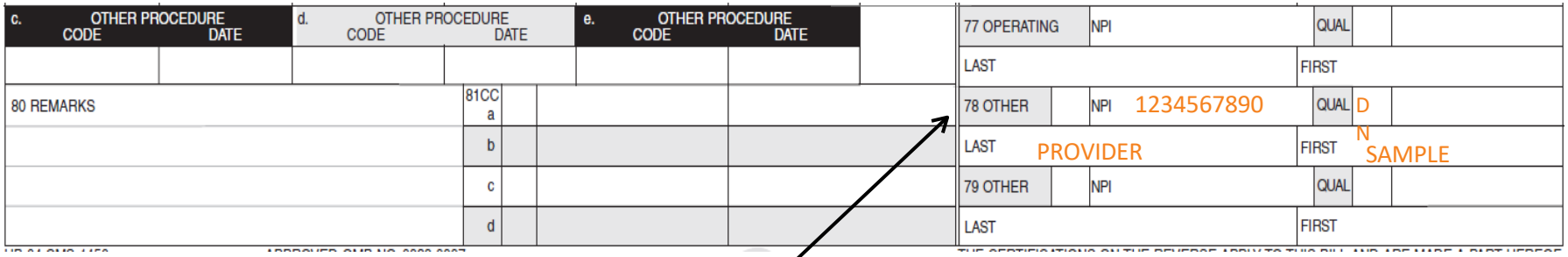
Box 17:

- Enter ordering, referring or supervising provider name to the right of the dotted line.
- Enter the 2-digit qualifier (ordering=DK, referring=DN, or supervising =DQ) to the left of the dotted line.
- Note: 2-digit qualifier not required for pharmacy claims.

Box 17b: Enter Individual Type 1 NPI number of the ordering, prescribing or referring provider.

OPR Requirement
UB-04 Claim Form

Enter the OPR information in Box 78 of the UB-04 claim form.



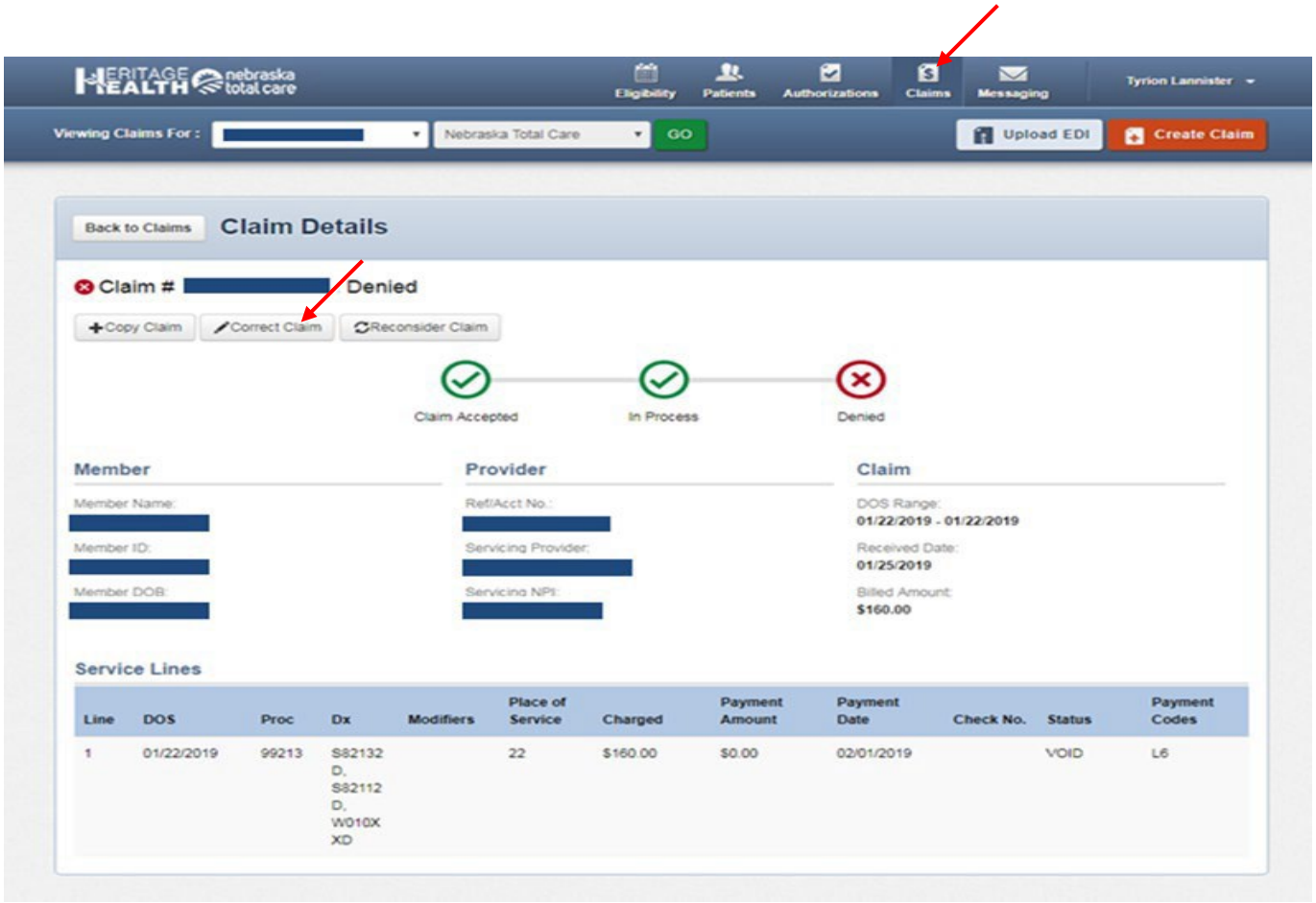
Box 78:

