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Welcome Letter

Dear Provider,

Thank you for becoming a participating provider with Optum Care Network–New York. As our partner in value-based care, we will work together to provide affordable, high-quality health care to your patients and help them live their best lives. Our goal is to let you focus on the practice of medicine first and foremost and on your own well-being.

The Optum Care Network gives your practice the support of a health care industry leader while you remain independent to make your own care decisions. Our national team of doctors will link your care with the latest evidence-based breakthroughs. And our local support team offers resources to help you deliver exceptional care to your patients.

This provider manual offers valuable information about the Optum Care Network–New York and how we will partner most effectively. The manual is a user-friendly reference guide and educational resource for both you and your staff.

Visit our home page https://professionals.optumcare.com/ to review our secure provider portal beginning 1/1/22. The provider portal conveniently enables you verify eligibility, review claims status, submit and review authorizations, and review any medical inquiries.

The staff at Optum Care Network–New York will work collaboratively with you to create a positive experience for your staff and your patients. For comments, questions or suggestions on the materials, please feel free to the contact the Optum Care Network staff.

Sincerely,

Peter J. Kelly
President, Optum Care Network-New York
Chief Value Officer, Optum Tri-State Region
Provider Manual Overview

The manual contains important information about Optum Care Network-New York (OCNY) policies and procedures, claims submission and adjudication requirement. General recommendations are provided to support and enable participating providers and their staff to deliver effective care for members of Optum Care.

This manual is not intended to be exhaustive nor contractually binding. In the event of a conflict or inconsistency between this administrative manual and your network contractual agreement or applicable federal and state statutes and regulations, the terms of the contractual agreement along with federal and state statutes and regulations shall control.

Optum Care reserves the right to supplement this manual to ensure the information, terms and conditions remain in compliance with all governing Center for Medicare Service (CMS) regulations and relevant federal and state laws. Please refer to health plan provider manuals for specific policies and procedures when applicable.

The purpose of this manual is to provide key information to our contracted network providers and support you in delivering effective care for mutual patients in accordance with Optum Care Network and industry standards. As policies and procedures change, updates will be incorporated into this electronic version of the provider manual.

At Optum, we aim to meet individual patient’s needs through a connected set of practices and services. We look forward to working with you and providing the support you need to improve the health and well-being of your patients.

Delegation Defined

Delegation is the formal process or contract granting an enterprise authority to execute specific functions on behalf of an organization. In the case of Optum Care Network-New York (OCNY), it refers to health plans. Ultimately, the health plan is the responsible party. As the delegating party, the health plan must remain apprised of the delegate’s actions, ensuring adherence to compliance standards.

In full delegation, this translates to providing services on behalf of the aforementioned plans to provide care management services, administer utilization management, and adjudicate claims for providers among other services. OCNY has additional plan relationships that serve to delegate specific functions of health plan work.

Please contact your Practice Performance Manager if you have additional questions.
**Contact Information**

**OCNY Main Number**  
General Information  
8 a.m.-8 p.m., Monday-Saturday, ET  
Phone: 866-565-3468

**OCNY Resources**  
https://professionals.optumcare.com/resources-clinicians.html

**Website Address**  
https://www.optumcare.com

**Provider Portal**  
https://professionals.optumcare.com/

**Customer Service**  
Eligibility, claims/auth status, general billing questions  
8 a.m.-8 p.m., Monday-Saturday, ET  
Phone: 866-565-3468

**Prior Authorization Intake**  
8 a.m.-5 p.m., Monday-Friday, ET  
Online Requests: https://professionals.optumcare.com/  
Phone (only when online isn’t available): 866-565-3468  
Fax (only when online isn’t available):  
    New Requests: 855-248-4063  
    Part B/Expedited Requests: 855-244-8503

**Claims**  
Payer ID  
LIFE1

Claims Mailing Address  
PO Box 30781, Salt Lake City, UT 84130-0781

Claims Issue Escalation  
opshelp@optum.com  
(Please first contact the Service Center)

**Health Care Coordination**  
Pre-authorization, hospital  
pre-notification, emergent  
admission, case management  
8 a.m.-5 p.m. Monday-Friday, ET  
Phone: 866-565-3468  
Fax: 844-700-5131

**OCNY Directory Searches**  
(Provider, Facilities)  
http://www.optum.com

**Credentialing**  
*Refer to your Payer-Specific Provider Manual

**Practice Performance Managers**  
OCNYMarketOps@caremount.com

**Network Development**  
OCNYnetwork@caremount.com
Practice Engagement
Each OCNY provider group is assigned a Practice Performance Manager (PPM). Your Practice Performance Manager, together with their network medical director partner, work to help you succeed in 5-Star quality, patient experience, risk adjustment, care management, affordability, contracting, and growth. The PPM is responsible for provider performance management which is tracked by designated provider metrics, inclusive minimally of STAR gap closure and coding accuracy.

Practice Performance Manager Responsibilities

- **Primary Single Point of Contact with Clinic**
  - Partners with clinic leadership to strive for optimal performance in quality, accurate risk adjustment, and affordability initiatives to improve long-term clinical outcomes while lowering the total cost of care
  - Leads and schedules meetings with clinics
  - Coordinates Medicare Advantage marketing and growth
  - Provides management service coordination
  - Updates clinics on new wrap around services
  - Communicates incentive program elements and achievements
  - Resolves and escalates concerns (Claims issues/processes, etc.)

- **Analytics & Performance Management**
  - Ensures clinic has all data and analytics to ensure success in patient care delivery
  - Supports delivery of monthly strategic packets
  - Provides attestation point of care tool delivery and tracking
  - Provides dashboard performance and incentive reporting
  - Creates strategy and action plans for targeted provider groups to increase health care delivery, star ratings, and maximize on gap closures

- **Training/Education**
  - Assesses and coordinates training needs (e.g. Provider Portal Training, Attestation completion, CAHPS/HOS member experience)
  - Supports Primary Care Provider (PCP), staff, and clinic administrator education on risk adjustment, quality, and affordability
  - Provides ongoing strategic recommendations, training and coaching to provider groups on program implementation and barrier resolution.

