Jefferson Health Plans | Health Partners Plans

Annual Training for Ancillary Providers

November 12, 2025

Welcome!

There is **no sound** until the webinar begins.

Webinar **will be recorded**. Participation in the webinar is agreement to recording.

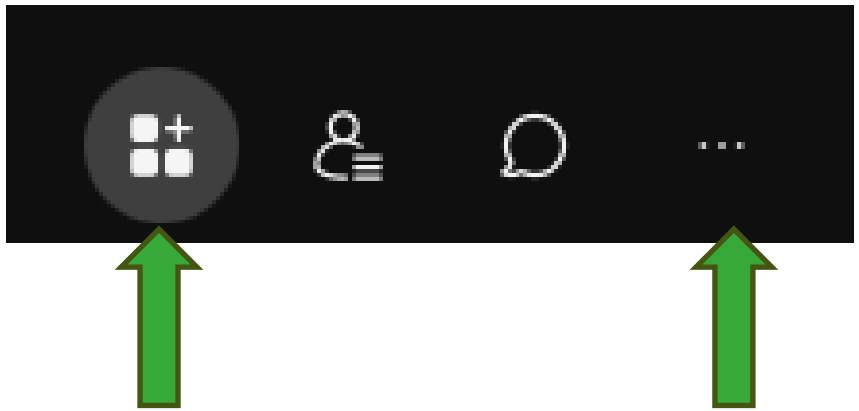
All participants phones have been **muted** except for the presenter.

Any unanswered questions today, will be addresses **following the presentation**.

Please use the chat for any technical issues.

Polling and Q&A in Webex

Slido Q&A can be accessed through either the Apps or the Ellipsis icons located at the bottom right corner of your screen.



The Pennsylvania Department of Human Services (DHS) requires Managed Care Organizations (MCOs) to ensure their providers attend at least one MCO-sponsored training during the course of the year. *By attending this session, you fulfill that requirement.*

Additional training is required for providers who provide service to Medicare members.

- Medicare Providers' FDR Requirements | Jefferson Health Plans
  - Delegated Vendor Information

Annual Training for Ancillary Providers: Agenda

Agenda

- **Medicare Beneficiary Information**
- **Community Health Choices**
- **Data Changes and Validation**
- **Medical Records Request**
- **Utilization Management and Prior Authorization**

Additional Covered Topics:

- Home Care
- Shift Care
- EVV: HHAeXchange
- Home Infusion
- Durable Medical Equipment
- Skilled Nursing Facility
- Home and Inpatient Hospice
- Ambulatory Surgical Center
- MHK Prior Authorization Process
- Cultural & Linguistic Requirements and Services
- Complaints, Grievances, and Appeals
- What's New?
- Appendix

Who We Are

Jefferson Health Plans | Health Partners Plans

Jefferson Health Plans/Health Partners Plans is a not-for-profit Pennsylvania-licensed Managed Care Organization (MCO) providing comprehensive healthcare coverage in Pennsylvania and New Jersey.

Our focus is on improving health outcomes through a wide range of initiatives that support member compliance and help to eliminate barriers to care.

Thank you for being part of our provider network and helping us to improve the health outcomes of our members.

Offering High Quality and Affordable Health Plans

Jefferson Health Plans Medicare Advantage

Jefferson Health Plans Individual and Family Plans
(Commercial ACA product)

Health Partners Plans Medicaid

Health Partners Plans CHIP

Provider Tools & Resources

Online Tools & Resources

Quickly find important information on our Provider Portal and Website.

Provider Portal

The Provider Portal contains:

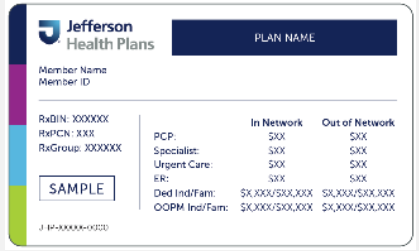
- **Eligibility & Benefits** – Verify patient coverage instantly.
- **Claims Management** – View claims status and submit claims reconsideration requests with ease.
- **Authorization Requests** – Submit and check prior authorizations in real time.

Website Resources

- Prior Authorizations– View online formularies PA guidelines and request forms
- **Tools and Resources**–Provider Manual, Directory, Formularies, Policy Bulletin Library, Form & Supply Requests, Training & Eduction Quick Reference Guide
- Clinical Resources - Preventative and clinical care guidelines, developmental screening information, and telehealth resources.

2025 Product ID Cards

2025 Product ID Cards

Health Partners Plans Medicaid **Payor ID# 80142** (9-digit ID - all numerical digits)	  Issued beginning 7/30/2025	**PO Box 21228** **Tampa, FL 33622**
Jefferson Health Plans Individual and Family Plans **Payor ID# 80142** (12-digit ID, starting with a "J")		**PO Box 21228** **Tampa, FL 33622**
Health Partners Plans CHIP **Payor ID# 80142** (10-digit ID starting with a "3" or a "9")	  Issued beginning 9/9/2025	**PO Box 21228** **Tampa, FL 33622**

Effective **December 1st, 2025**, Imagenet will be responsible for the intake of all paper claims submissions.

2025 Product ID Cards – Medicare Advantage

Jefferson Health Plans Medicare Pennsylvania

HMO/DSNP Payor ID# 80142

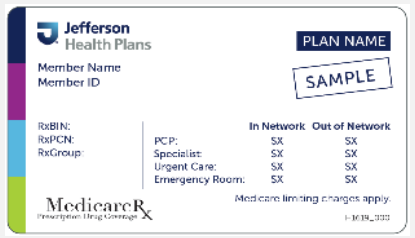
(7-digit ID number starting with a "5")

PO Box 21228
Tampa, FL 33622

Jefferson Health Plans Medicare Pennsylvania

PPO Payor ID#RP099

(9-digit ID starting with all numerical digits)



PO Box 21247
Tampa, FL 33622

Jefferson Health Plans Medicare New Jersey

HMO Payor ID#80142
PPO Payor ID#NJ099

(7-digit ID number starting with a "5")

PO Box 21367
Tampa, FL 33622

*When a patient presents without a Member ID card, check Provider Portal for eligibility
*Older versions of Member ID cards are still valid

13

2025 Product Overview

Health Partners Plans Medicaid Benefits

Our members have $0 copays in 2025 for covered Medicaid physical health services and prescription drugs

Health Partners Plans Medicaid Plans provides all the benefits of Medicaid, including:

- Primary care doctor and specialist office visits
- Hospital services
- Lab services
- Prescriptions
- Routine dental care for children and adults
- Checkups and immunizations and for children and adults
- Routine eye exams for children and adults
- Glasses and/or contact lenses for all children (two pairs of glasses or contacts, or one pair of each, covered yearly)
- Members aged 21 years and older are eligible to receive one pair of eyeglasses or contact lenses a year.

