Provider Orientation
AGENDA

1. Overview of the Affordable Care Act
2. The Health Insurance Marketplace
3. Verification of Eligibility, Benefits and Cost Shares
4. Specialty Referrals
5. Provider Relations
6. Risk Adjustment
7. Public Website and Secure Portal
8. Prior Authorization
9. Pharmacy
10. Claims
11. Complaints/Grievances and Appeals
12. Specialty Companies/Vendors
13. Provider Manual and Provider Took Kit
14. Contact Information
The Affordable Care Act

Key Objectives of the Affordable Care Act (ACA):

- Increase access to quality health insurance
- Improve affordability

Additional Parameters:

- Dependent coverage to age 26
- Pre-existing condition insurance plan (high risk pools)
- No lifetime maximum benefits
- Preventative care covered at 100%
- Insurer minimum loss ratio (80% for individual coverage)
The Affordable Care Act

Reform the commercial insurance market – Marketplace or Exchanges

- No more underwriting – guaranteed issue
- Tax penalties for not purchasing insurance
- Minimum standards for coverage: benefits and cost sharing limits
- Subsidies for lower incomes (100% - 138% FPL)
Health Insurance Marketplace

Online marketplaces for purchasing health insurance

Potential members can:

• Register
• Determine eligibility for all health insurance programs (including Medicaid)
• Shop for plans
• Enroll in a plan
• Exchanges may be State-based or federally facilitated or State Partnership –
  
  *Georgia is a Federally Facilitated Marketplace*

  *The Health Insurance Marketplace is the only way to purchase insurance AND receive subsidies.*
Subsidies come in the form of:

- Advanced Premium Tax Credits (APTC)
- Cost Share Reductions (CSR)

All Benefit Plans have cost shares in the form of copays, coinsurance and deductibles

- Some members will qualify for assistance with their cost shares based on their income level.
- This assistance would be paid directly from the Government to the member’s health plan.
WHAT YOU NEED TO KNOW…
Verification of Eligibility, Benefits and Cost Share

Member ID Card:

* Possession of an ID Card is not a guarantee eligibility and benefits
Providers should always verify member eligibility:
  • Every time a member schedules an appointment
  • When the member arrives for the appointment

Eligibility verification can be done via:
  • Secure Provider Portal
  • Calling Provider Services, 1-877-687-1180

Panel Status
  • PCPs should confirm that a member is assigned to their patient panel
  • This can be done via our Secure Provider Portal
  • PCPs can still administer service if the member is not and may wish to have member assigned to them for future care
Verification of Eligibility, Benefits and Cost Share

Eligibility, Benefits and Cost Shares can be verified in 3 ways:

1. **The Ambetter secure portal found at: provider.pshpgeorgia.com**
   - If you are already a registered user of the Ambetter from Peach State Health Plan secure portal, you do NOT need a separate registration!

2. **24/7 Interactive Voice Response system**
   - Enter the Member ID Number and the month of service to check eligibility

3. **Contact Provider Service at: 1-877-687-1180**
Verification of Eligibility

- To view the member’s eligibility status locate the member on the eligibility or patient list tab.
- Member’s name is a clickable link to the Member Health Record.
Verification of Cost Shares

- To view the member’s cost share, locate the member on the eligibility or patient list tab.

- Member’s name is a clickable link to the Member Health Record.

- Select the Cost Sharing tab to view information about the patient’s financial responsibility.

- Cost sharing information will be displayed by service type – Medical, Dental, Vision or Pharmacy.
Verification of Benefits

- To view member benefits locate the member on the eligibility or patient list tab.
- Member’s name is a clickable link to the member’s Health Record.
- Select the Summary of Benefits tab to view additional information about the member’s benefits.
Specialty Referrals

- Members are educated to seek care or consultation with their Primary Care Provider first.

- When medically necessary care is needed beyond the scope of what a PCP provides, PCPs should initiate and coordinate the care members receive from specialist providers.

- **PAPER REFERRALS ARE NOT REQUIRED FOR MEMBERS TO SEEK CARE WITH IN-NETWORK SPECIALISTS.**
What Resources are Available to our Providers?