- Enter the ordering, referring or supervising provider's name and Individual Type 1 NPI number.
- Enter the 2-digit qualifier (ordering=DK, referring=DN, or supervising =DQ) in the box next to the "QUAL" field.

Corrected Claim Submission

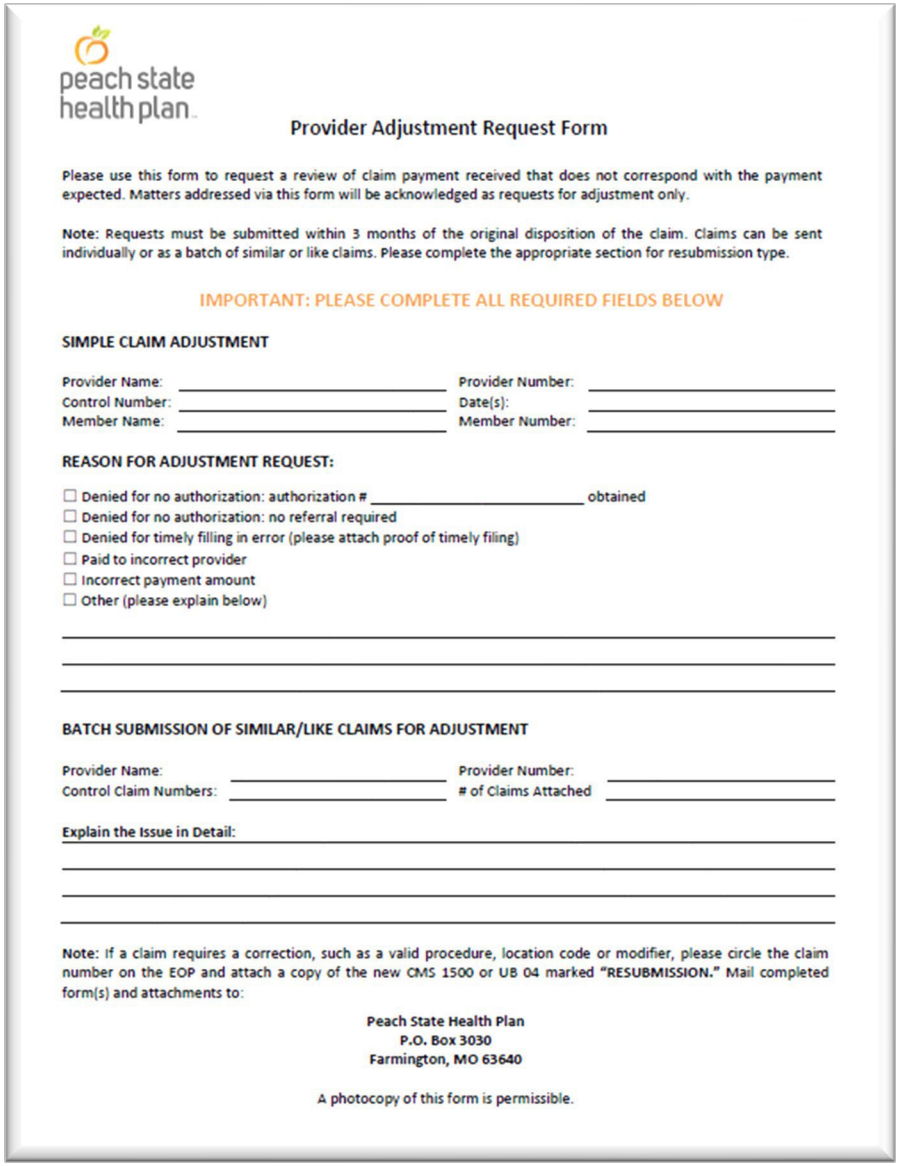
- A **corrected claim** may be submitted to correct or change information submitted on the original provider claim.
- Corrected claims are subject to timely filling deadlines and must be submitted within six (6) months from the month of service or within three months from the EOP, whichever is later.
- A corrected claim may only be submitted **after** the original claim has completed the adjudication process.
- Corrected Claim submission options:
  - Paper
  - Electronically: Provider Secure Portal or approved Clearinghouse
- The “Correct Claim” button on the claim detail screen should be used to correct a claim on the Provider Secure Portal.