Additional Benefits:

- Fitness center memberships
- Nutrition education and counseling
- Member events and education

Health Partners Plans CHIP Benefits

Health Partners Plans CHIP is available to children up to age 19 at low or no cost, based on household income and is offered in all counties within PA.

Health Partners Plans CHIP covers:

- Doctor and well-childcare visits
- Prescriptions
- Dental checkups and cleanings, and orthodontics (including braces when medically necessary)
- Eye exams and eyeglasses
- Mental health and substance abuse services
- Nutrition counseling
- Fitness center membership
- And much more!

Jefferson Health Plans Individual and Family Plans Portfolio (Pennsylvania)

HMO

- **3** Bronze plans *(1 new plan launch for 2025)*
- **3** Silver plans *(Term'd 3 Off-X plans for 2025)*
- **3** Gold plans (*1 new plan launch for 2025)*

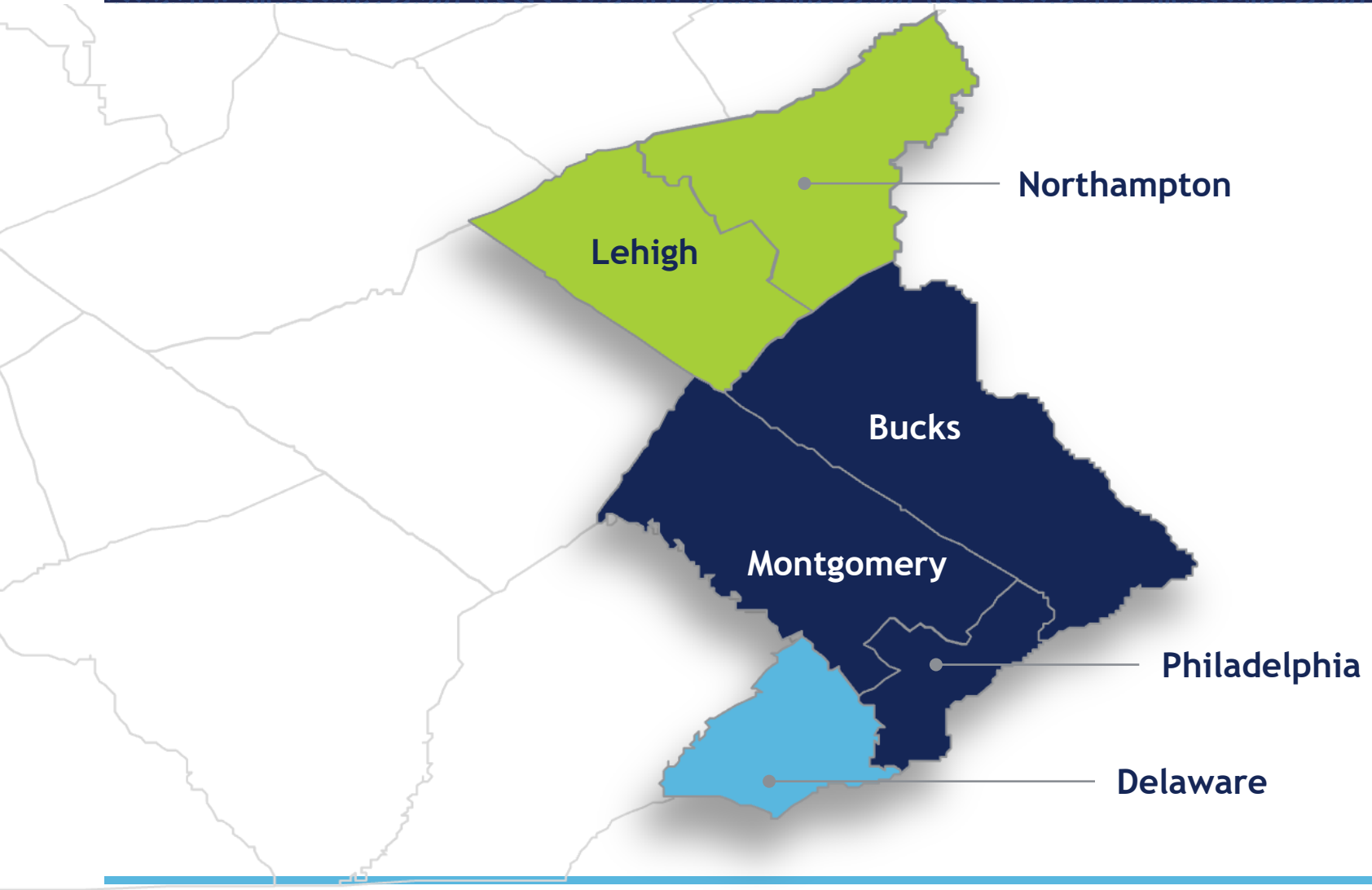
Jefferson Health Plans HMO Portfolio:	
3 **Bronze** Plans:	• $0 Deductible • Total • Value
3 **Silver** Plans:	• $0 Deductible • Balanced • Total
3 **Gold** Plans	• $0 Deductible • Total • Value

NEW: PPO

- **3** Bronze plans
- **3** Silver plans
- **3** Gold plans

Jefferson Health Plans PPO Portfolio:	
3 **Bronze** Plans:	• $0 Deductible • Total • Value
3 **Silver** Plans:	• $0 Deductible • Balanced • Total
3 **Gold** Plans	• $0 Deductible • Total • Value

Jefferson Health Plans Individual & Family Plans – 2025 Service Area



- Existing service area (HMO)
- Expanded service area (both HMO and PPO)
- Expanded service area (HMO)

Jefferson Health Plans Medicare Advantage Plan Portfolios

HMO

- Strong HMO offering for members that qualify for an LIS or are willing to pay a premium for lower cost sharing and MOOP
- Positioned to perform strongly in Eastern PA region with robust network
- Aligned to Jefferson Health System and positioned to perform strong in Jefferson core footprint

State	Product(s)
PA	• Complete ($0) • Prime ($40.90) • Give Back ($0) +$125 Part B
NJ	• Silver ($0) • Platinum ($30)

PPO

- Ideal landing spot for members that want to be outside base service area.
- Positioned to perform strongly within and outside of Jefferson core footprint on with robust network