- Dedicated Provider Relations Contact
- Provider Servicing and Operations Team
- Provider Performance Team contact
- Provider Secure Portal
- Provider Communications
- Community Based Medical Director & Clinical Teams
- Community Health Services Team
- Provider Practice HEDIS Education Team
Provider Relations Servicing and Operations Specialist

• 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
Provider Performance Specialist

The Provider Performance team 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 & Interpreta)
• Incentive Programs
Provider Relations

2018 Umbrella Incentive Program
## Umbrella Pay for Performance Overview

<table>
<thead>
<tr>
<th>Objective</th>
<th>Enhance quality of care through a PCP driven program with a focus on preventive and screening services which align with State goals while promoting engagement with members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligible Members</td>
<td>All PSHP Members (including Medicaid, Medicare, and Marketplace), who have been formally assigned to a Provider group</td>
</tr>
</tbody>
</table>
| Performance Incentive | Each measure has its own incentive amount paid after achieving the minimum target score, with increasing percentages earned at each threshold  
- Target 1 pays 50% of the incentive dollar amount  
- Target 2 pays 75% of the incentive dollar amount  
- Target 3 pays 100% of the incentive dollar amount |
| Measures | HEDIS Measures are based on 2018 NCQA technical guidelines and Quality Compass 50th, 75th, 90th percentiles. |
| Measurement Time Period | HEDIS Calendar year January 1 – December 31 – But can adjust targets off cycle based on updates from NCQA and the State |
| Reports and Payments |  
- Monthly reporting with two interim payouts and annual reconciliation  
- Program pays to TIN |
Umbrella Incentive Program (cont.)

- Program combines all products
- Program pays to TIN
- No contract amendment – Letter outlining the program sent to PCPs. Monthly gap reports through provider Portal.
- Payment per measure based on target achieved
- Incentives are paid on each compliant member event once the target has been met for that specific measure
- Incentives are paid on each compliant member event once the target has been met for that specific measure
- Each measure is evaluated independently and can qualify and receive an incentive payment for one, multiple or all of the measures
- 3 tier targets are set by the plan based on low, medium, and high thresholds
- No claw back feature – No recoupment of past payments if scores drop in later periods
Risk Adjustment 101

10/25/2019
What is Risk Adjustment?

• The process by which health plans are reimbursed based on the health status of their members
• Implemented to pay health plans more accurately for the predicted health care cost of members by adjusting payments based on demographics as well as health status
• Helps ensure that health plans are appropriately compensated for the high risk members they enroll
• A risk score compares the predicted costs for members of a health plan with that of the average cost for the population eligible for enrollment
How Does it Work?

- Diseases groups contain major diseases and are broadly organized into body systems
- Categories of medical conditions map to a corresponding group of diagnosis codes
  - Referred to as Risk Adjustment Models
- Families or hierarchical groups(categories) are used in risk adjustment
  - Used to provide payment for only the most severe or complicated illness within a category
- Diagnosis codes carry a risk adjustment value in the risk adjustment model
  - The more severe or complex a diagnosis is, the higher its value
- These values, along with demographic indicators are used to calculate the patient’s risk score
  - This allows for recognition of coexisting diseases when calculating payment by recognizing multiple chronic conditions which leads to higher cost to care for patients
Provider’s Role

- Physician data is critical for accurate risk adjustment.
  - Physicians are the largest source of ambulatory data for the risk adjustment models.
- Risk adjusted payment relies on accurate diagnosis coding on claims and complete medical record documentation.
- Specificity of diagnosis is substantiated by the medical record
  - Utilization of specific diagnosis codes help to articulate the severity of coding being addressed during each visit.
The Importance of Accurate Documentation

• Risk adjusted payment relies on accurate diagnosis coding on claims and complete medical record documentation

• Specificity of diagnosis coding is substantiated by the medical record
  – Utilization of the most specific diagnosis codes helps to articulate the severity of the conditions being addressed at each visit

• Documentation and coding depicts the level of disease severity, comorbidities, underlying disease, and other factors that contribute to the level of complexity for the patient encounter
  – Allows for assignment of the most specific diagnoses

• Accurate documentation and coding helps ensure health plans are reimbursed appropriately to provide funds to care for their sicker members
Each record must:

