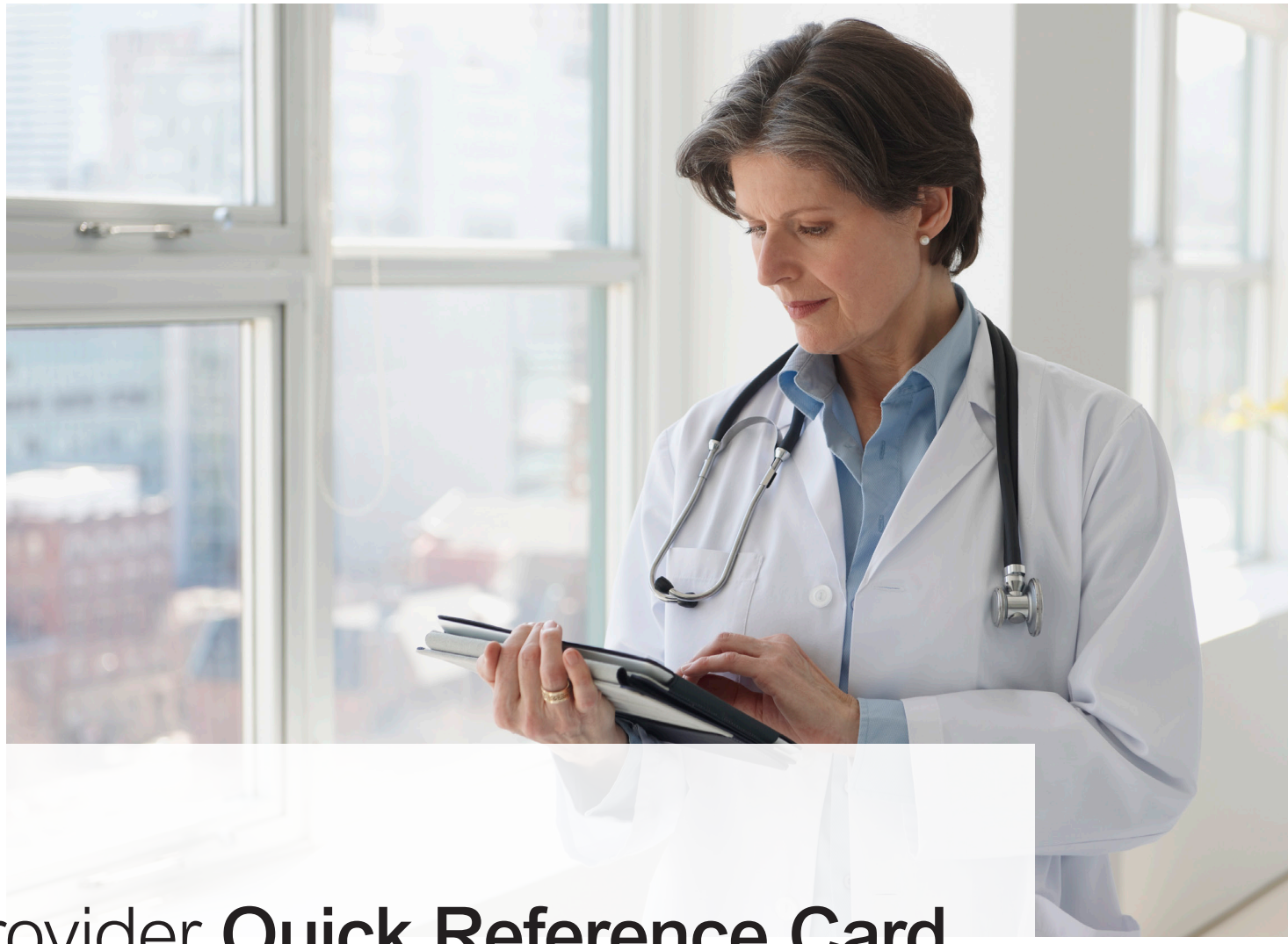
Anthem

Medicaid



Provider **Quick Reference Card**

Precertification/notification requirements | Important phone numbers | Revenue codes

https://providers.anthem.com/ny

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 quick reference card (QRC) or recommendations to improve it, call your local provider relationship management representative. We want to hear from you and improve our service so you can focus on serving your patients!

Precertification/notification instructions and definitions

Precertification — Precertification means the authorization of specific services or activities before they are rendered or occur. This is also known as prior authorization (PA).