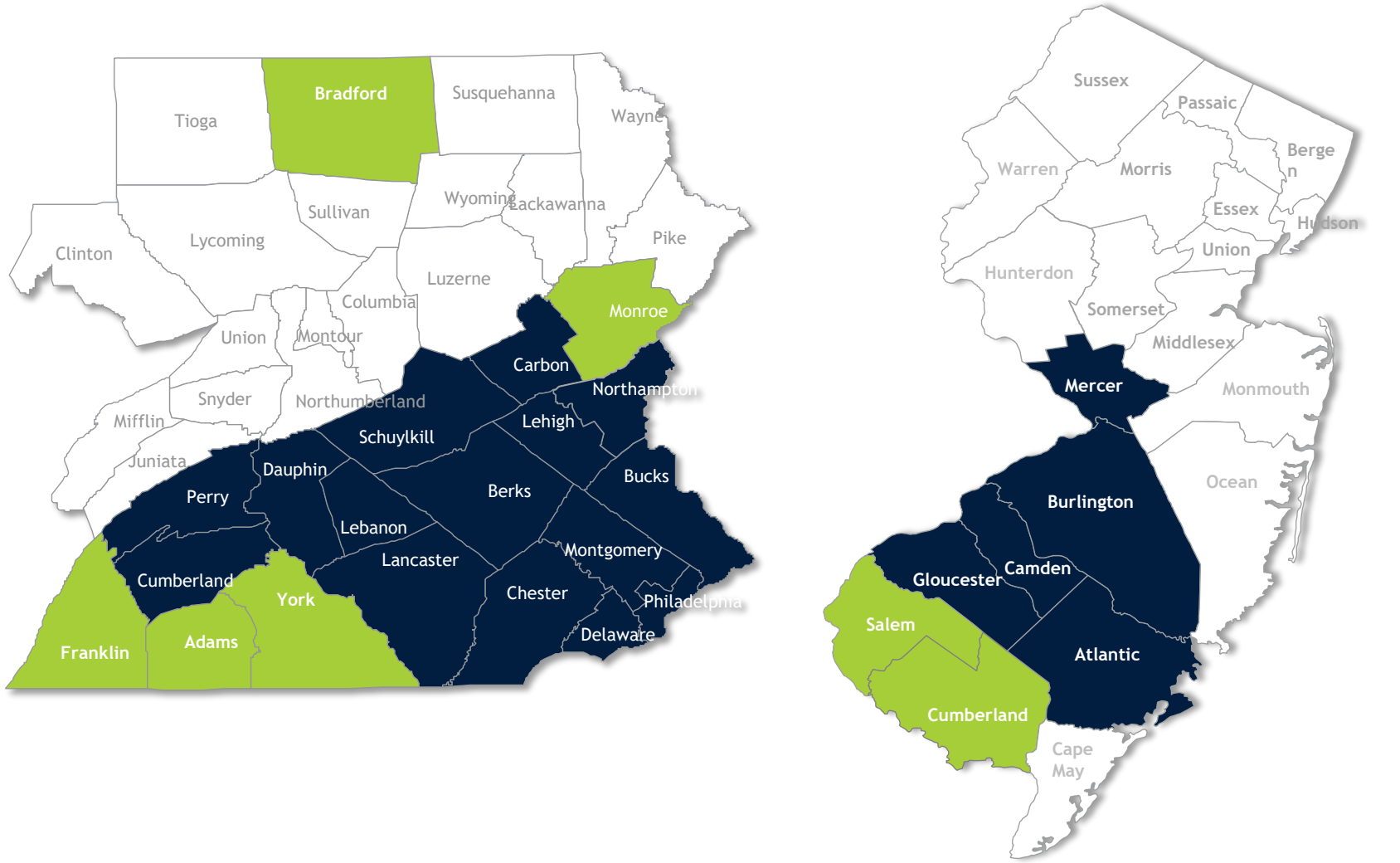
State	Product(s)
PA	• Flex ($0) • Flex Pro ($20) • Flex Plus ($37)
NJ	• Choice ($0) • Choice Plus ($35)

DSNP

- Special and Dual Pearl plan members have both Medicare and Medicaid coverage.
- Special plan members are also referred to as Dual Special Needs Plan (DSNP) members.

State	Product(s)
PA	• Special • Dual Pearl
NJ	N/A

Jefferson Health Plans Medicare Advantage - 2025 Expansion Markets



2024 Service Area

2025 Expansion counties (all products)

Medicare Beneficiary Information

Qualified Medicare Beneficiaries (QMB)

The Qualified Medicare Beneficiary (QMB) eligibility group is a Medicaid eligibility group through which states pay Medicare premiums and cost-sharing for certain low-income Medicare beneficiaries.

All Medicare providers and suppliers, including pharmacies, are prohibited by Federal law from billing Medicare beneficiaries in the (QMB) eligibility group for Medicare Part A or Part B cost-sharing.

This includes Medicare Part A and Part B deductibles, coinsurance, and copayments.

Identifying QMBs

- To ensure compliance, Jefferson Health Plans Medicare Advantage providers and suppliers should:
  - Implement processes to ensure compliance with QMB billing prohibitions.
  - Make sure their office staff and vendors are using systems to identify the QMB status of Medicare beneficiaries

- To assist in this process, CMS provides several ways to identify the QMB status. For a full explanation, please visit: The CMS MedLearn Matters article

Balance Billing Dual Eligible Members: Medicare/Medicaid

Fully Dual Eligible beneficiaries are not directly responsible for their appropriate cost share amounts. These charges are payable by Medicaid (the CHC plan).

Medicaid (CHC) will remain the payer of last resort.

Providers may not balance-bill participants when Medicaid, Medicare, or another form of TPL does not cover the entire billed amount for a service delivered.

Please note that Jefferson Health Plans Medicare Advantage Special and Dual Pearl (DSNP) members are fully dual eligible.

Community HealthChoices

Community HealthChoices

Community HealthChoices (CHC) plan beneficiaries are 21 or older and have both Medicare and Medicaid or receive long- term support through Medicaid. There are three CHC plans:

- PA Health & Wellness (Centene)
- AmeriHealth Caritas (Keystone First CHC/AmeriHealth Caritas Pennsylvania CHC)
- UPMC

Keep in Mind:

- Our members eligible for CHC were notified by the state that they must enroll with a CHC plan.
- Pennsylvania auto-enrolled members into one of the three plans if they did not choose a plan.
- Medicare is the **primary** payor and drives the care. Medicaid benefits are accessed after Medicare benefits have been exhausted.
- As a participating provider, you **can** provide services to Jefferson Health Plans Medicare Advantage members and submit claims, even if they are enrolled in a CHC (Medicaid) plan.
- Our Care Coordinator can assist you with coordinating services between Medicare and Medicaid.