Correct Claim: Web Portal



Claim Reconsiderations

- A **claim reconsideration** is a formal request to have a claim that has received an adverse determination "reconsidered."
- A claim reconsideration is the first step in the claim dispute process.
- Claims reconsiderations must be submitted within six (6) months from the month of the date of service or three (3) months from the claim denial (EOP), whichever is later.
- The **Provider Adjustment Request** form is used to submit a claim reconsideration request.



peach state health plan

Provider Adjustment Request Form

Please use this form to request a review of claim payment received that does not correspond with the payment expected. Matters addressed via this form will be acknowledged as requests for adjustment only.

Note: Requests must be submitted within 3 months of the original disposition of the claim. Claims can be sent individually or as a batch of similar or like claims. Please complete the appropriate section for resubmission type.

IMPORTANT: PLEASE COMPLETE ALL REQUIRED FIELDS BELOW

SIMPLE CLAIM ADJUSTMENT

Provider Name: _____ Provider Number: _____
Control Number: _____ Date(s): _____
Member Name: _____ Member Number: _____

REASON FOR ADJUSTMENT REQUEST:

☐ Denied for no authorization: authorization # _____ obtained
☐ Denied for no authorization: no referral required
☐ Denied for timely filling in error (please attach proof of timely filing)
☐ Paid to incorrect provider
☐ Incorrect payment amount
☐ Other (please explain below)

_____
_____
_____

BATCH SUBMISSION OF SIMILAR/LIKE CLAIMS FOR ADJUSTMENT

Provider Name: _____ Provider Number: _____
Control Claim Numbers: _____ # of Claims Attached _____

Explain the Issue in Detail: _____
_____
_____
_____

Note: If a claim requires a correction, such as a valid procedure, location code or modifier, please circle the claim number on the EOP and attach a copy of the new CMS 1500 or UB 04 marked **"RESUBMISSION."** Mail completed form(s) and attachments to:

Peach State Health Plan
P.O. Box 3030
Farmington, MO 63640

A photocopy of this form is permissible.

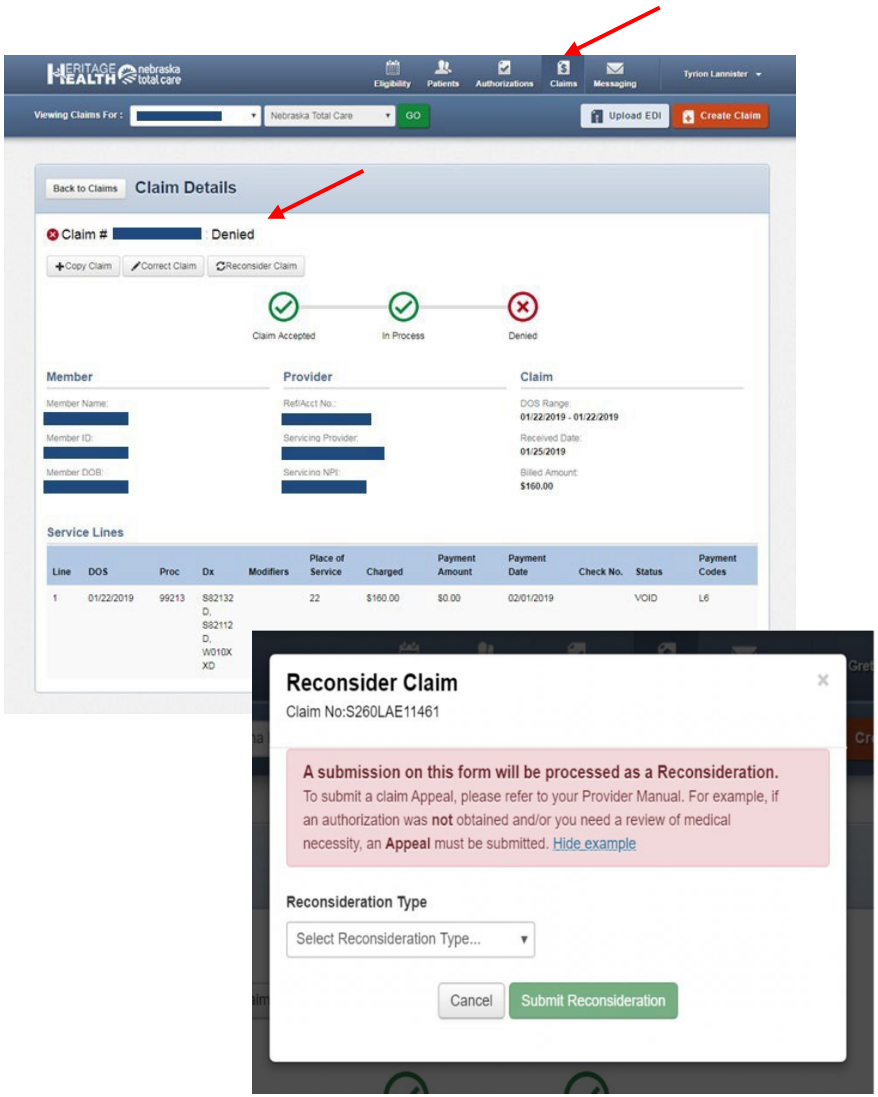
Claim Reconsiderations (cont'd)