- **Member Focus**
  - Supports member eligibility issues/resolution
  - Provides wraparound services utilization, education, and tracking, sharing best practices to improve CAHPS / HOS member experience

Credentialing
Credentialing refers to the process performed by the health plan to verify and confirm that an applicant meets the established policy standards and qualifications for consideration in the OCNY Network.
Providers Joining Your Practice

Unless the practice has a credentialing sub-delegation arrangement in place with the health plan, all providers joining an existing practice must complete the health plan’s credentialing process. Until such time as the provider has successfully completed the credentialing process, claims may not be reimbursed appropriately and/or denied payment. Contact your Practice Performance Manager or health plan Credentialing department at least 60 days prior to your new provider seeing patients to minimize any reduction or denial of payment.

Health Plan Credentialing

Health plan will retain the credentialing for network providers in 2022. Please refer to the UnitedHealthcare and Humana health plan provider manuals for:
- Types of providers credentialed
- Facilities adding location(s)
- Type of facilities
- Sub-delegation of credentialing
- Recredentialing
- Corrective Action
- Provider/facility rights
- Changes to your practice/facility
- Termination of participation
- Closing your practice

Closing your Practice

Closing your practice due to retirement or business considerations is a complex undertaking. OCNY would like to support you in locating resources for your transition and identifying actions needed. The process can be very different for primary care providers and specialists. Please utilize your resources with OCNY by contacting your Practice Performance Manager to assist in planning the logistics. The table below provides details to help prepare for such a change.

<table>
<thead>
<tr>
<th>Considerations</th>
<th>PCP</th>
<th>Specialist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notify PPM and health plan via letter or email with a copy of the patient notification letter</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Create letter notifying patients of change</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Communicate how patients may obtain their records</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Provide recommendations for new providers</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Communication how to contact the office during and after the transition</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Communicate changes to non-OCNY health plans</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Instruct patients to contact the health plan regarding a PCP change</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Close patient panel</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Identify patients currently in care management</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Provide access to medical records to OCNY (current year)</td>
<td>x</td>
<td>x</td>
</tr>
</tbody>
</table>
Contracting

OCNY’s Provider and Facility Participation Agreements allow OCNY to contract with health plans as a risk bearing entity and to take delegation of services. Please refer to your agreement for specifics. Refer to the Credentialing section to determine eligibility to participate.

OCNY holds the following contracts:

<table>
<thead>
<tr>
<th>Entity Name</th>
<th>Market Product Name</th>
<th>Plan Type</th>
<th>Start Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>UnitedHealthcare Insurance Company of New York</td>
<td>AARP Medicare Advantage Value Care</td>
<td>Local PPO</td>
<td>2022</td>
</tr>
<tr>
<td>UnitedHealthcare Insurance Company of New York</td>
<td>United Healthcare Medicare Advantage Choice Plan 1</td>
<td>Regional PPO</td>
<td>2022</td>
</tr>
<tr>
<td>UnitedHealthcare Insurance Company of New York</td>
<td>United Healthcare Medicare Advantage Patriot</td>
<td>Regional PPO</td>
<td>2022</td>
</tr>
<tr>
<td>UnitedHealthcare Insurance Company of New York</td>
<td>United Healthcare Medicare Advantage Choice Plan 4</td>
<td>Regional PPO</td>
<td>2022</td>
</tr>
<tr>
<td>Humana Insurance company of New York</td>
<td>Humana Choice Partnered (PPO).</td>
<td>Local PPO</td>
<td>2022</td>
</tr>
<tr>
<td>Direct Contract Model</td>
<td>Medicare Fee for service</td>
<td>DCE</td>
<td>2022</td>
</tr>
</tbody>
</table>

This list is subject to change. Please contact your Practice Performance Manager or Network Development for details.

For OCNY attributed members, your OCNY participation agreement will supersede your direct health plan agreement.

Roster Maintenance

All providers must be identified by individual or entity name, TIN, individual NPI, organizational NPI, and CCN (if applicable).

Providers are permitted to add/delete individual practitioners throughout the calendar year to ensure OCNY retains the most accurate reflection of participating providers. To satisfy program requirements, the following data points must be provided when adding or requesting to delete providers:

- Provider Full Name
- Provider Title (MD, DO, NP, etc.)
- Provider NPI
- Provider Specialty (Follow Taxonomy List Provided by OCNY)
- Provider TIN
- Group NPI
- Legal Provider Name
- Primary Address (Street, State, Zip)
- Primary Address Phone Number
- Primary Address Fax Number
- Remittance Address (Street, State, Zip)
• Tax Address (Street, State, Zip)

For providers who either join or depart a practice, OCNY requires notification of the provider’s addition or deletion within 15 days of the occurrence to maintain compliance with program policies and procedures.

Claims

OCNY is delegated to adjudicate and pay claims for selected health plans. Providers and facilities are responsible for verifying patient eligibility, benefits and obtaining referrals/authorizations, if applicable, prior to services being rendered. Please refer to the table below.