Community HealthChoices

Resources

- CHC Fact Sheet
- Adult Benefit Package
- Long-Term Services and Supports Benefits Guide
- Coordination With Medicare
- Populations Served By CHC
- Eligibility Verification System (EVS)

Claims Overview

Clearing House: Smart Data Solutions

- **Smart Data Solutions (SDS)** is fully connected to accommodate Electronic Data Interchange (EDI) claim submissions for our two Payor IDs.
- Providers may sign-up through the SDS provider portal by emailing SDS directly at stream.support@sdata.us.

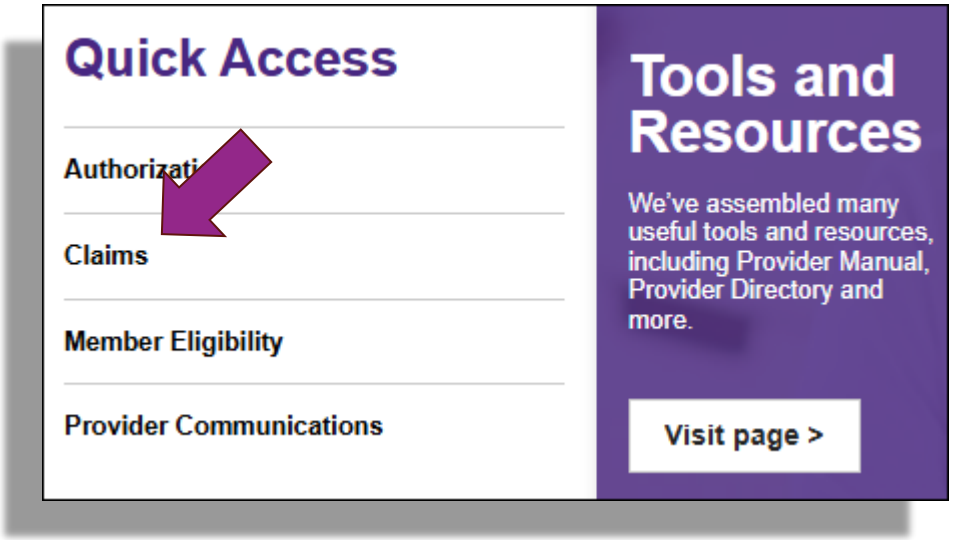
Smart Data Solutions

- When submitting to Smart Data Solutions, include the following information:
  - First Name
  - Last Name
  - Email
  - Phone
  - Organization name, NPI, and Tax ID

- If you have any questions, please contact the Provider Services Helpline at 1-888-991-9023 (Monday to Friday, 9 a.m. to 5:30 p.m.)

Claims Status and Reconsideration

- The Provider Portal can be used to check the status of a claim, or to request a reconsideration determination.
- Reconsiderations must be made timely by the requestor. Please be sure to have the claim number available to initiate your request.



Timely Filing

Initial Submissions	Reconsiderations	Coordination of Benefits
180-days from date of service or discharge date	180-days from the date of Explanation of Payment (EOP)	60-days from date of other carriers (EOP)

Understanding Offsets and Credit Balances

Offsets

- **An Offset** is created when the provider returns the payment for a claim, which creates a negative balance.
- A returned check is often accompanied with a letter explaining why the funds paid should be returned.

Credit Balances

- A Credit Balance is the amount owed as a result of a claim overpayment made to a provider. Once a claim is identified, it is retracted, and a credit is formed.
- These credits are subtracted from each claim submitted afterward until the balance is satisfied.
- If the total credits exceed the amount owed, your EOP will show a payment of $0.

Explanation of Payment- Example

- The Explanation of Payment (EOP) outlines the adjudication of your claims.
- Denial reason codes will appear at the line level and claim level of your EOP with the full description of the denial at the bottom of the EOP.
    - Here is an example of a common transportation denial reason code: PI97

Explanations

Administered by	Code	Description
HealthPartnersPlans	PI97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

- PI97 may appear on your EOP if the mileage payment is considered inclusive to the trip itself.
- If you have any additional questions about mileage/trip claims, please refer to provider contract.
    - For information on Ambulance policy, please visit our Policy Bulletin Library.

Coordination of Benefits

Health Partners Plans Medicaid is the payor of last resort; therefore, is secondary payor to all other forms of health insurance coverage (e.g., Medicare). Except for preventive pediatric care, if other coverage is available, the primary plan must be billed before we will consider any charges.

After all other primary and/or secondary coverage has been exhausted; providers should forward a secondary claim and a copy of the Explanation of Payment (EOP) from the other payor to Jefferson Health Plans/Health Partners Plans within 60 days. Secondary claims may also be filed electronically following the HIPAA compliant transaction guidelines.

For more information, visit: Provider Manual Chapter 12: Provider Billing & Reimbursement

Encounter Data

Participating providers must provide encounter data for professional services on properly completed CMS-1500 forms or electronic submission in an ASC X12N 837P format for each encounter.

For professional claims, providers who are registered as home health providers, hospice providers, certified nutritionists, DME, X-ray clinics, and renal dialysis providers must include the referring provider on their claim submissions. The data can be submitted in the referring provider loop (2310A) or the ordering provider loop (2420E), whichever is appropriate to your claim situation.

Claims that do not include a referring provider may be subject to denial/retraction.

Credentialing

Credentialing and Recredentialing

Applications Facility and Ancillary Provider credentialing application can be found on our website at: Credentialing

Our goal is to process all credentialing applications within 60 days of receipt of a complete application.

Individual providers are recredentialed within 36 months or less. Providers are notified four months prior to their recredentialing due date.

For more information, please visit our Provider Manual Chapter 11: Provider Practice Standards & Guidelines

Provider Credentialing Process to Link Active Providers

- Participating provider groups that would like to link an actively participating provider should submit a signed, linkage request on company letterhead to datavalidation@jeffersonhealthplans.com with the following:
  - Group Name
  - Group NPI
  - Individual NPI
  - Tax ID
  - Effective date of the linkage
  - Complete address (including phone/fax number)
  - Contact information

Revalidation of Medical Assistance Providers

MA Revalidation:
Providers must revalidate MA enrollment (including 13-digit service locations) every 5 years. Check PROMISe for your due date and apply at least 60 days in advance.

