Amerigroup RealSolutions®
Medicare Advantage Plans

Provider Quick Reference

Precertification/notification requirements

Important phone numbers ■ Health services information

Medicare Advantage

https://providers.amerigroup.com

SSO-PEC-0767-16

Easy access to **precertification/notification requirements** and other important information

For more information about requirements, benefits and services, visit our provider website to get the most recent, full version of our provider manual. If you have questions about this document or recommendations to improve it, call your local Provider Relations representative. We want to hear from you and improve our service so you can focus on serving your patients!

For code-specific requirements for all services, log on to https://providers.amerigroup.com and select Precertification Lookup from our Quick Tools menu.

Requirements listed are for network providers. In many cases, out-of-network providers may be required to request precertification for services when network providers do not.

Precertification and notification instructions and definitions

Precertification

The act of authorizing specific services or activities before they are rendered or occur.

Notification

Telephonic, fax, or electronic communication received from a provider to inform us of your intent to render covered medical services to a member.

- Give us notification prior to rendering services outlined in this document.
- For emergency or urgent services, give us notification within 24 hours or the next business day.
- There is no review against medical necessity criteria; however, member eligibility and provider status (network and non-network) are verified.

Data required for notification/precertification:

- Member ID number
- Name of referring provider
- Name of individual referred to provider
- Number of visits/services
- Dates of service
- Diagnosis
- Current Procedural Terminology (CPT) code

Clinical information is required for precertification. (The Authorization Request Form is also available online.) Clinical staff is available during normal business hours from 8 a.m. to 5 p.m. local time.

Request precertifications and give us notifications:

Online

https://providers.amerigroup.com

By phone

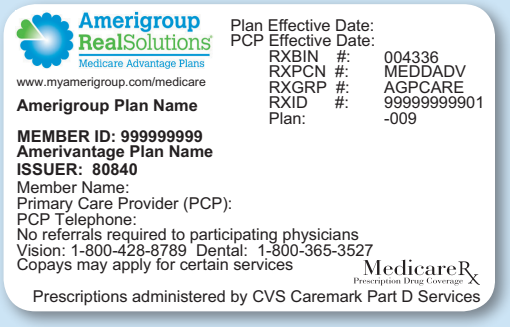
1-866-805-4589

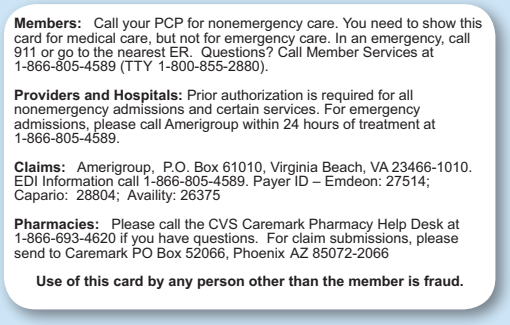
By fax

- **Behavioral health outpatient services**
  1-800-505-1193
- **Behavioral health inpatient services**
  1-877-434-7578
- **Therapies, home health, durable medical equipment and discharge planning**
  1-866-959-1537
- **Concurrent review clinical documentation for inpatient**
  1-888-700-2197
- **Initial admission notification and all other services**
  1-866-959-1537

Member ID cards

All members receive an ID card containing their name, member number and information about their benefits. Members should use their ID cards when receiving services.





Important Contact Information

Dedicated Service Unit (DSU)

Contact the DSU at 1-866-805-4589 for member eligibility, the Nurse HelpLine and pharmacy services.

Provider website and IVR available 24/7/365:

To verify eligibility, check claims and referral authorization status, and look up precertification/notification requirements, visit https://providers.amerigroup.com.

Can't access the Internet? Call the DSU and simply say your national provider ID when prompted by the recorded voice. The recording guides you through our menu of options — just select the information or materials you need when you hear it.

Health Services

Nurse HelpLine • 1-866-805-4589

Members can access a network of board-certified physicians for telephonic consultations 24 hours a day, 7 days a week and 365 days a year.

Case Management Services • 1-866-805-4589

We offer case management services to members who are likely to have extensive health care needs. Our nurse case managers work with you to develop individualized care plans, including identifying community resources, providing health education, monitoring compliance, assisting with transportation, etc.