- Claim reconsideration requests may be submitted electronically via the Provider Secure Portal or by mail.
- Mailed claim reconsideration requests should be submitted to:
  - Peach State Health Plan
  - PO Box 3030
  - Farmington, MO 63640-3812
- The Provider Adjustment Request Form is required for claim reconsideration requests submitted by mail and by provider secure portal.

Claim Reconsiderations (cont'd)

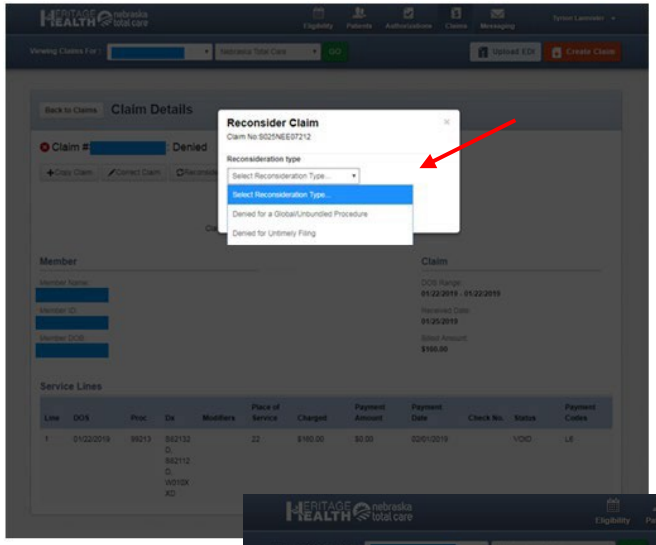
- Within the Claims tab, navigate to the Claim Details page of a paid or denied claim.
- The **Reconsider Claim** button will be visible unless a web-initiated reconsideration is already in progress.
- Select **Reconsider Claim** to open Reconsider Claim pop-up window with a Reconsideration type dropdown.

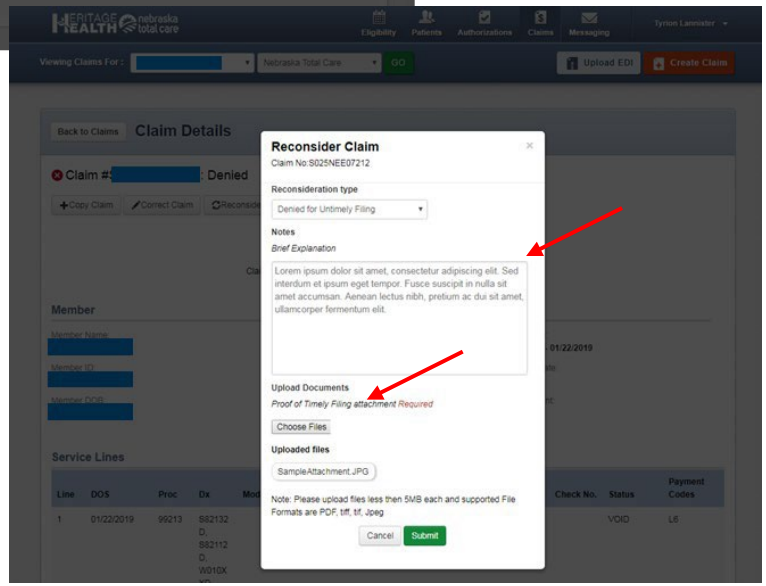
- **Please Note: Claims Tracker is only for Reconsiderations. Providers are not to use this for Appeals**