Notification — Notification is telephonic, fax, or electronic communication received from providers to inform us of their 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.

Request precertification and give us notification:

- Using our preferred method online on our **provider website.**
- By phone at **800-450-8753**.
- By fax at **800-964-3627**.
- Behavioral health fax: Please use the correct Medicaid form located on the **provider website**.

For code-specific requirements for all services, our **provider website** and select **Request Precertification**.

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

BH/substance use

Anthem offers BH benefits for the following:

- **Medicaid Managed Care (MMC)** is state-sponsored health insurance assisting those unable to afford medical care.
- **Child Health Plus (CHPlus)** is a state-sponsored, no- or low-cost health insurance program available to members of low-income families ages 0 to 19 who are not eligible for MMC and do not have other health insurance.
- **Health and Recovery Plan (HARP)** is an enhanced benefit for MMC members with complex BH needs. It is comprised of physical health, BH, pharmacy, and waiver services. HARP is for adults meeting certain health condition criteria established by the New York State Department of Health. HARP helps members get the care they need while keeping them in their homes and communities.

Please visit our **provider website** for a *Benefit QRC*. For further questions, please contact Provider Services toll free at **800-450-8753**.

Services	Authorization needed
Medically supervised outpatient Withdrawal — ambulatory detoxification New York State Office of Alcoholism and Substance Abuse Services (OASAS)	No.
Outpatient substance abuse disorders (SUD) services (OASAS — BH solo/group practice)	No authorization required for non-intensive outpatient services. For intensive outpatient and outpatient substance use rehabilitation, notification required for participating providers within 2 business days of admission for first 28 days. Concurrent review required for additional days.
Opioid treatment program methadone maintenance services — OASAS services	No.
Outpatient services mental health (OMH) services, BH solo/group practice	No.
Comprehensive psychiatric emergency program (CPEP)	No, hospital needs to bill as CPEP.
Crisis services — including mobile crisis	No, notify plan within 24 hours of rendering the service.
Inpatient hospital detoxification (OASAS service)	Yes, authorization required for out-of-network (OON) providers. Notification required for participating providers within 2 business days of admission for first 28 days. Concurrent review required for additional days.
Inpatient medically supervised detoxification (OASAS service)	Yes, authorization required for OON providers. Notification required for participating providers within 2 business days of admission for first 28 days. Concurrent review required for additional days.
Inpatient treatment Substance abuse rehabilitation (OASAS service)	Yes, authorization required for OON providers. Notification required for participating providers within 2 business days of admission for first 28 days. Concurrent review required for additional days.
Inpatient psychiatric services	Notification required within 2 business days of the admission. If notified and member does not meet state identified triggers, concurrent review starts day 30. If member meets triggers, concurrent review starts as need for adults and day 15 for members less than 18. OON providers require authorizations.
Continuing day treatment	Yes.
Partial hospitalization	Yes.
Personalized recovery oriented services	No.
Assertive community treatment	Yes.
Intensive case management/supportive case management	Now under health home (HH) — no authorizations monitoring of care plan
HH care coordination and management	Now under HH — no authorizations, monitoring of care plan
Rehabilitation services for residential SUD treatment supports (OASAS service)	Yes, provide notification within 2 business days for participating providers and first 28 days is authorized. Concurrent review required for additional days.

Services	Authorization needed
Rehabilitation (covered for HARP): • Psychosocial rehabilitation • Community psychiatric support and treatment (CPST)	No.
Peer supports (covered for HARP)	No.
Habilitation (covered for HARP): • Habilitation • Residential supports in community settings	Yes.
Family support and training (covered for HARP)	No.
Employment supports (covered for HARP): • Prevocational • Transitional employment • Intensive supported employment • Ongoing supported employment	Yes.
Education support services (covered for HARP)	Yes.
Supports for self-directed care (covered for HARP): • Information and assistance in support of participation direction	Yes.
Financial management services: • Mobile crisis	No.
Child and family treatment support services (CFTSS): • Family peer support • Community psychiatric and supports treatment (CPST) • Other licensed practitioner (OLP) • Psychosocial rehabilitation (PSR) • Youth peer support services (YPS) • Crisis intervention	No.
Crisis intervention: • Children's crisis residence	Notification required.
Residential crisis support	Notification required.
Intensive crisis residence	Notificaiton required.
29-I Health Facility	No.