✓ Contain member name and DOS on each page
✓ Be complete and legible
✓ Show medical necessity
✓ Support what is coded and billed
✓ Be able to stand alone
✓ Contain only standard medical abbreviations
✓ Contain a legible hand written or authenticated electronic signature with credential's
Medical Record Documentation Tips

• A condition only exists when it is documented
  – Diagnoses do not carry over from visit to visit or year to year
• A condition can be coded and reported as many times as patient receives care and treatment for the condition
  – Do not code for conditions that were previously treated and no longer exist
• Conditions can be coded when documentation states condition is being monitored and treated by a specialist
  – “Patient on Coumadin for atrial fibrillation; followed by Dr. Hill”
• Co-existing conditions can be coded when documentation states that the condition affects the care, treatment, or management of the patient.
  – “Sugar free cough syrup prescribed due to Type 2 DM”
• Physicians and practitioners should code all documented conditions that co-exist at the time of the encounter/visit that require or affect patient care, treatment, and/or management.
Top 10 HCC Flags

- Diabetes
- Asthma/ COPD
- Major Depressive Disorder/ Bipolar, Psychosis, or Delusional Disorder
- Breast, prostate, benign/uncertain brain tumors, and other cancers
- Rheumatoid Arthritis and Specified Autoimmune disorders
- Specified Heart Arrhythmias'
- Completed pregnancies with any level of complications
- Chronic Hepatitis
- Seizure Disorders
- Congestive Heart Failure
What you can do to help?

• Encourage your patients to come in for annual visits. During this visit existing diagnoses can be **recaptured**, and new diagnoses coded.

• Ensure that **documentation** is specific and accurate.

• Make sure that a **signature with credentials** is present on each date of service.

• Ensure **coding is captured at the highest level of specificity**. *Eg. A member who is diabetic with complications should be coded with the proper diagnoses.*
## Peach State RA Programs

Peach State partners with Risk Adjustment vendors to support Risk Adjustment activities.

<table>
<thead>
<tr>
<th>Program (Vendor)</th>
<th>Program Description</th>
<th>Incentive / Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>SMAS (Change Healthcare)</td>
<td>Telephonic outreach to assist members with scheduling a PCP visit, and selecting a PCP if one is needed.</td>
<td>If the member schedules and completes his/her appointment they will receive a $25 “My Health Pays” incentive.</td>
</tr>
<tr>
<td>In Home (USMM)</td>
<td>A CMS qualified provider goes into the member’s home to complete a health assessment that will address risk/care gaps.</td>
<td>N/A</td>
</tr>
<tr>
<td>RADV (Change Healthcare)</td>
<td>A random sample of 200 members selected by CMS to have their records audited. The audit is to validate that claims and medical records for selected dates of service match.</td>
<td>N/A</td>
</tr>
<tr>
<td>HQPAF (Optum)</td>
<td>Provers are sent an assessment form that caters specifically to a selected member that addresses the risk/gaps of the member. Once the form is completed and returned to Optum within a certain timeframe, the provider is given an incentive.</td>
<td>There is an opportunity to receive an incentive of up to $100. The provider must submit the required documentation within 60 days of treating the member. After the 60 day window, the incentive decreases to $25.</td>
</tr>
<tr>
<td>Chart Chase (Change Healthcare &amp; Optum)</td>
<td>Retrospective chart retrieval to review prior year's data.</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Public Website

Information contained on our Website

• The Provider and Billing Manual
• Quick Reference Guides
• Forms (Notification of Pregnancy, Prior Authorization Fax forms, etc.)
• The Pre-Auth Needed Tool
• The Pharmacy Preferred Drug Listing
• And much more…
Secure Provider Portal

Information contained on our Secure Provider Portal

- Member Eligibility & Patient Listings
- Health Records & Care Gaps
- Authorizations
- Claims Submissions & Status
- Corrected Claims & Adjustments
- Payments History
- Monthly PCP Cost Reports
Secure Provider Portal

Registration is free and easy.

- Click Create An Account to register
- Instructional Registration Video and PDF file available on this page
- Contact your Provider Network Specialist with any questions
Secure Provider Portal

PCP Reports

- PCP reports available on Ambetter from Peach State Health Plan’s secure provider web portal are generated on a monthly basis and can be exported into a PDF or Excel format.