PROMISE System Check:
Providers should regularly review PROMISe to confirm demographic details, service locations, revalidation dates, and ensure their PROMISe ID is active. Visit the DHS website for instructions and requirements.

Enrollment (revalidation) applications located at: http://www.dhs.pa.gov/provider/promise/enrollmentinformation/S_001994

Data Changes and Validation

Quarterly Provider Data Validation

Provider data validation forms are mailed to all non-delegated provider practices quarterly. It's imperative that these forms are reviewed and returned as soon as possible

Benefits:

- Provides members with accurate provider information.
- Allows for timely and accurate claims payments.

For more information or if you have not received your quarterly data validation form, please email datavalidation@jeffersonhealthplans.com

Demographic Changes

- Please notify the Network Management department immediately in writing when any of the following occurs:

  - Site relocation
  - Full practice terms
  - Site location terminations
  - Telephone number change
  - Change in hours of operation
  - Provider practice name change
  - Additions/deletions of providers
  - Change in patient age restrictions
  - Change in payee information (W-9 required)

- All professional provider data changes must be emailed to datavalidation@jeffersonhealthplans.com

Additional Pathways for Demographics Changes

Ancillary providers including Physical, Occupational, and Speech Therapy, should email changes to the applicable email box below:

Contracting@jeffersonhealthplans.com

- Initial contract (roster and application required)
- Change in group/practice ownership
- Tax ID change or NPI Change (W-9 form is required)

ProviderData@jeffersonhealthplans.com

- Additions/links/terms of hospital based/facility-based/PT/OT/Speech providers (hospital-based profile or roster required)
- Change in payee information (W9 is required)
- Change in hours of operation
- Telephone number change
- Change in age restriction

Medical Records Request

Medical Records Request from Quality Management

- Jefferson Health Plans/Health Partners Plans requests medical records for many reasons. For example:
  - Credentialing medical record review (MRR)
  - Stars and HEDIS
  - Pay for Performance (P4P)
  - Investigation of Quality of Care (QOC) referrals/Quality of Care Inquiry
  - Complaints/Grievances

- Per your contract:
  - Records do not need a patients or head of household release form signed
  - Records are provided at the providers' expense for the quality assurance programs

- Record reviews are conducted by trained & licensed clinical staff.

Medical Records Request from Quality Management

- **We receive records via many platforms:**
  - Electronic Medical Record (EMR) view or read-only access *(preferred)*
    - We work with several EMR systems to retrieve records such as but not limited to: EPIC, Cerner and Athena
    - We will always contact the provider's office prior to retrieving records with the member information and reason for the review.
      - E-mail
      - Secure fax
      - Third Party Vendor
      - Ciox/Datavant
      - MRO Portal

- If you have a preferred method of medical record collection, please let us know at: Quality@jeffersonhealthplans.com.
- **Please include**:
  - The office manger or clinical contact
  - Contact person's email, phone number
- We will provide correspondence with the member's name, DOB, ID number, and the reason for the request.

Quality Management Department Contact Information

Reason for Medical Record Request	Email Address	Fax
STARS-HEDIS initiative	Hedis_records@jeffersonhealthplans.com	215-967-9230
Care Gaps	Caregap_records@jeffersonhealthplans.com	215-967-9230
Audit	Audit@jeffersonhealthplans.com	215-967-4477
QOC/Complaints	Quality@jeffersonhealthplans.com	267-515-6648
CIOX/Datavant	Smart Request Portal ID#1336327	
MRO Portal	Quality@jeffersonhealthplans.com	

Utilization Management and Prior Authorization

Utilization Management (UM)

Our UM department is dedicated to ensuring members receive the most appropriate care for their specific needs. Decisions are based on medical necessity, appropriateness of care and services, coverage availability, and whether an item qualifies as a medical necessity.

We follow product-specific definitions of medical necessity, National and Local Coverage Determinations (NCDs & LCDs), and 2024 InterQual® criteria—specifically from the Subacute and SNF modules.

UM decision-makers are not offered financial incentives that encourage coverage denials or under-utilization of services.

For more information, visit: Provider Manual Chapter 8: Utilization Management

Prior Authorization (PA) Overview

- *Effective 10/1/2025, PA requests should be submitted through the designated provider portal.*
- PAs are processed either through MHK on our Provider Portal or eviCore, depending on the service.
- Use our Prior Authorization Management Tools to determine the appropriate submission type.
- Drug specific PA forms are available on our Prior Authorization webpage.
- *Specialists do not need referrals for any of our plans but must keep the PCP informed of all care rendered.*

Disenrollment Planning

Providers may be contacted for discharge/ transition planning for disenrolled members. We may remain responsible for up to **6 months** post-disenrollment unless the member selects another plan.

•**Non-Participating Facility Transfers**: For elective admissions or transfers, the **PCP, referring specialist, or hospital** must call **Inpatient Services at 1-866-500-4571**

Urgent/Expedited Requests

- Providers must request prior authorization at least **7 days in advance** for non-emergent services. Requests are processed per **state and federal regulations.** ***Failure to follow this timeline may delay non-urgent services.**
- **Expedited requests must meet one of these criteria points.** Requests not meeting this criteria may be processed under the standard timeframe for your line of business.

Urgent/Expedited Care Services	Urgent/Expedited Medical or Severe Condition
Care needed within 24 hours to prevent an Emergency Medical Condition	A serious illness or injury that should be treated within 24 hours to prevent it from becoming a crisis or emergency. *Also includes care needed to avoid delays in hospital discharge or admission.

- For more information, please see our **Urgent and Expedited Authorization Requests Tip Sheet.**

MHK Best Practices

Submitting an Authorization

- Begin by searching for the member in HealthTrio: *Date of Birth (DOB), Member ID, and Last Name.*
- Navigate from left to right, top to bottom.
- Always use the navigation buttons within the application.
- *HealthTrio times out after 20 minutes of inactivity.

Viewing an Authorization

If you have submitted an authorization request that you are now unable to locate, please follow the timeframes below before checking on its status:

- **Urgent Requests**: Wait 24 to 48 hours before checking status.
- **Standard Requests**: Wait 7 days before checking status.

Prior Authorization Submission

PAs are processed either through MHK on our Provider Portal or eviCore.