Cardiac rehabilitation

Precertification is required.

Chemotherapy

- Precertification is required for inpatient chemotherapy services.
- No precertification is required for chemotherapy procedures when performed in outpatient settings by a participating facility, provider office, outpatient hospital, or ambulatory surgery center.
- For information on coverage and precertification requirements for chemotherapy drugs, please see the **Pharmacy** section of this QRC.

Children's home- and community-based services (HCBS)

Must be authorized, based on care plan review:

- Accessibility modifications
- Adaptive and assistive equipment
- Caregiver/family supports and services
- Community self-advocacy training and support
- Habilitation
- Palliative care
- Prevocational services
- Respite
- Supported employment

Chiropractic services

Chiropractic care is not a covered service for adults. This is a covered benefit under the Medicaid fee-for-service program for children younger than 21 years of age as part of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program only when ordered by a physician.

Clinical trials

- MMC members: Experimental treatment is covered on a case-by-case basis.
- CHPlus members: This is not a covered benefit. Precertification is required.

Court-ordered services

Precertification is required for coverage of all services.

Dental services

- Members may self-refer for dental checkups and cleaning exams. Dental benefits are administered through Liberty Dental, a network vendor. Dental procedures requiring anesthesia, planned inpatient admission or services at an outpatient ambulatory center must first be approved by Liberty. If approved, Liberty will notify us and a precertification request for anesthesia services will be completed. For temporomandibular joint (TMJ) services, see the **Plastic/cosmetic/reconstructive surgery** section of this QRC.
- MMC members: Members may self-refer to *Article 28* clinics not in-network operated by academic dental centers to obtain covered dental services. Orthodontic care is covered. See the **Orthodontic care** section of this QRC.
- CHPlus members: All necessary procedures requiring dental anesthesia for simple extractions and other routine dental surgeries not requiring hospitalization are covered and include in-office conscious sedation.

Dermatology services

- No precertification is required for an in-network provider for evaluation and management (E&M), testing, and most procedures.
- Services considered cosmetic in nature are not covered.
- Services related to previous cosmetic procedures are not covered.

Diagnostic testing

- No precertification is required for routine diagnostic testing.
- Precertification is required for video electroencephalography.
- Precertification from Carelon Medical Benefits Management, Inc. is required for coverage of magnetic resonance angiograms, MRIs, CT scans, nuclear cardiac tests and positron emission tomography scans. Carelon Medical Benefits Management can be contacted by phone at **800-714-0040**.

Durable medical equipment (DME)

For the definition of DME, please see your provider manual. No precertification is required for (PA may apply under pharmacy benefit where applicable):

- Glucometers.
- Nebulizers.
- Dialysis and end-stage renal disease equipment.
- Gradient pressure aids .
- Infant photo/light therapy.
- Sphygmomanometers.
- Walkers.
- Orthotics for arch support.
- Heels, lifts, or shoe inserts/wedges issued by a network provider.

Precertification is required for certain DME including all DME billed with an RR modifier (rental) and DME items costing more than $1,500. Precertification may be requested by completing a *Certificate of Medical Necessity* (*CMN*), available on our website. Precertification can also be requested by submitting a physician order, a *Precertification Request Form* and an itemized invoice. A properly completed and physician-signed *CMN* must accompany each claim for the following services:

- Hospital beds
- Support surfaces
- Motorized and manual wheelchairs
- Continuous positive airway pressure machines
- Lymphedema pumps
- Osteogenesis stimulators
- Transcutaneous electrical nerve stimulators
- Seat lift mechanisms
- Power-operated vehicles
- External infusion pumps
- Parenteral and enteral nutrition and oxygen

Enteral formula requires precertification and is provided through DME as a medical benefit rather than a pharmacy benefit. Precertification must be obtained through a DME vendor. Enteral formula and nutritional supplements are covered for:

- Children who have metabolic or absorption disorders.
- Individuals who have rare, inborn metabolic disorders.
- Tube-fed individuals who cannot chew or swallow.

Durable medical equipment (DME) (cont.)

Specific gradient compression stockings are covered when prescribed as treatment of open venous ulcers and for pregnant members. Certain items are considered comfort items and are not covered. For code-specific precertification requirements for DME, please visit our website.

See the **Disposable medical supplies** section of this QRC for guidelines relating to disposable medical supplies.