<table>
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<tr>
<th>Plans</th>
<th>Submit to</th>
<th>Claims Submission Information</th>
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<tr>
<td>United Healthcare PPO – Medicare Advantage</td>
<td>OCNY</td>
<td>Electronic Claims: Payer ID#: LIFE1</td>
</tr>
<tr>
<td>• AARP Medicare Advantage Value Care</td>
<td></td>
<td>Clearing House: Optum 360</td>
</tr>
<tr>
<td>• United Healthcare Medicare Advantage</td>
<td></td>
<td>Paper Claims: PO Box 30781</td>
</tr>
<tr>
<td>Choice Plan 1</td>
<td></td>
<td>Salt Lake City, UT 84130-0781</td>
</tr>
<tr>
<td>• United Healthcare Medicare Advantage</td>
<td></td>
<td></td>
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<tr>
<td>Patriot</td>
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<tr>
<td>• United Healthcare Medicare Advantage</td>
<td></td>
<td></td>
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<tr>
<td>Choice Plan 3</td>
<td></td>
<td></td>
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<tr>
<td>• United Healthcare Medicare Advantage</td>
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<tr>
<td>Choice Plan 4</td>
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Humana HMO – Medicare Advantage
• Humana Choice Partnered (PPO)

OCNY
Electronic Claims: Payer ID#: LIFE1
Clearing House: Optum 360
Paper Claims: PO Box 30781
Salt Lake City, UT 84130-0781

CMS Direct Contract Model (DCE)
• Medicare Fee for service

CMS
*Follow existing CMS claim submission process

Claims Submission

Claims should be submitted electronically to LIFE1. Paper claims, though not preferred, can be mailed to:

**OCNY Paper Claims**
PO Box 30781
Salt Lake City, UT 84130-0781

**OCNY Electronic Claims**
Payor ID#: LIFE1
Clearinghouse: Optum 360

Reimbursement

Reimbursement for services is defined in your practice/facility participation agreement. However, your reimbursement is affected not only by the terms of your Agreement, but also the following:

• Patient’s eligibility at the time of the service.
• Whether services provided are covered benefits under the patient’s health plan.
• Whether services are medically necessary as required by the patient’s health plan.
• Whether services were without prior approval/authorization if authorization is required.
• Patient copayments, coinsurance, deductibles, and other cost-share amounts due from the patient and coordination of benefits with third-party payors as applicable.
• Adjustments of payments based on coding edits described above.
All services must comply with all federal laws, rules, and regulations applicable to individuals or entities receiving federal funds, including without limitation Title VI of the Civil Rights Act of 1964, Age Discrimination Act of 1975, Americans with Disability Act, and Rehabilitation Act of 1973. Please refer to your Provider/Facility Agreement for additional terms.

Nothing contained in the agreement or provider manual are intended to be a financial incentive or payment which directly or indirectly acts as an inducement for providers/facilities to limit medically necessary services.

**Electronic Funds Transfer**

OCNY supports claims payments via electronic remittance advice (ERA) and electronic funds transfer (EFT) via InstaMed. ERA/EFT is a convenient, paperless, and secure way to receive claim payments. Funds are deposited directly into your designated bank account and include the TRN Reassociation Trace Number, in accordance with CAQH CORE Phase III Operating Rules for HIPAA standard transactions.

If you have not set up your InstaMed account, please go to [https://register.instamed.com/eraeft](https://register.instamed.com/eraeft) to register or contact InstaMed Customer Service via telephone or email.

**Toll Free Telephone:**

(866) INSTAMED or (866) 467-8263

**Email:**

support@instamed.com

**Help Portal:**

[https://help.instamed.com/providers/s/](https://help.instamed.com/providers/s/)

**Training Tools:**

[https://www.instamed.com/support/providers](https://www.instamed.com/support/providers)

**Charging Members**

Practices and facilities are responsible for verifying patient eligibility and benefits prior to services including, but not limited to, obtaining authorization for services. Practices and facilities are responsible for the collection of copays, co-insurance and/or deductibles as applicable. Please refer to CMS guidelines for details.

Additionally, per your OCNY participation agreement, practices and facilities shall not charge a Medicare Advantage patient for non-covered services under the patient’s plan unless the patient has received a pre-service organization determination notice of denial from OCNY or health plan before any such services are rendered. Please refer to your participation agreement for complete language.

**Clinical Claims Review**

Clinical records may be requested for further review by our Clinical Claims Review (CCR) department to determine if a service is considered medically necessary. These determinations are based on review of the member's medical information that supports the need for a particular service. These determinations are based on standard medical necessity guidelines.
Provider Dispute Resolution Process

The Optum Care goal is to provide affiliated physicians and providers with readily accessible information that works to expedite interaction with our organization and will assist providers in their managed care and business operations.

For how to submit a provider dispute please follow the dispute language on explanation of payment (EOP). Each provider dispute must contain, at a minimum, the following information:

- Provider’s name
- Provider’s TIN
- Provider’s contact information
- Clear identification of the disputed item such as the claims number and the date of service
- Clear explanation of the issue
- Provider’s explanation why the action taken is incorrect

Releasing a Patient from your Practice

Please refer to the UnitedHealthcare and Humana health plan provider manuals for releasing a patient from your practice.

Patient Re-Assignment

Optum Care Network manages patients assigned to primary care providers (PCPs) for Humana Medicare Advantage HMO, AARP Medicare Advantage HMO through UnitedHealthcare (UHC MA). In rare instances, patients may be assigned to your practice but wish to see another doctor. When this occurs, the patient must notify the health plan, and the assignment must be corrected in their system(s). Patients who have not been seen by your practice but have been assigned to you should not be re-assigned to another primary care provider in the practice unless the patient has initiated the process. See also Population Health.

For Humana patients:

- Patients can call the Humana customer service number on the back of their ID card to request a different PCP, or
- Complete a PCP change form and fax to Humana.

For UHC MA patients:

- Patients should call the UHC customer service number on the back of their ID card to request a different PCP.

Compliance

Medicare Compliance Expectations and Training

The Centers for Medicare & Medicaid Services (CMS) requires Medicare Advantage (MA) organizations and Part D plan sponsors to annually communicate specific Compliance and Fraud, Waste and Abuse (FWA) requirements to their “first tier, downstream, and related entities” (FDRs). FDRs include contracted physicians, health care professionals, facilities and ancillary providers, as well as delegates, contractors, and related parties. CMS and other federal or state regulators require that you and your employees meet certain FWA and general compliance requirements.