Claim Reconsiderations (con't)

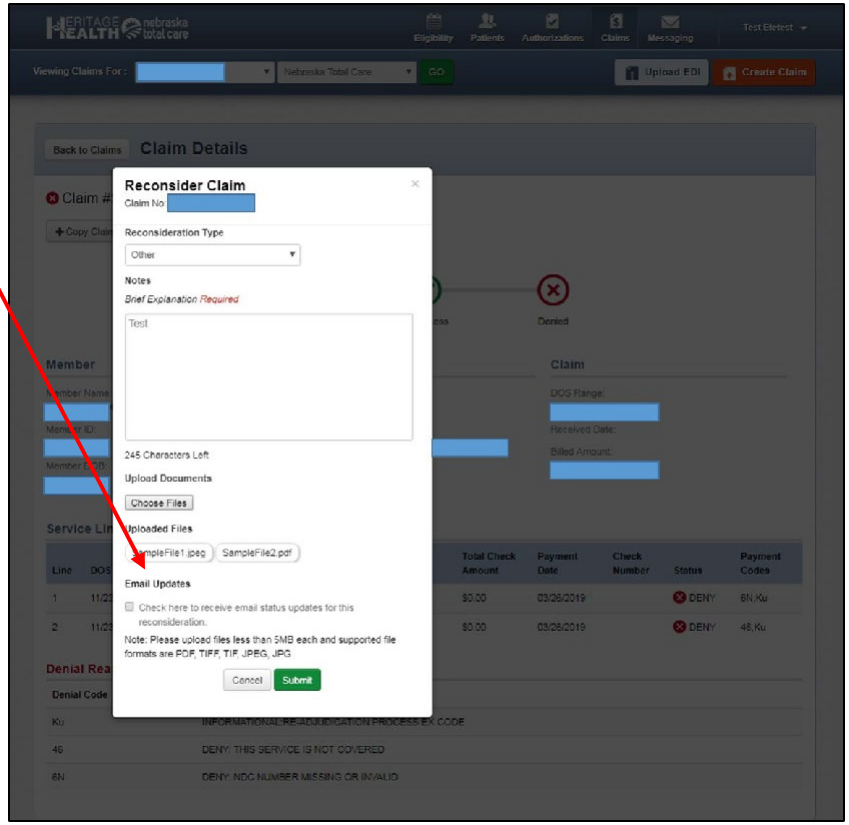
- From the dropdown, select a Reconsideration Type.
  - Examples:
    - "Denied for Global/Unbundled Procedure"
    - "Denied for Untimely Filing"
    - "Other"
- Ability to add notes and upload documents.
  - The form is dynamic; depending on the dropdown item selected, notes and/or documents may be required.





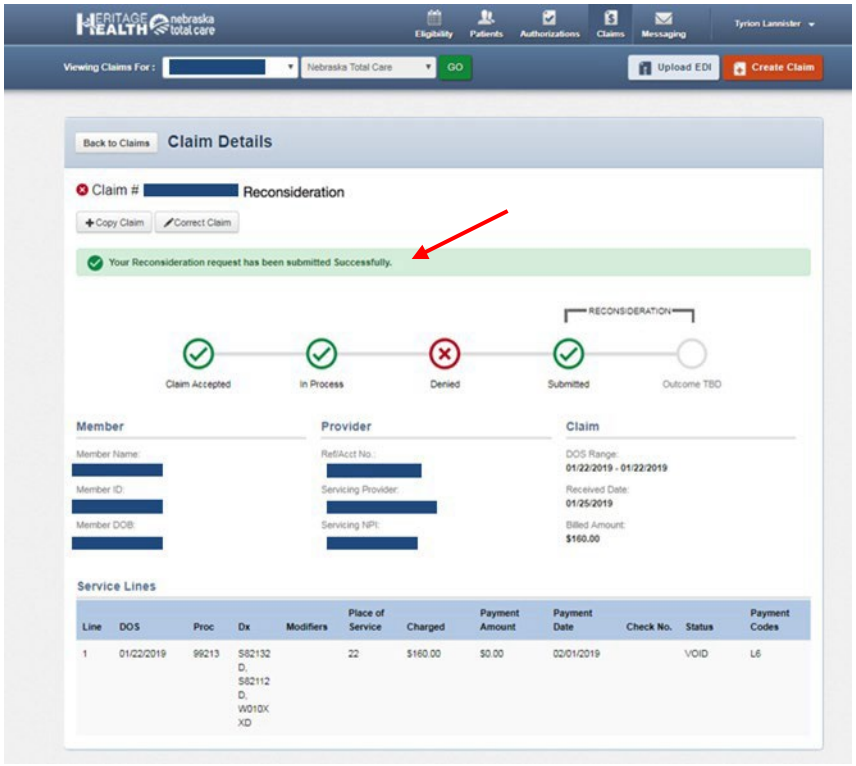
Claim Reconsiderations (con't)