JEFFERSON HEALTH PLANS/HEALTH PARTNERSPLANS

- Clinics
- Short procedure units
- Ambulatory surgery centers
- Services performed in-office
- Hospital outpatient departments

eVICORE

- Oncology
- Joint & Spine Surgery
- Cardiology Studies/Procedures
- Chemo Home Infusion Medications
- Interventional Pain Management
- Advanced Radiology services
- Therapy services (PT, OT and ST)*

Health Partners Plans CHIP does not require PA for therapy services.

Prior Authorization Submission: Pharmacy

- There are specific medications on the formulary that require prior authorization.
- Drug specific prior authorization forms are available to help expedite the process with specific clinical criteria on our Prior Authorization webpage.

To request a prior authorization, the physician or a member of his/her staff should contact our Pharmacy department at 1-866-841-7659, Monday through Friday, 8 a.m. to 6 p.m.

Requests can also be faxed to 1-866-240-3712.

In the event of an immediate need after business hours, please call Member Relations at 1-800-553-0784. The call will be evaluated and routed to a clinical pharmacist on-call 24/7.

Prior Authorization Requirements for Transportation

Health Partners Plans Medicaid Jefferson Health Plans Medicare Advantage Jefferson Health Plans Individual and Family Plans	
Required	**Transportation**
No	**•Non-Emergent Land**
Yes	**•Air** **•Water**

Non-participating providers may require authorization as a condition of payment based on the member's individual coverage.

For information on products/services that require authorization as a condition of payment for out of network services, please contact the Utilization Management/Prior Authorization line at 1-866-500-4571, prompts 2 and 4.

Behavioral Health Non-Emergent Transportation

Behavioral health non-emergent (stretcher) transportation does not require prior authorization for all lines of business.

Health Partners Plans Medicaid ambulance providers must have an active PROMISe ID# and all claims must include a behavioral health ICD-10 diagnosis code.

All behavioral health transports must be for a level of transport appropriate to the documented need for our members to a behavioral health facility.

Effective January 1, 2025, we are removing the requirements for medical necessity reviews/prior authorization requirements for non-emergent land transportation for **Jefferson Health Plans Medicare Advantage** members.

Home Care

Home Care

Home Health services include Skilled Nursing (RN, LPN), Home Health Aide (HHA), Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST) and Social Work (SW) visits.

- **Requests must include a valid order for home health services and include supporting clinical documentation.**
- Home Care servicing providers are required to provide a Notice of Medicare Non-Coverage (NOMNC) to beneficiaries within 5 business days once care has ended.
- Please visit cms.gov for information.

Home Care Prior Authorization Requirements

- Home health agencies can use the Provider Portal to submit all prior authorization requests.
- All required clinical documentation is to be submitted with all requests for prior authorization.
- Providers have 5 business days from initial start of care to submit requests to be considered timely.
- All ongoing home care requests are expected to be submitted *before* services are rendered.
- We make every attempt to provide determinations as quickly as possible when all required documentation is received timely.

Health Partners Plans Medicaid	Jefferson Health Plans Medicare Advantage	Jefferson Health Plans Individual and Family Plans
• 2 business days to render a determination for all standard pre-service requests. • 30 calendar days to render a determination on all retrospective requests. • 14 days to render a determination for all standard pre-service request. • Extension timeframe is 14 days	• 14 days to render a determination for all standard pre-service request.	• 15 calendar days to render a decision. • 30 days for retro.

Mandatory Home Care Documentation Requirements

- **Orders:** Signed and dated (verbal) orders that include services dates/frequency
- **Referrals:** Signed and dated for the home care evaluation and/or start of care following a hospital or post-acute discharge
- **Clinical Discharge Summary:** From the inpatient stay
- **Visit Notes:** Ongoing request
  - Wound care notes
  - Therapy notes
- **Plan of Care (485):** Signed and dated by the overseeing provider in 30 days of the start of care (SOC) and certification period

Home Care/ Home Infusion Verbal Order Requirements

Health Partners Plans Medicaid, Health Partners Plans CHIP, Jefferson Health Plans Medicare Advantage

- **All orders must be signed and dated with the date of receipt.**
- **Verbal Orders**: Must include the **ordering practitioner's name** and the **name/credential** of the person taking the order.
  - May be taken by a **Registered Nurse**, **qualified therapist** (PT, OT, SLP, MSW), or **pharmacist** (home infusion).
  - May be signed by a **RN, supervisor, or qualified therapist**.
  - Must be **countersigned and dated** by the ordering practitioner (MD, DO, NP, PA, CNS, Certified Midwife, DPM) **within 2 weeks**.
- **Written Orders:** Can be documented by individuals authorized under **state and federal laws.**
- **Prescriptions**: Must be written by practitioners **within their scope of practice**

DHS and CMS Home Care Order Requirements

Health Partners Plans Medicaid, Health Partners Plans CHIP, Jefferson Health Plans Medicare Advantage

- **Signed Orders:** Required for all Home Health service requests and must match the diagnosis and services.
  - New services or changes require new orders.
  - **Written Orders:** Must include **date, time, and credentials** of the certifying practitioner.
  - **Valid sources** include MD, DO, NP, PA, CNS, Certified Midwife, or DPM.
  - **Acceptable documentation:** referral, prescription, discharge instructions, POC/485, letter of medical necessity, electronic referral, etc.
- **Plan of Care (POC):** Must be **signed and dated within 30 days** of the Start of Care (SOC) AND Recertification.
  - A **referral does not replace** the need for a signed POC
- **Prescriptions:** Must be written **within scope of practice.**

Shift Care (Skilled Nursing, Home Health Aide Services, Medical Day Care)

Shift Care

Requests submitted through provider portal (Shift Care Authorization Form)

Letter of medical necessity (LOMN) is signed and dated, and is required from certifying practitioners (NP, PA, DO, MD, CNM, DPM, etc.)

Specific number of hours per day/week/duration

Work verification if hours are being requested for the legally responsible relative to attend work

Prior Authorizations: Shift Care Additional Information

Additional information needed for prior authorization request to assess medical necessity:

- Recent office visit notes within the last 6 months.
- If member has autism, a copy of the member’s autism diagnostic report or recent developmental pediatrics' note.
- For work verification, add a LOMN from physician if parent is disabled

(if reason why SC services are being requested).

Electronic Visit Verification: HHAeXchange

HHAeXchange

HHAeXchange is the Electronic Visit Verification (EVV) vendor.

- EVV is required for all shift care home health aide visits.
- **EVV is required for ALL home health visits.**
- Providers have **60 days** to accept members in HHAeXchange once authorization is approved.
- Providers are required to report all missed shifts weekly to Jefferson Health Plans.

For assistance with HHAeXchange, email support@hhaexchange.com.