FDRs are expected to have an effective compliance program, which includes training and education to address FWA and compliance knowledge. Optum Care Network--New York expectation remains that
FDRs, and their employees, are sufficiently trained to identify, prevent and report incidents of non-compliance and FWA. This includes temporary workers and volunteers, the CEO, senior administrators or managers, and sub delegates who are involved in or responsible for the administration or delivery of MA or Part D benefits or services.

We have general compliance training and FWA resources available at unitedhealthgroup.com. The required education, training, and screening requirements include the following:

**Standards of conduct awareness**

What you need to do:
- Provide a copy of your own code of conduct, or the UnitedHealth Group's (UHG's) Code of Conduct at unitedhealthgroup.com > About > Ethics & Integrity > UnitedHealth Group’s Code of Conduct. Provide the materials annually and within 90 days of hire for new employees.
- Maintain records of distribution standards (i.e., in an email, website portal or contract) for 10 years. We, our plan sponsors, or CMS, may request documentation to verify compliance.

**Fraud, waste, and abuse and general compliance training**

What you need to do:
- Provide FWA and general compliance training to employees and contractors of the FDR working on MA and Part D programs.
- Administer FWA and general compliance training annually and within 90 days of hire for new employees.

**Exclusion checks**

Prior to hiring or contracting with employees, you must review federal (HHS-OIG and GSA) and state exclusion lists, as applicable. This includes the hiring of temporary workers, volunteers, the CEO, senior administrators or managers, and subdelegates who are involved in or are responsible for the administration or delivery of Medicare Advantage plan sponsor benefits or services delegated to Optum Care Network--NY.

What you need to do
Make sure potential employees are not excluded from participating in federal health care programs. For more information or access to the publicly accessible excluded party online databases, use the following links:
- General Services Administration (GSA) System for Award Management at sam.gov/sam

Review the exclusion lists every month and disclose to Optum Care Network--New York any exclusion or any other event that makes an individual ineligible to perform work directly or indirectly on federal health care programs. Maintain a record of exclusion checks for 10 years. We, our plan sponsors, or CMS, may request documentation of the exclusion checks to verify they were completed.

**Preclusion list policy**

The Centers for Medicare and Medicaid Services (CMS) has a preclusion list effective for claims with dates of service on or after April 1, 2019. The preclusion list applies to both MA plans as well as Part D plans. The preclusion list is comprised of a list of prescribers and individuals or entities who:
- Are revoked from Medicare, are under an active reenrollment bar, and CMS has determined that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program; or
- Have engaged in behavior for which CMS could have revoked the prescriber, individual or entity to the extent possible if they had been enrolled in Medicare and that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program.
- Have been convicted of a felony under federal or state law within the previous 10 years and that CMS deems detrimental to the best interests of the Medicare program.
Care providers receive a letter from CMS notifying them of their placement on the preclusion list. They have the opportunity to appeal with CMS before the preclusion is effective. There is no opportunity to appeal with Optum Care Network--NewYork or the plan sponsor. CMS updates the preclusion list monthly and notifies MA and Part D plans of the claim rejection date, the date upon which we reject or deny a care provider’s claims due to precluded status. Once the claim-rejection date is effective, a precluded care provider’s claims will no longer be paid, pharmacy claims will be rejected, and the care provider will be terminated from the Optum Care Network--New York. Additionally, the precluded care provider must hold Medicare beneficiaries harmless from financial liability for services provided on or after the claim rejection.

**Reporting Misconduct**

If you identify compliance issues and/or potential fraud, waste or abuse, please report it to us immediately so that we can investigate and respond appropriately. Please see the reporting misconduct section of the UnitedHealth Group code of conduct at https://www.unitedhealthgroup.com/viewer.html?file=/content/dam/UHG/PDF/About/UNH-Code-of-Conduct.pdf

Reports may be made anonymously, where permitted by law.

**For UHC Medicare Advantage members at:**

uhc.com/fraud or by calling 1-844-359-7736

**Methods for Reporting Suspected or Detected Noncompliance to Humana**

**Examples of methods offered by Humana:**

- By telephone: Ethics Help Line, 1-877-5-THE-KEY (1-877-584-3539)
- Online: Ethics Help Line Web reporting site: www.ethicshelpline.com
- By email: ethics@humana.com (Ethics Office)

Suspected or detected FWA violations may also be reported directly to Humana’s Special Investigations Referral department by calling 1-800-614-4126, emailing siureferrals@humana.com, or faxing 1-920-339-3613.

**Privacy**

You must make reasonable efforts to limit Protected Health Information (PHI) as defined under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule to the minimum necessary when using or disclosing PHI. The minimum necessary standard should not affect treatment, payment or health care operations (TPO). The Privacy Rule requires written member authorization for uses and disclosures that fall outside of the TPO.

**Non-discrimination**

You must not discriminate against any patient with regard to quality of service or accessibility of services because they are our member. You must not discriminate against any patient on the basis of:

- Race
- Gender identity
- Ethnicity
- National origin
- Religion
- Sex and gender
- Age
- Mental or physical disability or medical condition
- Sexual orientation
- Claims experience
- Medical history
You must maintain policies and procedures to demonstrate you do not discriminate in the delivery of service and accept for treatment any members in need of your service.

**Marketing Compliance**

For the purposes of this provider manual, “marketing” includes any information, whether oral or written, that is intended to promote or educate current or prospective Medicare beneficiaries about any Medicare plans, products, or services.

All contracted practices and facilities are required to comply with all current CMS regulations regarding marketing. As of January 2019, CMS has clarified that providers may interact with their patients regarding plan options when relevant to the course of treatment or at the patient’s request. A summary of the rules are as follows, however please refer to [https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Guidance.html](https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Guidance.html) for the most current and in-force information.