- Providers may opt in or out of email updates using the **Email Updates checkbox**
- Email Updates are triggered when Reconsideration Letters are posted
- Provider's email address populates from portal
  - Not editable on form
- Emails will only generate for submitted cases
- Select **Submit** after populating all required fields.



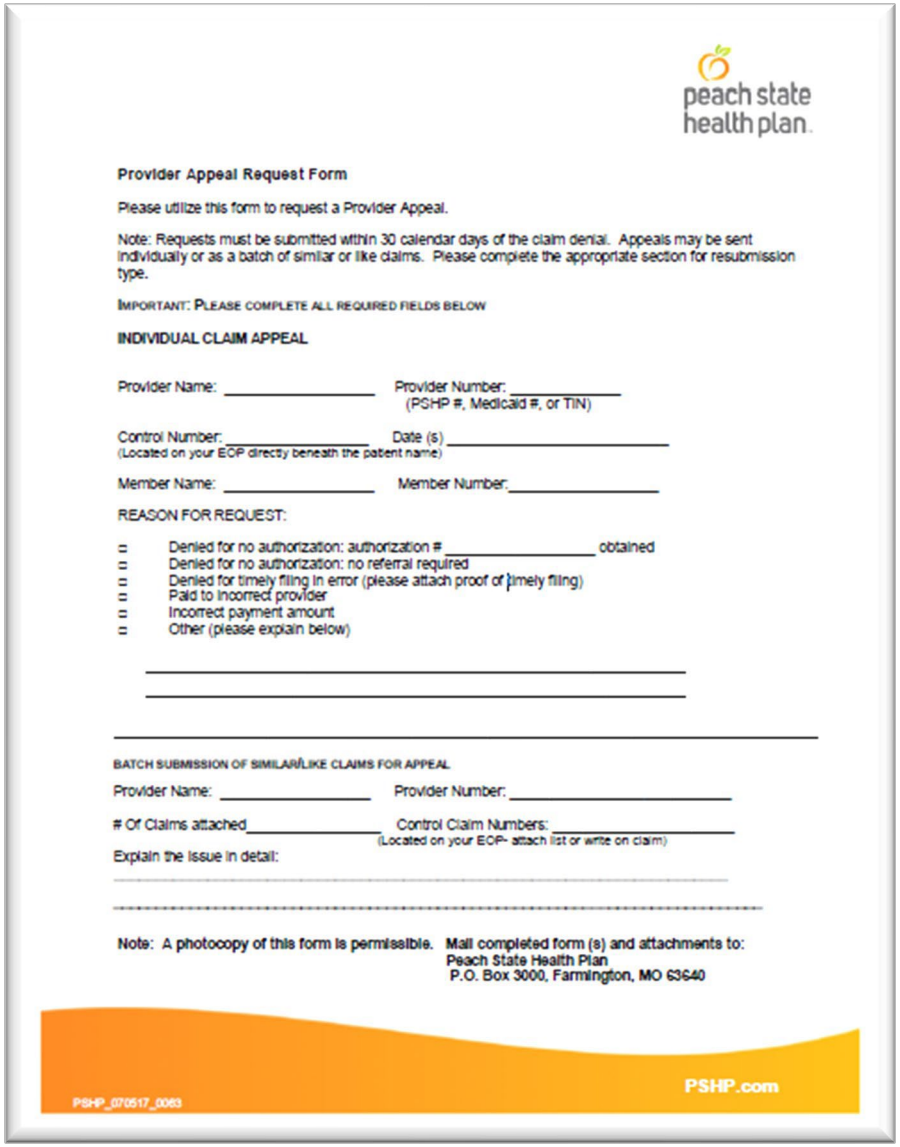
Claim Reconsiderations (con't)

- Upon submission, a success banner will be displayed.
- The tracker graphic will be updated to reflect that a reconsideration is in progress.
- **Reconsider Claim** button is no longer available.
- Claim status is updated.



Claim Appeals

- A claim appeal is a formal request for a review of an adverse claim reconsideration determination.
- A claim appeal must be filled within thirty (30) calendar days from the date of the claim denial (EOP).
- A Provider Appeal Request Form must be submitted to request a claim appeal.
- A claim appeal acknowledgement letter will be sent within ten (10) business days of the claim appeal.