EVV Claims Submission via HHAeXchange - Home Health/Shift Care

- As part of our ongoing commitment to accuracy and efficiency of claim payments, and our concerns over an increased volume of billing errors, **effective September 1, 2025**, all Electronic Visit Verification (EVV) claims billed by Home Health/Shift Care providers for Health Partners Plans Medicaid members **must be billed** through HHAeXchange.
- **EVV claims directly submitted to Health Partners Plans Medicaid will be rejected, which will cause delays in claims processing and payments.**
- As a reminder, we partnered with HHAeXchange in 2021 to provide a free EVV and billing tool for member placement, scheduling, authorization management, communication, and EVV compliance for home health aide services. Visit www.hhaexchange.com to submit claims and for additional resources.

HHAeXchange

- Contact HHAeXchange for claims submission related issues and assistance with setting up an account.
- If the provider has multiple locations, be sure to accept the member into correct location that will be servicing and later submitting a claim for the member.
- Allow **24 hours** for an approved authorization to appear in the HHAeXchange portal.
- For claims EOP disputes, please contact our Provider Services Helpline at 1-888-991-9023.

Electronic Visit Verification Points

Electronic Visit Verification claims will be rejected if they fail to meet one of the 7 required verification points below:

1. The type of service provided
2. The name of the individual receiving the services
3. The date of service delivery
4. The location of service delivery
5. The name of the individual providing the service
6. The time the service begins and ends
7. Claims should always include the referring provider

Home Infusion

Home Infusion

Health Partners Plans Medicaid Jefferson Health Plans Individual and Family Plans Health Partner Plans CHIP	Jefferson Health Plans Medicare Advantage: Medical Part B	Health Partners Plans Medicaid Jefferson Health Plans Medicare Advantage: Medical Part B Individual and Family Plans
• Obtained from a physician (MD,DO) or practitioner (NP, PA, CNS, Certified Midwife, DPM). • Written orders must have the date, time, and credentials of the certifying practitioner. • Prior Authorization is required for all Biologics, **nursing and supplies do not require authorization when services are performed by a par provider. • Non-par providers require prior authorization for home infusion Biologics, intravenous feedings, nursing, and supplies. • A decision must be made within 24 hours, no extensions are allowed, and all required documentation must be submitted on time.	• Prior Authorization is required for J and B codes; nursing and supplies do not require authorization when services are reasonable and necessary. • Injectables (Home Infusion Therapy) are covered under the part D pharmacy benefit. Where these services are reasonable and necessary the medication being administered must be accepted as safe and effective treatment of the patient's illness or injury, must be a medical reason the medication cannot be taken orally.	• Intravenous, intramuscular, or subcutaneous injections and infusions, and hypodermoclysis or intravenous feedings require the skills of a licensed nurse to be performed (or taught) safely and effectively. • All requests are reviewed for medical necessity. • The frequency and duration of the administration of the medication must be within accepted standards of medical practice or must be a valid explanation regarding the extenuating circumstances to justify the need for the additional injections.

Durable Medical Equipment (DME)

Integra - DME Medicaid & Medicare

Submit all standard DME requests via provider portal

DME Medicaid and Medicare requests must include:

Current and Complete signed order by certifying practitioner: (NP, PA, DO, MD, CNM, DPM, etc.)

All requests must include

- DME provider name, NPI number of company supplying the equipment
- Supplier Contact name and phone/fax number
- Supporting current clinical and signed orders
- Correct CPT/HCPC codes with dates of service

DME requires prior authorization for all purchase items greater than $500 and all DME rentals

For all ongoing Continuation of Care Requests, Proof of Delivery is required

Exclusive to Medicaid or Medicare:

Medicaid: All miscellaneous codes require prior authorization.

*For more information, visit our website at Prior Authorization

Medicare: A face-to-face is required when applicable per Medicare guidelines (e.g., oxygen recertification)

Authorization does not guarantee payment Providers must keep all required documentation for review upon request. Payment will be recouped if documentation is missing.

Please visit our Form and Supply Requests page for a fillable DME Authorization Request Form

Mandatory DHS and CMS Oxygen Certification Requirements

Initial requests for oxygen must include a complete signed order from MD/DO/certifying practitioner.

- **A complete order consists of:**
  - Diagnosis code ICD10
  - Description of equipment ordered CPT/HCPC code
  - Directions for use of equipment (e.g., flow rate, frequency)
  - Date of prescription/date of physician's signature
  - Signature AND printed name of physician prescriber
  - Physician's license number or NPI
  - Physician prescriber must be enrolled in PA Medicaid when the prescription was written
  - Provider printed information on the prescription must match the provider signature

Oxygen certification requirements:

- The continued need for Oxygen must be certified every 6 months for **Health Partners Plans Medicaid** or every 12 months for **Jefferson Health Plans Medicare Advantage** as applicable
- Recertification can be a prescription or a certificate of medical necessity (if a prescription, must be complete)
- A prescription is needed every year, in addition to the recertification requirement
- Medicare requirements and criteria are based on NCD/Noridian LCD L33797
- A face-to-face is required when applicable per Medicare guidelines

Skilled Nursing Facility/ Pediatric Skilled Nursing Facility

Skilled Nursing Facility (SNF)

Jefferson Health Plans Medicare Advantage

- Prior authorization for post-acute skilled nursing admissions is required.
- All eligible members must meet CMS guidelines and evidence based clinical criteria.
- All requests are subject to a secondary review by a medical director.
- Documentation must be submitted promptly within 48 hours of the request. The requested services must be appropriate in duration and quantity, and should support the documented therapeutic goals.
- It does not have a custodial care benefit; **however**, dual enrolled (DSNP) members may be eligible under their secondary payer (Medicaid CHC).
- **Covers 100 days** of SNF per episode. Please refer to Medicare General information, Eligibility, and Entitlement Manual chapter 3 sect 10.4.1 for information.

Skilled Nursing Facility (SNF) continued

Jefferson Health Plans Medicare Advantage

- The services are reasonable and necessary for the treatment of a patient's illness or injury; i.e., are consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, and accepted standards of medical practice.
- SNFs are required to provide a Notice of Medicare Non-Coverage (NOMNC) to beneficiaries when their Medicare covered service(s) are ending 48 hours prior to the termination of services. The NOMNC informs beneficiaries on how to request an expedited determination from their Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) and gives beneficiaries the opportunity to request an expedited determination from a BFCC-QIO. A Detailed Explanation of Non-Coverage (DENC) is given only if a beneficiary requests an expedited determination. The DENC explains the specific reasons for the end of covered services.