**Guide Updates**

Optum Care Network--New York reserves the right to supplement this guide to ensure that its information and terms and conditions remain in compliance with all governing Center for Medicare and Medicaid Services (CMS) regulations and relevant federal and state laws. This guide will be amended as needed.

**Population Health**

OCNY has developed programs and resources in concert with health plans to support your practice around population health management. These programs and resources include, but are not limited to, complex care management, quality, risk adjustment programs, clinical education, patient engagement, affordability, and social determinants of health.

There are the following four guiding principles of the OCNY population health program:

- Promoting activities that drive quality outcomes.
- Focusing on prevention and early detection of conditions which may negatively impact the health or well-being of individuals.
- Expanding team-based care to include the broader health care continuum.
- Improving clinical outcomes while lowering the total cost of care.

**Quality & Risk Adjustment**

OCNY is committed to supporting our partners in delivering the highest quality of care. To that end, providers may be given the tools and resources to identify quality care gaps, understand best practices, outreach/engage patients to close quality care gaps, and provide tactical support for meeting requirements in accordance with Medicare’s quality standards.

All contracted providers are required to allow OCNY access to patient charts, for OCNY-attributed patients, as part of supporting quality initiatives and clinical documentation accuracy. As an essential part of ensuring all data is captured and reported to health plans, OCNY performs chart reviews through remote EMR access, fax, and on-site access to your practice. Data for only your OCNY attributed patients is reviewed and processed. The chart abstraction and review process can capture documentation to
close care gaps and potential coding opportunities, which contribute to incentive payment measurements under the Quality Incentive Program.

What does this mean to your practice?

- OCNY will deploy chart abstraction staff to facilitate the capture of clinical documentation to close quality care gaps; or
- OCNY will work with your practice to collect records either directly via fax or EMR, or through a third party to facilitate accurate capture of quality care gaps and conditions.
- Practice Performance Managers will work with practices to provide education, consultation, and materials to help our providers improve their systems and processes to impact highest quality of care.

Clinical Quality Program

The Clinical Quality Program Team is committed to promoting healthy lifestyles and ensuring the highest standards of medical care are provided to all patients through education, information and preventive care. Our objectives are aimed at driving processes that support continuous quality improvements such as measurement, trending, analysis, intervention and re-measurement. Our goal is to ensure our patients have access to health care that is safe, timely, effective and patient-centered.

The Clinical Quality Program Team consists of licensed clinicians, such as nurses and social workers, who reach out to patients using a telephonic approach. In the event we are unable to reach a patient, we send letters that provide education, support and information about how to contact us. We also access multiple medical record databases to gather information used to close HEDIS Quality care gaps. All quality care gaps closed by the Clinical Quality Department are submitted as supplemental data.

Quality Supplemental Data Submission/Primary Source Verification (SDS/PSV)

From HEDIS® reporting to medical record review support, audit management, and performance assessment, the Quality SDS/PSV Operations Team is committed to helping our providers maximize data and processes to increase HEDIS scores and bottom-line performance. This team also conducts HEDIS® "hybrid" medical record requests and reviews each spring. Hybrid measures allow additional information from a medical chart to be used to complement claims data to provide a full picture of the care/services provided.

What does this mean to your practice?

- Respond to records requests in a timely manner.
- Remember to document all the care you provide in your patients’ medical records.
- Be sure to accurately code all claims.

Quality Performance

Medicare Advantage Health Plans are required to collect and report Star measure performance for their Medicare Advantage (MA), Prescription Drug Plan (PDP) and MA Special Need Plans (SNP) patients. Plan ratings are reported publicly by health plan and contract and can be found at [https://www.medicare.gov/plan-compare](https://www.medicare.gov/plan-compare).

The Star Ratings Program is consistent with CMS’ Quality Strategy of optimizing health outcomes by improving quality and transforming the health care system. CMS’ Quality goals are based on the six
priorities set out in the National Quality Strategy. These priorities include safety, patient/caregiver-centered experience and outcomes, care coordination, clinical care, population/community health, efficiency and cost reduction.

OCNY is committed to achieving 5 Stars to improve patient health. Star Rating metrics are reported by health plans to CMS and those Medicare Advantage Plans with an overall rating of 4 or more Stars are eligible for quality bonus payments. These funds are used to provide patient care and enhance participating physician reimbursement.

CMS shall use the following sources for quality reporting:
1. Medicare claims (medical and pharmacy claims) submitted for items and services rendered to patients.
2. Any other relevant data from the patients’ medical record (EMR).
3. For Performance Year 2022 and subsequent Performance Years, results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) or other patient experience surveys.

Risk Adjustment Factor

Risk Adjustment Factor (RAF) is a numeric measurement based on health conditions a patient has (specifically those that fall within a CMS-assigned Hierarchical Condition Category or HCC), as well as demographic factors such as Medicaid status, gender, age/disabled status and whether the patient lives in an institution (for 90 days or longer) or not.

RAF is a relative measure of probable costs to meet the health care needs of the individual. RAF is used by Centers for Medicare and Medicaid Services (CMS) to adjust capitation payments to payors and thus to OCNY for each Medicare Advantage (MA) member. As such, complete and accurate reporting of patient data is critical.

CMS requires providers to identify and document all conditions that may fall within an HCC at least once, each calendar year at a qualified visit. Documentation in the patient’s medical record must support the presence of the condition and indicate the provider’s assessment and treatment plan. OCNY supports an accurate RAF score for your practice through in-home assessments, chart review, outreach support, and attestation forms. Detail and education material on how to properly document patients’ conditions will be provided by your PPM.
**Provider Attestations**

To support providers in submitting accurate documentation and coding, OCNY provides Attestations. Attestations list the gaps in care by member which includes historical chronic conditions, suspected conditions, screenings and quality measures. Attestations are used by providers at the point of care to promote early detection and ongoing assessment of chronic conditions for our members. The goal of Attestations is to help providers perform a complete and comprehensive annual assessment for their patients. PPMs are available to support all aspects of the attestation process.