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Provider Appeal Request Form

Please utilize this form to request a Provider Appeal.

Note: Requests must be submitted within 30 calendar days of the claim denial. Appeals may be sent individually or as a batch of similar or like claims. Please complete the appropriate section for resubmission type.

IMPORTANT: PLEASE COMPLETE ALL REQUIRED FIELDS BELOW

INDIVIDUAL CLAIM APPEAL

Provider Name: _____ Provider Number: _____
(PSHP #, Medicaid #, or TIN)

Control Number: _____ Date (s) _____
(Located on your EOP directly beneath the patient name)

Member Name: _____ Member Number: _____

REASON FOR REQUEST:

- ¤ Denied for no authorization: authorization # _____ obtained
- ¤ Denied for no authorization: no referral required
- ¤ Denied for timely filing in error (please attach proof of timely filing)
- ¤ Paid to incorrect provider
- ¤ Incorrect payment amount
- ¤ Other (please explain below)

_____
_____

_____

BATCH SUBMISSION OF SIMILAR/LIKE CLAIMS FOR APPEAL

Provider Name: _____ Provider Number: _____

Of Claims attached_____ Control Claim Numbers: _____
(Located on your EOP- attach list or write on claim)

Explain the issue in detail:

Note: A photocopy of this form is permissible. Mail completed form (s) and attachments to:
Peach State Health Plan
P.O. Box 3000, Farmington, MO 63640

PSHP_070517_0063

PSHP.com

Claim Appeals (con't)

- If the initial adverse claim determination is upheld, the provider will be notified of the decision in writing within thirty (30) calendar days of the receipt of the claim.
- If the decision is overturned, the provider will be notified through a newly issued Explanation of Payment (EOP).
- Claim Appeal requests should be submitted to:

  Peach State Health Plan

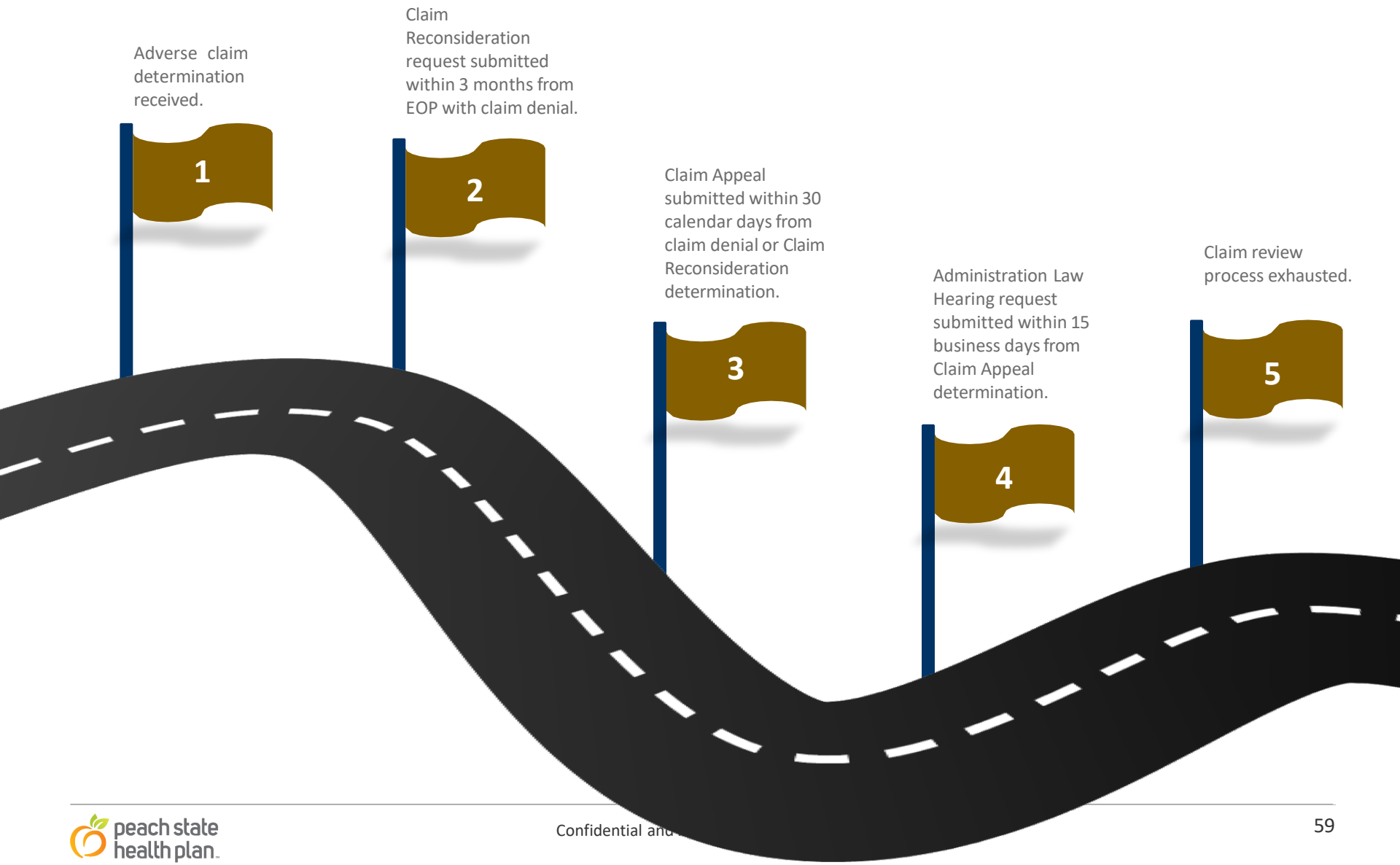
  PO Box 3000
  Farmington, MO 63640-3812