PCP Reports Include

- Patient List with HEDIS Care Gaps
- Emergency Room Utilization
- Rx Claims Report
- High Cost Claims
Prior Authorization

Procedures / Services*

- High Tech Imaging (i.e., CT, MRI, PET)
- Infertility
- Obstetrical Ultrasound
  - One allowed in 9 month period, any additional will require prior authorization except those rendered by perinatologists.
  - For urgent/emergent ultrasounds, treat using best clinical judgment and this will be reviewed retrospectively.
- Pain Management

* This is not meant to be an all-inclusive list
Prior Authorization

Inpatient Authorization*

- All elective/scheduled admission notifications requested at least 5 business days prior to the scheduled date of admit including:
  - All services performed in out-of-network facilities
  - Behavioral health/substance use
  - Hospice care
  - Rehabilitation facilities
  - Transplants, including evaluation
- Observation stays exceeding 48 hours require Inpatient Authorization
- Continued on next slide

* This is not meant as an all-inclusive list
Prior Authorization

Inpatient Authorization, cont.*

• Urgent/Emergent Admissions
  – Within 1 business day following the date of admission
  – Newborn deliveries must include birth outcomes

• Partial Inpatient, PRTF and/or Intensive Outpatient Programs

* This is not meant to be an all-inclusive list
Prior Authorization

Ancillary Services*

- Air Ambulance Transport (non-emergent fixed-wing airplane)
- DME
- Home health care services including, home infusion, skilled nursing, and therapy
  - Home Health Services
  - Private Duty Nursing
  - Adult Medical Day Care
  - Hospice
  - Furnished Medical Supplies & DME
  - Home Dialysis
- Continued on next slide

* This is not meant to be an all-inclusive list
Prior Authorization

Ancillary Services, cont.

• Orthotics/Prosthetics
  – Therapy
  – Occupational
  – Physical
  – Speech
• Hearing Aid devices including cochlear implants
• Genetic Testing
• Quantitative Urine Drug Screen

* This is not meant to be an all-inclusive list
## Prior Authorization

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scheduled admissions</td>
<td>Five business days prior to the scheduled admission date</td>
</tr>
<tr>
<td>Elective outpatient services</td>
<td>Five business days prior to the scheduled admission date</td>
</tr>
<tr>
<td>Emergent inpatient admissions</td>
<td>Notification within one business day</td>
</tr>
<tr>
<td>Observation – 48 hours or less</td>
<td>Notification within one business day for non-participating providers</td>
</tr>
<tr>
<td>Observation – greater than 48 hours</td>
<td>Requires inpatient prior authorization within one business day</td>
</tr>
<tr>
<td>Emergency room and post stabilization, urgent care and crisis intervention</td>
<td>Notification within one business day</td>
</tr>
<tr>
<td>Maternity admissions</td>
<td>Notification within one business day</td>
</tr>
<tr>
<td>Newborn admissions</td>
<td>Notification within one business day</td>
</tr>
<tr>
<td>Neonatal Intensive Care Unit (NICU) admissions</td>
<td>Notification within one business day</td>
</tr>
<tr>
<td>Outpatient Dialysis</td>
<td>Notification within one business day</td>
</tr>
</tbody>
</table>

*This is not meant to be an all-inclusive list*
Utilization Determination Timeframes

<table>
<thead>
<tr>
<th>Type</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prospective/Urgent</td>
<td>Seventy-two (72) hours (3 calendar days)</td>
</tr>
<tr>
<td>Prospective/Non-Urgent</td>
<td>Fifteen (15) calendar days</td>
</tr>
<tr>
<td>Emergency services</td>
<td>60 minutes</td>
</tr>
<tr>
<td>Concurrent/Urgent</td>
<td>Twenty-four (24) hours (1 calendar day)</td>
</tr>
<tr>
<td>Retrospective</td>
<td>Thirty (30) calendar days</td>
</tr>
</tbody>
</table>

* This is not meant to be an all-inclusive list
Pre-Auth Check Tool

Are Services being performed in the Emergency Department?