Educational consultation

No notification or precertification is required.

Emergency services

No precertification or notification is required for emergency care given in the ER. If emergency care results in admission, notification to Anthem is required within 24 hours or the next business day. For observation precertification requirements, see the **Observation** section of this QRC.

Enteral formula

Precertification is required:

- Enteral formula and nutritional supplements are covered under the DME benefit and must be obtained through a DME provider rather than a pharmacy.
- Covered MMC members consist of:
  - Tube-fed individuals who cannot chew or swallow food.
  - Those with rare inborn metabolic disorders requiring specific medical formulas to provide essential nutrients not available through other means.
  - Children who require medical formulas due to mitigating factors in growth and development.
- Coverage for CHPlus members is based on medical necessity for the treatment of specific diseases. The covered amount is up to $2,500 per CY for modified solid food products containing low/modified protein used to treat inherited diseases of amino acid and organic acid metabolism.

EPSDT visit:

- Members may self-refer for these services.
- Utilize EPSDT schedule and document visits.
- Vaccine serum is received under the Vaccines for Children program.
- MMC members: Chiropractic services are covered for children younger than age 21 as part of the EPSDT program only when ordered by a physician.
- CHPlus members: Services are covered according to the medical need and visitation schedules established by the American Academy of Pediatrics. Preventive services are not covered under EPSDT.

Family planning/sexually transmitted disease care:

- MMC members may self-refer to an in-network or out-of-network provider.
- Covered services include pelvic and breast examinations,
- laboratory work, drugs, genetic counseling, and devices/supplies related to family planning (for example, intrauterine devices).
- Infertility services and treatment are not covered (with the exception of ovulating agents: bromocriptine, clomiphene, letrozole and tamoxifen for members meeting certain criteria).

Gastroenterology services:

- No precertification is required for in-network providers for E&M, testing, or certain procedures.
- Precertification is required for upper endoscopy, bariatric surgery (including insertion, removal and/or replacement of adjustable gastric restrictive devices), and subcutaneous port components. See the **Diagnostic testing** section of this QRC.

Gynecology:

- Members may self-refer to network providers.
- No precertification is required for E&M, testing, and most procedures.

Hearing aids:

- Precertification is required for digital hearing aids.
- MMC members: Hearing aids (including replacements and repairs) are covered. Hearing aid batteries are covered.
- CHPlus members: Hearing aids (including batteries and repairs) are covered.

Hearing screening:

- No notification or precertification is required by the network provider for coverage of diagnostic and screening tests, hearing aid evaluations, or counseling.
- Simple hearing exams require PCP referral only.
- CHPlus members: One hearing examination per CY is covered. If an auditory deficiency requires additional hearing exams and follow-up exams, these exams will be covered.

Home-delivered meals:

- Home-delivered meals are only covered for managed long-term care members.

HH care:

- Precertification is required for all services.
- Covered services include skilled nursing; HH aide; physical, occupational and speech therapy services; social work services; and telehealth services when provided by agencies approved by the New York State Department of Health.
- CHPlus members: Home care services are limited to 40 visits per CY for all types of service combined. Private duty nursing is not a covered benefit.

Hospital admission:

- Elective admissions require precertification for coverage.
- Emergency admissions require notification within 24 hours or the next business day.
- To be covered, preadmission testing must be performed by one of our preferred laboratory vendors. See your *Provider Referral Directory* for a complete listing of participating vendors.
- Rest cures, personal comfort and convenience items, and services and supplies not directly related to the care of the patient (such as telephone charges, take-home supplies, and similar costs) are not covered.

Laboratory services (outpatient):

- All laboratory services furnished by non-network providers require precertification except for hospital laboratory services in the event of an emergency medical condition.
- For offices with limited or no office laboratory facilities, laboratory tests may be referred to one of our preferred laboratory providers. See your *Provider Referral Directory* for a complete listing of participating providers.

Medical supplies:

For definitions of consumable and disposable medical supplies, please see your provider manual:

- MMC members: Medical supplies are covered and billable under medical benefits similar to DME. There are some medical supplies such as insulin syringes covered under pharmacy. For code-specific coverage information, please visit our website.
- CHPlus members: Medical supplies are not covered with the exception of diabetic supplies and medical supplies routinely furnished as part of a clinic/office visit covered by Anthem. Medical supplies used during home care services are covered as part of the home care service rate. A list of these supplies can be found in the Medicaid Management Information Systems HH services part of the provider manual.