Attestations are developed using the following sources of data:
- Diagnoses, procedures, and results reported in prior years.
- Diagnoses and results found by nurses or coders (or, in some cases, M.D.) performing a chart review.
- Data inferred from labs tests, medication fills, and CMS Return files.
- Attestations will be shared with providers in one of two forms:
  1. Healthcare Quality Patient Assessment Form (HQPAF)
     - The form is printed and delivered by the PPM for completion by the clinician.
     - The information on the HQPAF form should be used to assist you in addressing care opportunities during the patient encounter.
     - The PPM will support your practice in completing chart reviews and identifying open care gaps. The HQPAF process would be incorporated in your practice’s daily workflow.
  2. Electronically via DataCORE
     - DataCORE is a cloud-based, point-of-care application that will display member risk and quality information, dashboards, and reports within an EMR or via a user portal.
     - DataCORE will have the following features:
       i. Display previously coded and suspected HCCs with the ability to accept, disagree or defer the conditions presented
       ii. Display of and ability to take action on member quality gaps
       iii. Embedded interactions to utilize EMR workflows
       iv. Ability to upload supporting documentation
       v. Access to gap dashboard and reports
       vi. Access to referrals and clinical education
  3. Paper form via DataCORE
     - The form is printed and delivered by the PPM for completion by the clinician.
     - The information on the form should be used to assist you in addressing care opportunities during the patient encounter.
     - The PPM will support your practice in completing chart reviews and identifying open care gaps. The DataCORE process would be incorporated in your practice’s daily workflow.

**Coding and Documentation Ongoing Education**

As more of our work and payment structures are measured by data, it is increasingly important that we educate and prepare ourselves and our systems to capture the complexity of the care that we provide. To support clinical documentation and an accurate picture of each patient’s health and RAF, OCNY provides ongoing education for clinicians and staff as well as regular feedback through reporting and analytics.

OCNY has a team to help each clinic stay up to date, so they can provide the most accurate coding and documentation of each patient’s clinical status. Our educators will help providers with diagnostic coding issues, medical record review, documentation standards, and education opportunities that support this ever-changing work in health care. Additionally, OCNY will provide ongoing education and information with industry coding changes as they relate to risk adjustment. OCNY’s goal is to help promote the highest quality of care to our patients.
What does this mean to your practice?

- OCNY will provide clinical documentation education and resources to providers and clinic staff to support ongoing development of Risk Adjustment coding and Quality metric recognition coding (CPT Category II).
- Our educators can evaluate documentation and coding behavior and identify recommendations for improvement.
- We will provide consultation and education to help our network partners improve their systems and processes to ensure complete, accurate, and compliant Risk Adjustment and Quality reporting.

Opportunities and Services

- We will perform reviews of medical documentation to ensure all offices capture chronic HCC (hierarchical condition categories) that would affect the risk adjustment reimbursement, and any subsequent shared savings.
- OCNY also analyzes data from inpatient hospitalizations, diagnostic testing, outpatient procedures and services, home health care services, durable medical equipment, rehabilitative therapies, and pharmacy reviews for the possibility of chronic codes that have not been addressed in the calendar year.
- OCNY will prepare feedback and training materials to educate providers and their staff on any audit outcomes and will help with accurate documentation procedures.
- OCNY will communicate with providers and staff coding and documentation trends and help implement correct diagnosis reporting.
- OCNY will perform routine audits of documentation and coding in accordance with compliance policies and procedures and communicate the results to the offices.
- We will follow up with written and verbal education regarding coding and compliance to physicians, clinical staff, and non-clinical staff. You will also be able to request OCNY educators to come to your clinics and help with any coding or documenting issues.
- OCNY educators will remain apprised of the latest guidelines and relay that information to the clinics and staff. We will provide any updates of new codes or coding issues. OCNY will send emails with webinars, coding materials, and any other education needed.

Medical Management

Prior authorizations
Prior authorization requirements can be found by logging in through https://professionals.optumcare.com/portal-login.html or calling OCN at 1-866-565-3468. Additionally, Medicare Advantage prior authorization requirements can be found on the Provider Portal at UHCprovider.com.

Requesting prior authorization
To submit a prior authorization notification, sign in to professionals.optumcare.com/portal-login.html. If online is not available, call 1-866-565-3468 or fax your notification to:

- New Auth (General): 1-855-248-4063
- Part B New Auth: 1-855-244-8503
- Clinicals Submission for Auth: 877-940-3604

OCNY CMS Direct Contracted Model (DCE) products follow traditional Medicare Prior Authorization requirements.
Submitting a prior authorization request online for Medicare Advantage members who have an OCNY network PCP
Log in through Optum Care Provider Portal at https://professionals.optumcare.com/portal-login.html and navigate to the prior authorizations area. Then click to start a new request, fill out the form and click Submit.

For urgent requests call: 1-866-565-3468

Prior authorization provider notification process
When a prior authorization request is approved, OCNY will notify the provider and enrollee so the provider may proceed with the service delivery.

When an adverse determination is made, OCNY will notify both the provider and enrollee with a formal written notification that includes member appeal rights and next steps. The provider may also use the OCNY provider portal, found at https://professionals.optumcare.com/portal-login.html, to see the status of a prior authorization request.