YES □  NO □

<table>
<thead>
<tr>
<th>Types of Services</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the member being admitted to an inpatient facility?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the member having observation services?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are anesthesia services being rendered for pain management or dental surgeries?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the member receiving hospice services?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are services, other than DME, orthotics, prosthetics, and supplies, being rendered in the home?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Enter the code of the service you would like to check:

69436

Check

N 69436 - TYMPANOSTOMY GEN ANES
No authorization required.
Prior Authorization can be requested in 3 ways:

1. The Ambetter secure portal found at provider.pshpgeorgia.com

2. Fax Requests to: 1-855-685-6508
   The fax authorization forms are located on our website at ambetter.pshpgeorgia.com

3. Call for Prior Authorization at 1-877-687-1180
Prior Authorization

Prior Authorization will be granted at the CPT code level

- If a claim is submitted that contains CPT codes that were not authorized, the entire claim will be denied.

- If additional procedures are performed during the procedure, the provider must contact the health plan to update the authorization in order to avoid a claim denial.

- It is recommended that this be done within 72 hours of the procedure; however, it must be done prior to claim submission or the claim will deny.

- Ambetter will update authorizations but will not retro-authorize services.
  - The claim will deny for lack of authorization.
  - If there are extenuating circumstances that led to the lack of authorization, the claim may be appealed.
Pharmacy
Pharmacy

• Ambetter Preferred Drug List (PDL)
• Specialty Medication Prior Authorization Form
• Non-Specialty Medication Prior Authorization Form

https://ambetter.pshpgeorgia.com/provider-resources/pharmacy.html
Pharmacy Prior Authorization requests should be submitted based on the type of medication: specialty, non-specialty or buy and bill.

- Envolve Pharmacy Solutions: 1-866-399-0929 (on specialty medications)

- AcariaHealth: 1-855-521-1728 (specialty medications)

- Peach State Health Plan Pharmacy Department: 1-866-374-1579 (buy and bill medications)
Claims

**Clean Claim**
- A claim that is received for adjudication in a nationally accepted format in compliance with standard coding guidelines and does not have any defect, impropriety, lack of any required documentation or particular circumstance requiring special treatment that prevents timely payment

**Exceptions**
- A claim for which fraud is suspected
- A claim for which a third party resource should be responsible
Claim Submission

The timely filing deadline for initial claims is 180 days from the date of service or date of primary payment when Ambetter is secondary.

Claims may be submitted in 3 ways:

1. The secure web portal located at provider.pshpgeorgia.com

2. Electronic Clearinghouse
   - Payor ID 68069
   - Clearinghouses currently utilized by Ambetter from Peach State Health plan will continue to be utilized
   - For a listing our the Clearinghouses, please visit our website at ambetter.pshpgeorgia.com

3. Paper claims may be submitted to:
   Ambetter from Peach State Health Plan
   PO Box 5010
   Farmington, MO 64640-5010
Claim Submission

Claim Reconsiderations (Level I)

- A written request from a provider about a disagreement in the manner in which a claim was processed.
- A Provider Request for Reconsideration and Claim Dispute form can be found on our website at ambetter.pshpgeorgia.com
- Must be submitted within 180 days of the Explanation of Payment.
- Claim Reconsiderations may be mailed to:
  Ambetter from Peach State Health Plan
  Attn: Reconsideration
  PO Box 5010 – Farmington, MO  63640-5010

Claim Disputes (Level II)

- Should be used only when a provider has received an unsatisfactory response to a request for reconsideration
- Must be submitted within 180 days of the Explanation of Payment
- A Provider Request for Reconsideration and Claim Dispute form can be found on our website at ambetter.pshpgeorgia.com
- The completed Claim Dispute form may be mailed to:
  Ambetter from Peach State Health Plan
  Attn: Claims Dispute
  PO Box 5000 – Farmington, MO  63640-5000
Claim Submission

Member in Suspended Status

- A provision of the ACA allows members who are receiving Advanced Premium Tax Credits (APTCs) a 3 month grace period for paying premiums.

- After the first 30 days, the member is placed in a suspended status. The Explanation of Payment will indicate LZ Pend: Non-Payment of Premium.

- While the member is in a suspended status, claims will be pended.

- When the premium is paid by the member, the claims will be released and adjudicated.

- If the member does not pay the premium, the claims will be released and the provider may bill the member directly for services.