Neurology:

- No precertification is required for in-network provider for E&M and testing.
- Precertification is required for neurosurgery, spinal fusion, or artificial intervertebral disc surgery. See the **Diagnostic testing** section of this QRC.

Observation:

- Observation services are covered for patients seen, evaluated, and admitted to an observation unit.

Obstetrical (OB) care:

- No precertification is required for coverage of OB services including OB visits, certain diagnostic tests, and laboratory services when performed by a participating provider.
- Notification is required at the first prenatal visit. No precertification is required for coverage of labor/delivery or for circumcision for male newborns up to 12 weeks of age.
- Notification of delivery is required within 24 hours with newborn information.
- OB case management programs are available to members. See the **Diagnostic testing** section of this QRC.
- No precertification is required for sonograms. One sonogram is covered per pregnancy. Additional sonograms are covered with submission of supportive applicable diagnosis codes.

Ophthalmology:

- No precertification is required for E&M, testing, or certain procedures.
- Precertification is required for repair of eyelid defects.
- Services considered cosmetic in nature are not covered. See the **Diagnostic testing** and **Vision** sections of this QRC.

Oral maxillofacial:

- Precertification is required.
- See the **Plastic/cosmetic/reconstructive surgery** section of this QRC.

Orthodontic care:

- Precertification is required.
- MMC members: Orthodontic care is covered for children up to age 21 who have severe problems with teeth such as crooked teeth, a cleft palate, or a cleft lip causing difficulty chewing foods. Providers should call Liberty Dental at **888-352-7924**.
- Services are not covered for CHPlus members.

Orthotics and prosthetics:

See your provider manual for definitions of orthotics and prosthetics:

- Precertification is required for certain orthotic devices. For code-specific precertification requirements for DME, please go to our website.
- Precertification is not required for orthotics such as arch support, heels, lifts, and shoe inserts/wedges when issued by an in-network provider.
- MMC members: Orthotics and prosthetics are covered according to New York state Medicaid criteria. See the **Prescription footwear** section of this QRC.
- CHPlus members: Orthotic devices prescribed solely for use during sports and cranial prosthetics (for example, wigs) are not covered. Dental prosthetics are covered only in the treatment of congenital abnormalities. They are also covered as part of reconstructive surgery or if needed as a result of accidental injury to sound, natural teeth. Prosthetics must be provided within 12 months of the accident.

Otolaryngology: ear, nose, and throat services:

- No precertification is required for an in-network provider for E&M, testing, and procedures.
- Precertification is required for tonsillectomies and/or adenoidectomies, nasal/sinus surgery, and cochlear implant surgery/services. See the **Diagnostic testing** section of this QRC.

Out-of-area/out-of-network care:

Precertification is required except for coverage of emergency care including self-referral, family planning, and OB care:

- Out-of-area care is only covered for emergent services. Elective services are not covered.
- Out-of-network care is only covered for continuity of care for new enrollees in which the provider leaves the network or if an
- in-network provider is not available to perform the service.
- CHPlus members: This is not a covered benefit except for emergency services.

Outpatient/ambulatory surgery:

- Precertification requirement is based on the service performed. Please visit our website for requirements.
- MMC members: Services are not covered for knee arthroscopy when the primary diagnosis is osteoarthritis of the knee (without mechanical derangement of the knee).

Pain management:

- Precertification is required for coverage of all services and procedures.
- MMC members: Services are not covered for prolotherapy, intradiscal steroid injections, facet joint steroid injections, systemic corticosteroids, and traction (continuous or intermittent) for lower back pain.

Personal care services (PCS):

- Precertification is required for PCS.
- Level I (up to eight hours per week) and level II PCS are covered.

Personal emergency response system (PERS):

- Precertification is required for PERS. It is based on a physician or nurse practitioner's order and a comprehensive assessment. This assessment must include an evaluation of the member's physical disability status, the degree the member is at risk for an emergency (due to medical/functional impairments or disability) and the degree of social isolation.
- Assessment for PERS services must be made in coordination with authorization procedures for home care services including PCS.