Case managers are available during normal business hours from 8 a.m. to 5 p.m. local time. For urgent issues, assistance is available after normal business hours, on weekends and on holidays through Provider Services at the DSU at 1-866-805-4589.

Disease Management Centralized Care Unit (DMCCU) Services • 1-888-830-4300

DMCCU services include educational information like local community support agencies and events in the health plan's service area. Services are available for members with the following medical conditions: asthma, bipolar disorder, COPD, CHF, CAD, diabetes, HIV/AIDS, hypertension, obesity, major depressive disorder, schizophrenia and transplants.

Preferred Laboratory Vendors

Please refer Amerigroup* members to Laboratory Corporation of America (LabCorp) or Quest Diagnostics for all laboratory services. Precertification is required to refer members to nonparticipating laboratory vendors except for emergencies and services exempted by state or federal regulations. For more information or to request services, contact:

- LabCorp at 1-800-345-4363 or labcorp.com
- Quest Diagnostics at 1-866-697-8378 or questdiagnostics.com

Relay Service • 711

Member Services • 1-866-805-4589

*In New Mexico, Amerigroup Community Care of New Mexico, Inc. In Texas, Amerigroup members in the Medicaid Rural Service Area are served by Amerigroup Insurance Company; all other Amerigroup members are served by Amerigroup Texas, Inc. In Washington, Amerigroup Washington, Inc.

Other Important Contact Information continued

Claims Services

Electronic Data Interchange (EDI)

To get started using EDI or for help, call the Amerigroup EDI Hotline at 1-800-590-5745.

We accept electronic claims through three clearinghouses:

Clearinghouse	Payer ID	Telephone number
Capario	28804	1-800-792-5256
Emdeon	27514	1-877-469-3263
Availity	26375	1-877-334-8446

Online Claims

Amerigroup provides an online resource designed to significantly reduce the time your office spends on eligibility verification, claims status and authorization status. Visit our website at https://providers.amerigroup.com.

Telephonic Claims

If you are unable to access the Internet, you may receive claims, eligibility and authorization status over the telephone at any time by calling our toll-free automated Provider Services line at the DSU at 1-866-805-4589.

Paper Claims

Submit claims on original claim forms (CMS-1500 or CMS-1450) printed with dropout red ink or typed (not handwritten) in large, dark font. CMS-approved modifiers must be used appropriately based on the type of service and procedure code. Mail to:

Claims, Amerigroup
P.O. Box 61010, Virginia Beach, VA 23466-1010

Timely Filing

Timely filing is governed by the terms of the provider agreement. Timely filing for each market is the same as the Amerigroup timely filing requirement for its Medicaid product in each state and within the number of days listed in the table to the right from the date of service.

Market	Timely Filing
Florida	180 days
Georgia	180 days
Maryland	180 days
New Jersey	180 days
New Mexico	90 days
Tennessee	120 days
Texas	95 days

Administrative Complaints/Payment Disputes

The appropriate Medicare appeals process is determined by the liable party, not by the initiator. The Amerigroup time frame to review your request will commence once your appeal is routed to the appropriate department. Please refer to the denial letter or Explanation of Payment (EOP) issued to determine the correct appeals process. Administrative complaints/payment disputes must be filed within 120 calendar days of the initial Amerigroup decision. Send administrative complaints/payment disputes to:

Payment Dispute Unit, Amerigroup
P.O. Box 61599
Virginia Beach, VA 23466-1599

Medicare Member Appeals

The appropriate Medicare appeals process is determined by the liable party, not by the initiator. Please refer to the denial letter or EOP issued to determine the correct appeals process to follow. All Medicare member appeals should be sent to:

Medicare Complaints, Appeals and Grievances
Amerigroup, P.O. Box 61116
Virginia Beach, VA 23466-1116

Fax: 1-888-775-3065

A physician's signature is required on all appeals submitted on behalf of a member; otherwise an Appointment of Representative form is required. In the event that failure to provide the service is life- or limb-threatening or that waiting the standard appeal time frame would be harmful to the member, please indicate if you are requesting an expedited/fast appeal.

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