Prior authorization time frames
The department strives to process each request as expeditiously as an enrollee’s condition requires. According to CMS regulations for organizational determinations, the determination must be rendered within the following time frames:

<table>
<thead>
<tr>
<th>Type of request</th>
<th>Turn-around time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expedited or urgent pre-service requests</td>
<td>72 hours</td>
</tr>
<tr>
<td>Standard or non-urgent pre-service requests</td>
<td>14 calendar days</td>
</tr>
<tr>
<td>Part B Drug Expedited or urgent pre-service requests</td>
<td>24 hours</td>
</tr>
<tr>
<td>Part B Drug Standard or non-urgent pre-service requests</td>
<td>72 hours</td>
</tr>
</tbody>
</table>

Prior authorization status
Prior authorization can be viewed by logging in through provider portal at https://professionals.optumcare.com/portal-login.html or by calling 1-866-565-3468.

Referrals
Medicare Advantage members who have selected an OCNY PCP, will need to coordinate services with their network PCP for specialists, ancillary care providers, facilities, and hospitals. The PCP will be the member’s first and foremost source of care. They can refer the member to other network physicians or specialists when additional care is needed.

As a managed care network, patients assigned to us are required to use providers/facilities from within our network for care. Keeping services in-network works to minimize administrative burden and keep costs contained. We have a diverse group of specialists and facilities within our network and are continuously working to grow and expand our reach in the community.

If your patient requires a specialist or facility that is not within the OCNY Network, we recommend the specialist/facility is contracted with the patient’s health plan. If the specialist/facility is not contacted with the plan, prior authorization is required. The OCNY and health plan prior authorization lists are subject to change. Updates to the lists will be provided to the network as needed. The most current prior authorization list can be found on the OCNY provider portal at: https://professionals.optumcare.com/portal-login.html.

In-Network (Office Visits) (Tier 1):
OCNY PCP to OCNY specialist referrals do not require precertification
OCNY specialist to OCNY specialist do not require precertification (UHC Only)

Out of Network Referral (Tier 2): Requires prior authorization from OCNY
Please note: Not all plans have out-of-network benefits.

Specialty care
We have a large network that includes skilled medical professionals in almost every specialty. The specialists we contract with are carefully chosen and will work closely with you to provide the patient with what is needed.

Hospital admission notification
Requirements for admission notifications
Facilities are responsible for admission notification for the following types of admissions:

- All planned/elective admissions for acute care
- All unplanned admissions for acute care
- All post-acute care admissions:
  - Skilled Nursing Facility (SNF)
  - Long Term Acute Care (LTAC)
  - Acute Inpatient Rehab (AIR)
- All admissions following outpatient surgery
- All admissions following observation stay

Unless otherwise indicated, admission notification must be received within 24 hours after actual weekday admission. For weekend and federal holiday admissions, notification must be received by 5 p.m. local time on the next business day.

Admission notification by the facility is required even if the physician supplied advance notification and a pre-service coverage approval is on file.

Receipt of an admission notification does not guarantee or authorize payment. Payment of covered services is contingent on coverage within an individual patient’s benefit plan, the facility being eligible for payment, any claim processing requirements, and the facility’s participation agreement with Optum.

Admission notifications must contain the following details regarding the admission:

- Patient name and health care ID number
- Facility name and National Provider Identifier (NPI) or Tax Identification Number (TIN)
- Admitting/attending physician name and TIN or NPI
- Description for admitting diagnosis or ICD-10-CM (or its successor) diagnosis code
- Actual admission date
- Inpatient or observation status

For emergency admissions when a patient is unstable and not capable of providing coverage information, the facility should notify Optum via phone or fax within 24 hours (or the next business day, for weekend or federal holiday admissions) from the time the information is known and communicate the extenuating circumstances. We will not apply any notification-related reimbursement deductions.

Reimbursement reductions for failure to timely provide admission notification
If a facility does not provide timely admission notification, the service may not be paid by Optum.

How to submit admission notifications
To notify OCN of hospital admissions no later than 24 hours after admission and 24 hours post discharge, sign in at https://professionals.optumcare.com/portal-login.html.
If online is not available, notifications can be submitted:

- **Phone**: 1-866-565-3468
- **Fax**: 1-844-700-5131

**Clinical Information for Hospital Admissions can be submitted:**

- **Online**: [https://professionals.optumcare.com/portal-login.html](https://professionals.optumcare.com/portal-login.html)
- **Fax**: 1-844-700-5131

**Referral vs. prior authorization vs. advanced notification**

The referral process, advance notification process, and prior authorization processes are separate processes.

A **referral** is required for a member to see a specialist and is originated by the assigned PCP through the provider portal. While a referral is required by the health plan to see a specialist, it is not an authorization for payment for services. While a referral is considered a pre-approval to see a specialist, it does not require authorization from OCNY. In simple terms, a referral can be considered as a warm hand-off from the PCP to the specialist to ensure communication of medical intent and patient history, appropriate care, and ease of access for the member. The health plan uses the referral process to ensure this process is followed.

A **prior authorization** is payment approval sought by a physician or health care provider from the member’s health plan for specific procedures, admissions, medical devices, medications, etc. The prior authorization process is a means of managing costs and the management of overall patient care based on evidence-based practices.

An **advanced notification** is notification to the health plan that an inpatient procedure or admission will occur, and a period of 5 days is recommended prior to the service delivery. A prior authorization request is often submitted at the same time the advance notification is done.

**Prior authorization & hospital admission peer-to-peer process**

The peer-to-peer process may be initiated before an adverse determination has been communicated to the member. The OCNY nurse or coordinator will contact the ordering physician to make them aware that the request may be denied. If the ordering physician has additional clinical information that may help the request meet medical necessity criteria, the ordering physician is encouraged to contact the OCNY medical director to provide such information. The peer-to-peer conversation gives the treating provider the opportunity to discuss the OCNY determination before an actual denial has occurred and before the initiation of the appeals process.