Pharmacy:

- Members receive pharmacy benefits through Anthem.
- The pharmacy benefit covers medically necessary prescriptions and over-the-counter (OTC) medications prescribed by a licensed provider. Exceptions and restrictions exist as the benefit is provided under a closed formulary/Preferred Drug List (PDL). Please refer to the appropriate *PDL* and/or the *Medicaid Medication Formulary* on the provider website. Here, you can find preferred products within therapeutic categories as well as requirements around generics, step therapy, quantity edits, and the PA process.
- Prescription and certain OTC drugs are covered for members. Enteral formula is covered under the DME benefit. See the **DME** section of this QRC. PA is required for all nonformulary drugs and certain formulary medications.
- Growth hormone injections solely for idiopathic short stature in children are not covered.
- Many self-injectable medications, self-administered oral specialty medications, and office-administered specialty medications are available through CarelonRx, Inc. Specialty Pharmacy and require PA.
- To find out if a specific medication requires precertification under medical benefit, please refer to our Precertification Lookup Tool found in the provider section of our website under *Quick Tools*.
- For a complete list of covered injectables, please visit the *Pharmacy* section of our website.
- Pharmacy claims are covered only at pharmacies enrolled with NYS Medicaid program.

Important phone numbers for pharmacy PA	
Initiate a PA request for medical injectables covered under the medical benefit for **all** members.	Anthem Provider Services **800-450-8753**
Schedule delivery once you receive a PA approval.	CarelonRx Specialty Pharmacy **833-255-0646**

Physiatry

Precertification is required for coverage of all services and procedures related to pain management. See the **Behavioral health** section of this QRC.

Physical medicine and rehabilitation:

Precertification is required for coverage of all services and procedures related to pain management. Inpatient rehabilitation requires precertification.

Plastic/cosmetic/reconstructive surgery (including oral maxillofacial services):

- No precertification is required for coverage of E&M codes.
- All other services require precertification for coverage. Services considered cosmetic in nature are not covered. Services related to previous cosmetic procedures (for example, scar revision, keloid removal resulting from pierced ears) are not covered. Reduction mammoplasty requires an Anthem medical director's review.
- Precertification is required for coverage of trauma to the teeth, oral maxillofacial, medical, and surgical conditions including TMJ disorder.

Podiatry:

- No precertification is required for E&M, testing, and procedures when provided by a participating podiatrist.
- Precertification requirement is based on the service performed.
- Visit our website for requirements.
- MMC members: Services provided for members younger than 21 and adults with diabetes must be covered upon referral. The referral must be for a physician, registered physician assistant, certified nurse practitioner or licensed midwife.

Point-of-care blood lead testing

Covered for children ages 6 and younger and pregnant women. Physician office laboratories and limited service must bill for in-office testing dates using CPT®-4 procedure code 83655.

Prescription footwear:

- Prescription footwear is covered for orthopedic footwear required by children under 21 and for shoes attached to lower-limb orthotic braces.
- Footwear as a component of a comprehensive diabetic treatment plan to treat amputation, ulcerations, pre-ulcerative calluses, peripheral neuropathy with evidence of callus formation, foot deformities or poor circulation is covered.

Radiation therapy:

- No precertification is required for coverage of radiation therapy procedures when performed by a participating facility or provider in the following outpatient settings: offices, outpatient hospitals and ambulatory surgery centers.

Radiology services:

See the **Diagnostic testing** section of this QRC.

Rehabilitation therapy, occupational therapy, physical therapy, and speech therapy (short term):

- No precertification is required for evaluation or coverage of outpatient therapy visits.
- Children requiring therapy services to improve their ability to learn or participate in a school setting should be evaluated for school-based therapy. Other therapy services for rehabilitative care will be covered as medically necessary.
- MMC members: Outpatient visits for physical, speech and occupational therapy are limited to 20 visits per service type, per CY. Limitations do not apply for children younger than 21 and individuals with developmental disabilities/traumatic brain injuries.
- CHPlus members: Services are covered based on medical necessity.

School-based services:

- MMC members: School-based services are not a covered benefit.
- CHPlus members: School-based services are covered within network.

Skilled nursing facility:

- Precertification is required.

Sleep studies:

- Precertification is required.

Smoking cessation counseling:

- No precertification or notification is required. Smoking cessation counseling must be provided by a physician, registered physician assistant, registered nurse practitioner, or licensed midwife during a medical visit. Group sessions are excluded.
- MMC members: All eligible members are allowed up to six counseling sessions within a continuous 12-month period. Use diagnosis codes 99406 and 99407.