Administrative Law Hearing

- An **Administrative Law Hearing (ALH)** is the final step in the claim appeal process.
- A provider must exhaust all available appeal and provider compliant options before submitting a request for an Administrative Law Hearing.
- Administrative Law Hearing requests must be submitted within fifteen (15) business days of the claim appeal being upheld.
- All request for an Administrative Law Hearing must be submitted in writing to:

Peach State Health Plan
Attn: Administrative Law Hearing Coordinator
1100 Circle 75 Parkway, Suite 1100
Atlanta, GA 30339

Claim Dispute Roadmap



Payment Integrity Vendors

Service	Specialty Company/Vendor
Credit Balances	AIM
Claim Overpayment	Connolly Health
Claim Overpayment , Third Party Liability	HMS
DRG Validation of inpatient claims	Cotiviti (iCRS)
Credit balance, Claim overpayment	Optum

Behavioral Health Clinical Trainings

Peach State Health Plan Clinical Provider Training

The Peach State Health Plan Clinical Provider Training Team is a dedicated team of behavioral health professionals led by Director, Lauren Castellon, and Clinical Provider manager, Aura Lopez.

Our team includes seven clinical provider trainers, including three senior trainers.

Most of our trainings offer CE (continuing education) credits for BH licenses as well as nursing licenses.

Our goal: To provide professional development and behavioral health clinical education, enhance integrated care and expand the use of evidence-based practices.

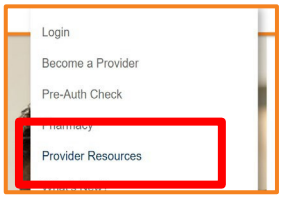
Where can you locate a listing of trainings?

Training topics:

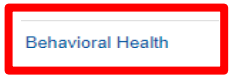
- ASAM
- Autism Spectrum Disorders
- Clinical Topics in Mental Health
- BH Screening Tools
- Cultural Competency/ Humility
- Eating Disorders
- Ethics
- Integrated Care
- Motivational Interviewing
- SBIRT
- Suicide Risk
- Substance Use Disorders Topics
- **And Many More!!!**

Step 1: Click For Providers

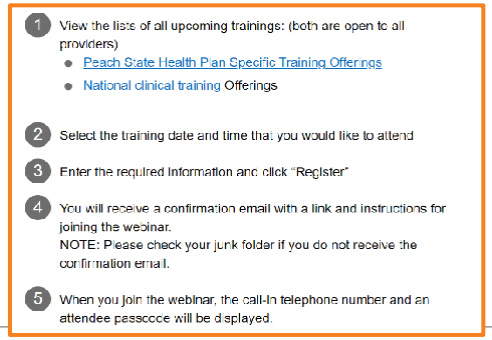
Step 2: Click Provider Resources



Step 3: Click Behavioral Health



Step 4: Scroll down "**TRAINING & EDUCATION**" to view the lists of upcoming trainings and for registration instructions.



- Link to Peach State Health Provider Training page: https://www.pshpgeorgia.com/providers/resources.html
- Link to Peach State Health Clinical Provider Trainings: https://attendee.gototraining.com/9x11d/catalog/1551338704302541312
- Questions? Email us at: bh_training@centene.com

Contact Information

Peach State Health Plan

Provider Services: 1-866-874-0633

Website: www.pshpgeorgia.com

Provider Portal: https://provider.pshpgeorgia.com