- The providers is responsible for verifying eligibility at the point of care to avoid non payment due to invalid member eligibility.
Claim Submission

Member in Suspended Status – Example

- **January 1**
  Member Pays Premium

- **February 1**
  Premium Due – Member does not pay

- **March 1**
  Member placed in suspended status

- **April 1**
  Member remains in suspended status

- **May 1**
  If premium remains unpaid, member is terminated. Provider may bill member directly for services rendered.

Claims for members in a suspended status are not considered “clean claims”.

* Note: When checking Eligibility, the Secure Portal will indicate that the member is in a suspended status.*
Claim Submission

Other helpful information:

Rendering Taxonomy Code
- Claims must be submitted with the rendering provider’s taxonomy code.
- The claim will deny if the taxonomy code is not present.
- This is necessary in order to accurately adjudicate the claim.

CLIA Number
- If the claim contains CLIA certified or CLIA waived services, the CLIA number must be entered in Box 23 of a paper claim form or in the appropriate loop for EDI claims.
- Claims will be rejected if the CLIA number is not on the claim.
- Group NPI is required on all claim submitted.
Claim Submission

Billing the Member:

• Copays, Coinsurance and any unpaid portion of the Deductible may be collected at the time of service.

• The Secure Web Portal will indicate the amount of the deductible that has been met.

• If the amount collected from the member is higher than the actual amount owed upon claim adjudication, the provider must reimburse the member within 45 days.
Claim Payment

PaySpan

- Ambetter partners with PaySpan for Electronic Remittance Advice (ERA) and Electronic Funds Transfer
- If you currently utilize PaySpan, you will need to register specifically for the Ambetter product
- **To register for PaySpan:**
  Call 1-877-331-7154 or visit [www.payspanhealth.com](http://www.payspanhealth.com)
Complaints/Grievances/Appeals

**Claims**
- A provider must exhaust the Claims Reconsideration and Claims Dispute process before filing a Complaint/Grievance or Appeal

**Complaint/Grievance**
- Must be filed within 30 calendar days of the Notice of Action
- Upon receipt of complete information to evaluate the request, Ambetter will provide a written response within 30 calendar days
Complaints/Grievances/Appeals

Appeals

• For Claims, the Claims Reconsideration, Claims Dispute and Complaint/Grievances process must be exhausted prior to filing an appeal

Medical Necessity

• Must be filed within 30 calendar days from the Notice of Action.
• Ambetter shall acknowledge receipt within 10 business days of receiving the appeal.
• Ambetter shall resolve each appeal and provide written notice as expeditiously as the member’s health condition requires but not to exceed 30 calendar days.
• Expedited appeals may be filed if the time expended in a standard appeal could seriously jeopardize the member’s life or health. The timeframe for a decision for an expedited appeal will not exceed 72 hours.
Complaints/Grievances/Appeals

- Members may designate Providers to act as their Representative for filing appeals related to Medical Necessity.
  - Ambetter requires that this designation by the Member be made in writing and provided to Ambetter

- No punitive action will be taken against a provider by Ambetter for acting as a Member’s Representative.

- Full Details of the Claim Reconsideration, Claim Dispute, Complaints/Grievances and Appeals processes can be found in our Provider Manual at: ambetter.pshpgeorgia.com
<table>
<thead>
<tr>
<th>Service</th>
<th>Specialty Company/Vendor</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision Services</td>
<td>Envolve Vision Benefits</td>
<td>1-800-334-3937 <a href="http://www.envolvevision.com">www.envolvevision.com</a></td>
</tr>
<tr>
<td>Dental Services</td>
<td>Envolve Dental</td>
<td>1-844-464-5632 <a href="http://www.pwp.envolvedental.com">www.pwp.envolvedental.com</a></td>
</tr>
<tr>
<td>Pharmacy Services</td>
<td>Envolve Pharmacy Solutions</td>
<td>1-866-399-0928 (Phone) 1-866-399-0929 (Fax)</td>
</tr>
</tbody>
</table>
Provider Tool Kit

Information included in the Tool Kit:

- Welcome Letter
- Ambetter Provider Introductory Brochure
- Secure Portal Setup
- Electronic Funds Transfer Setup
- Prior Authorization Guide
- Quick Reference Guide
- Provider Office Window Decal
Contact Information

Ambetter from Peach State Health Plan
Phone: 1-877-687-1180
TTY/TDD: 1-877-941-9231
Ambetter.pshpgeorgia.com
Questions