Specialty referral:

A referral is required for all specialty visits. The referral should be obtained from the member's PCP. There is no specific Anthem referral form. Referrals can be written on a prescription pad or provider stationery:

- No precertification is required for an in-network referral.
- All out-of-network nonemergent services require precertification.

Sterilization:

- No precertification or notification is required for coverage of sterilization procedures including tubal ligation and vasectomy for members 21 years of age or older.
- **A *Sterilization Consent Form* is required for claims submission.** For hysterectomies, use *Form 3133*. For sterilizations, use *Form 3134*.
- Reversal of sterilization is not a covered benefit.

Transportation (nonemergent):

- No precertification or notification is required except for coverage of planned air transportation (airplane).
- All nonemergency and routine transportation for members in New York is coordinated through Medical Answering Services, LLC. See the table detailing our service partners for the Medical Answering Services, LLC phone and fax numbers by product/area.
- MMC members: For members in the five boroughs, the state covers transportation services. For members in Nassau County, we cover transportation services.
- CHPlus members: This is not a covered benefit.

Urgent care center:

- No notification or precertification is required for participating or nonparticipating facilities.

Vision services:

- Vision services are administered through Superior Vision (formerly Block Vision). Members may contact Superior Vision at **800-428-8789**. Providers may contact Superior Vision at **800-243-1401**.
- MMC members: Members are allowed to self-refer to any participating vision services provider (optometrist or ophthalmologist) for refractive vision services once every two years* unless eyeglasses are lost, damaged, or destroyed. Eyeglasses and examinations are limited to once every 24 months unless justified as medically necessary. Contact lenses are covered once every 24 months only when medically necessary. Members diagnosed with diabetes are eligible for an annual eye (retinal) examination.
- CHPlus members: Vision examinations performed by a physician or optometrist for the purpose of determining the need for corrective lenses and to provide a prescription are covered. Vision examinations and eyeglasses are covered every 12-month period.

Please note: Members are financially responsible for upgrades of frames and/or lenses not deemed medically necessary (for example, personal preference upgrades).

* Unless justified as medically necessary.

Well-woman exam:

- Members may self-refer for these services.
- Well-woman exams are covered twice per CY when performed by a PCP or in-network gynecologist. The exam includes routine laboratory work, sexually transmitted disease screening, Pap tests and mammograms for members age 35 or older.

Revenue codes:

Precertification or notification is required for services billed by facilities with revenue codes for:

- Inpatient services.
- OB care.
- HH care.
- Hospice care.
- MRIs.
- High-dollar injectables.
- Chemotherapeutic agents.
- Pain management services.
- Rehabilitation (physical/occupational/respiratory therapy) services.
- Short-term rehabilitation (speech therapy) services.

For a list of the specific revenue codes requiring precertification, please visit our website.

Administrative, provider, health and claims services
Medical appeals

Medical Answering Services, LLC (nonemergent transportation)	• For MMC members in the five boroughs, call **844-666-6270**. • For all other MMC members, call **800-850-5340** or fax **315-299-2786**. **Mailing address:** • Medical Answering Services, LLC P.O. Box 12000 Syracuse, NY 13218 **Website:** • **www.medanswering.com**
Superior Vision (vision services)	• Member line: **800-428-8789** • Provider line: **800-243-1401**
Liberty Dental (dental services)	• Call **888-352-7924**
HearUSA (hearing services)	• Call **800-333-3389** (**800-300-3277** for TDD relay services). • Visit **https://hearusa.com**.
Carelon Medical Benefits Management; radiology, outpatient PT,OT, ST, genetic testing, sleep studies, cardiology — radiology studies, radiation/oncology treatment, pain and spine management, MSK — joint surgery (precertification)	• Call **800-714-0040**. • Visit **Carelon.com**.

Administrative, provider, health and claims services
Medical appeals

Provider Experience Program

Our Provider Services team offers precertification, case and disease management, automated member eligibility, claims status, health education materials, outreach services, and more. Call **800-450-8753** Monday through Friday from 8 a.m. to 6 p.m. ET.

Provider website and interactive voice recording available 24/7

To verify eligibility, check claims and referral authorization status, and to look up precertification/ notification requirements, visit our **provider website.**

Can't access the internet? Call Provider Services and simply say your NPI 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.