Please call 1-866-565-3468 for a peer-to-peer discussion during the hours of 8 a.m. to 5 p.m. ET, Monday through Friday.

The opportunity to discuss the determination is provided with the OCNY medical director making the initial determination or a covering OCNY medical director if the original OCNY medical director is not available. If the peer-to-peer discussion does not result in the authorization of the request, OCNY informs the provider and enrollee of their appeal rights during the notification.

**NOTE**: The peer-to-peer conversation may occur after the date/time provided during the notification call, however, once the adverse determination has been issued to the member, the initial adverse determination cannot be changed. If the peer-to-peer discussion does not result in the authorization of the request, OCNY informs the provider of the appeal rights.

For prior authorization only, Part B, Expedited and aged cases day 10 and greater are eligible for a peer-to-peer post decision discussion. A determination change is not available due to compliance
requirements on case turnaround times. For a final determination change, OCNY informs the provider of the appeal rights.

Health improvement

Optum Care affirmative statement

Our principles of ethics and integrity and code of conduct serves as a guide to acceptable and appropriate business conduct by the company’s employees and contractors.

- Utilization Management (UM) decision-making is based only on medical necessity, efficiency or appropriateness of health care services and treatment plans required by provider contractual agreement and the patient’s benefit plan
- Practitioners or other individuals are not rewarded for issuing denials of coverage or care
- Financial incentives for UM decision-makers do not encourage decisions that result in under-utilization nor are incentives used to encourage barriers to care and service
- Hiring, promoting, or terminating practitioners or other individuals is not based upon the likelihood or the perceived likelihood that the individual will support or tend to support the denial of benefit

Optum Care uses standardized, objective and clinically valid criteria that are compatible with established principles of health care and flexible enough to allow for variations. These criteria are based on reasonable medical evidence and acceptable medical standards of practice (i.e., applicable health plan benefits and coverage documents, national and local coverage determinations, CMS guidelines, and Milliman Care Guidelines). The criteria are applied in a flexible manner based on currently accepted medical or health care practices, consideration of patients with specialized needs (including, but not limited to, patients with disabilities), acute conditions or life-threatening illness and an assessment of the local delivery system.

Upon request from a patient, a patient’s representative, the general public, or a physician, the relevant criteria used to support the UM decision-making process may be released. Patients are instructed in their adverse determination letters that they may call the UM department to make a criteria request.

Physicians may contact the Optum Care UM department to obtain UM policy or criteria used in making medical decisions.

Care Management

OCNY’s Care Management team consists of registered nurses, social workers, and other care coordinators. Primary care offices can refer patients with complex care needs, but we also capture members in need of services from utilization management, pre-authorization trends, transitions of care (i.e., Hospital to Skilled Nursing), and members can also self-refer.

Care Management has oversight of the following programs:
- Transition Management
- Complex Care Management (medical/behavioral health)
- Disease Management/Condition Support
- Emergency Department Reduction Program

For additional information, please contact your Practice Performance Manager.
Identifying OCNY Members/Patients

Health plans assign patients based on PCP selection. In most cases, an identifier can be found on the patient’s health plan identification card listing OCNY as the “Provider Group” or by Payer ID (LIFE1). Please refer to the health plan identification card samples in the appendix. Additionally, providers and facilities should verify eligibility using the health plan’s portal.

Portal Access

Summary

Optum Care Provider Portal is a secure, internet-based, customized experience for providers to care for their patients and our members. A one-stop shop that has claims and member insights, prior authorizations, quality, risk adjustment and affordability performance data. Providers have enhanced decision-making tools to improve care and lower costs.

Optum Care Provider Portal provides access to the following:

- Attestation Review and Submission
- Eligibility Status
- Claims Status
- Prior Authorization Status
- Prior Authorization Submission
- Secure Messaging with Optum Care Network Teams

Direct Contracting Model

Direct Contracting Model or “DCM” shall refer to OCNY’s participation in CMS’s Direct Contracting Model. This is the most innovative payment system offered by CMS for Traditional Medicare and supports OCNY’s pursuit of the quadruple aim.

Claims Process

Submit DCM patient claims to your Medicare Administrative Contractor (MAC), using the same process in place for traditional Medicare beneficiaries. Medicare will adjudicate the claim according to Medicare’s standard reimbursement policy. Medicare will apply the rate contracted with OCNY to the otherwise payable amount for services. Medicare will send an Explanation of Payment (EOP) through their normal channels that will reflect your contracted rate with OCNY. Additionally, you will receive an EOP from Optum/OCNY when your contracted payment is completed.

The OCNY team receives weekly claims details file and can assist with general payment inquiries not covered by Medicare service authorization. Any questions relating to the claim determination should be directed to the MAC or CMS accordingly. Questions specific to the contracted payment itself should be directed to Optum.

Beneficiary alignment, beneficiary engagement

Alignment:

CMS uses claims-based alignment to align beneficiaries to the program for each performance year. Alignment is based off historical utilization patterns for each patient. Not all Medicare patients qualify for this program. Assigned patient list for contracted TINs is available through OCNY at any point of the performance year. All assigned Medicare beneficiaries are provided a written notice of their participation
in the program. OCNY shall not commit any act or omission, nor adapt any policy, that inhibits beneficiaries from exercising their freedom to obtain healthcare services.

**Engagement:**
OCNY may provide and may permit its DCM Participant Providers and Preferred Providers to provide the Part B Cost-Sharing Support Beneficiary Engagement Incentive and the Chronic Disease Management Reward Beneficiary Engagement Incentive to certain DC Beneficiaries.
ID Card Samples:

Participating plans and samples of their ID cards
These member ID cards are samples for illustration only; actual information varies depending on payer, plan and other requirements.

| 1. Participating health plan logo | 4. Plan name |
| 2. Payer ID | 5. Provider services toll-free number |
| 3. Network name | 6. Medical claims address |