Claims services

Timely filing is within 90 days from the date of service.

Electronic data interchange (EDI)

Call our EDI hotline at **800-590-5745** to get started. We accept claims through these clearinghouses:

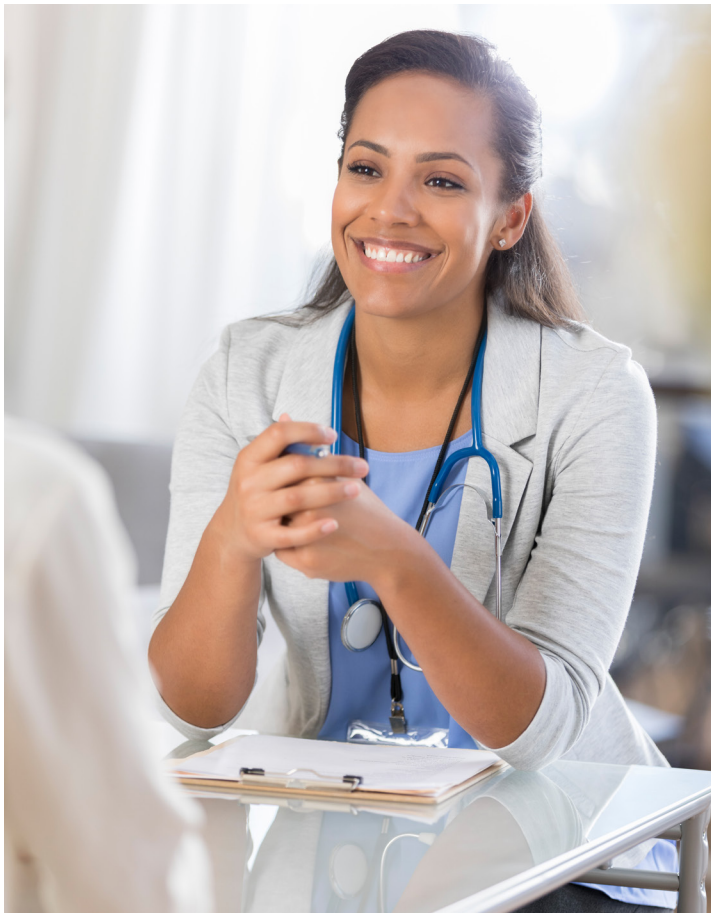
- Emdeon (payer 27514)
- Availity (payer 26375)
- Capario (payer 28804)

Paper claims

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

Anthem
New York Claims
P.O. Box 61010
Virginia Beach, VA 23466-1010

Please note: American Medical Association- and CMS-approved modifiers must be used appropriately based on the type of service and procedure code.



Payment disputes

Claim payment disputes must be filed within 45 calendar days of the adjudication date of the *Explanation of Payment*. Forms for provider appeals are located on our website and should be sent to:

Anthem
Payment Disputes
P.O. Box 61599
Virginia Beach, VA 23466-1599

Medical appeals

Medical appeals (also known as medical administrative reviews) can be initiated by the member or the provider on behalf of the member and must be submitted within 60 business days from the date of the notice of proposed action. Medical appeals can be submitted in writing to:

Anthem
Medical Appeals
P.O. Box 62429
Virginia Beach, VA 23466-2429

A provider submitting on behalf of a member can write a letter or use the *Provider Appeals Form* located on our website.

Health services

Case management services: 800-450-8753
We offer a case management program providing education and support to help members make informed healthcare choices. Our goal is to help members get the care they need, when they need it. A team of licensed nurses and social workers assist members by providing education about health conditions and assisting with provider appointments. This includes identifying community resources, providing health education, monitoring compliance, assisting with transportation, and more.

Disease Management/Population Health (DM/PH) services: 888-830-4300
We offer DM/PH services to members with the following medical conditions: asthma, bipolar disorder, chronic obstructive pulmonary disease, congestive heart failure, coronary artery disease, diabetes, human immunodeficiency syndrome (HIV)/acquired immune deficiency syndrome (AIDS), hypertension, major depressive disorder in adults and child/adolescent, schizophrenia, and substance use disorder. DM services include educational information like local community support agencies and events in the health plan's service area.

24/7 NurseLine: 800-300-8181 Members may call our 24/7 NurseLine for nursing advice 24/7.

Learn more about Anthem programs
https://providers.anthem.com/ny

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