Skilled Nursing Facility (SNF)

Health Partners Plans Medicaid

- Prior authorization for post-acute skilled nursing admissions is required.
- There must be an accepting facility prior to submitting the request or else the auth will not be processed.
- Has a bed hold benefit. The benefit provides a 15-day bed hold per hospital confinement. An authorization is required for payment. If we aren't notified of a need for a bed hold, those days will be denied.
- Has a 30-day custodial benefit, and authorization is required for payment.
- There is no more 30-day disenrollment.
- .

Skilled Nursing Facility (SNF) continued

Health Partners Plans Medicaid

- The documentation must be submitted timely and show that the services are appropriate in terms of duration and quantity, and that the services promote the documented therapeutic goals.
- The services are reasonable and necessary for the treatment of a patient's illness or injury; i.e., are consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, and accepted standards of medical practice.
- If member is applying for LTSS (CHC) proof of application is required. Auth will be reviewed for medical necessity, even beyond 30 days of skilled confinement. Once downgraded to custodial level of care, the 30 days will be given up front. If a CHC start date is not available on day 31, the auth will be put in CHC pended status until a start date is obtained. Once a start date is received, the auth will be updated to pay all remaining days.

Home and Inpatient Hospice

Home Hospice

Health Partners Plans Medicaid

- Participating providers do not require prior authorization.

Jefferson Health Plans Medicare Advantage

- Members convert to traditional Medicare for all hospice services
- Members may continue all Part B coverage unrelated to hospice diagnosis (dental, vision, etc.)

Inpatient Hospice

Health Partners Plans Medicaid

Inpatient hospice is a benefit for all Health Partners Plans Medicaid members.

- A member qualifies for inpatient hospice if they are actively dying or require treatment that can't be managed in the home.

Documents required for a pre-certification of a hospice admission are:

- Signed hospice election form
- Signed certificate of terminal illness
- Plan of care
- Current assessment of the member's condition/symptoms:
  - *What are the current exacerbating symptoms and interventions?*
  - *When did they start occurring?*
  - *Why is member unable to be managed at home?*
  - *Who is the member's support network?*

Inpatient Hospice Review Process

- Every inpatient hospice case will be reviewed for medical necessity by our medical directors.
- All inpatient hospice requests must be submitted with the required signed documentation before a medical necessity review is completed.
- If approved for inpatient level of care (LOC), 5 days will be approved.
- If the initial request or continued stay request is deemed not medically necessary, the request will be downgraded and be paid at a home hospice level of care.
- Appeal and P2P options will be available.

PA Medicaid Regulations and Codes

- We must be notified when members begin to receive hospice care, and when they end their hospice care.
- Outpatient hospice providers must educate members about the services that are included in hospice care, and that the member should not obtain these services from other providers while enrolled in hospice care. It is best practice to obtain and maintain a signed copy of this education in your records.
- We follow the PA Medicaid regulations/codes regarding the requirements of hospice care; please refer to the below:
  - Refer to 55 Pa. Code § 1101(General Provisions), 55 Pa. Code § 1130 (Hospice Services) and § 1101 (General Provisions), MA Bulletins, and the State Operations Manual Appendix M-Guidance to Surveyors: Hospice, and the Hospice Services Handbook.
  - Please note that Levels of Care must be documented as well, and that some services can only be provided when the member nears the end of life.

Ambulatory Surgical Center

Ambulatory Surgical Center Prior Authorization Requirements

Health Partners Plans Medicaid and CHIP
Jefferson Health Plans Medicare Advantage & Individual and Family Plans

- Services should be requested at least three weeks prior to scheduled procedure.
- Authorizations for services approved will remain open for 3 months, except organ transplant requests. which will remain open for 1 year.
- All services performed in an outpatient location that require Prior Authorization can be located on our website: Prior Authorization.

Cultural and Linguistic Requirements and Services

Cultural and Linguistic Requirements and Services

- Cultural Competency is one of the main ingredients in closing the disparities gap in health care.
- It requires a commitment from doctors and other caregivers to understand and be responsive to the different attitudes, values, verbal cues, and body language that people look for in a doctor's office by virtue of their heritage.
- Members have the right to receive services provided in a culturally and linguistically appropriate including: LEP, limited reading, vision, hearing skills, and those with diverse cultural and ethnic backgrounds. All providers are required, by law, to provide translation and interpreter services including qualified sign language interpreters.

Resources Available to Members

Member needing translation or language services, including sign language and TTY services, can call our **Member Relations line at 1-800-553-0784 (TTY 1-877-454-8477)**.

We have an online interpreter service that provides over 140 languages and is available 24 hours a day, seven days a week.

There is no cost to members for this service.

Americans with Disabilities Act

- As per Section 504 of the Rehabilitation Act of 1973, we require practitioners to abide by ADA requirements. These include:

- Handicapped parking spaces and restrooms
- Access ramps where applicable

If a practitioner's site does not meet ADA standards, alternatives include:

- Home visits
- Access at another site that meets ADA requirements
- Bathroom facilities elsewhere in the building or portable bathroom facilities

The Americans with Disabilities Act (ADA) requires providers to attest that their practice locations meet certain standards. You can use this link to attest. ADA Compliance Attestation

Non-Discrimination Policy

We recognize the diversity of our members and offer services that are sensitive to these differences. Members enrolled in our plan(s) have the right to receive and expect courteous, quality care regardless of race, color, creed, sex, religion, age, national or ethnic origin, ancestry, marital status, sexual preference, gender identity and expression, genetic information, physical or mental illness, disability, veteran status, source of payment, visual or hearing limitations, or the ability to speak English.

The Provider's Role with LGBTQ+ Patients

- Treat all patients with dignity; respect their identities
- Break the cycle of discrimination that creates barriers for LGBTQ+ communities to access healthcare
- Adopt best practices that are inclusive of and welcoming to LGBTQ+ communities
- Provide complete, unbiased, person-centered care that results in risk reduction and expanded

Complaints, Grievances, and Appeals

Complaints, Grievances and Appeals

When we deny, decrease, or approve a service or item different than the service or item requested because it is not medically necessary, a written grievance may be filed by the member, member's legal representative, healthcare provider or other member's representative (with the appropriate written consent of the member) to request a reconsideration.

In some cases, a member can ask DHS to hold a hearing because they disagree with our decision. A member must exhaust our Complaint or Grievance Process before requesting a Fair Hearing.

For more information, visit:

- Health Partners Plans Medicaid Member Handbook
- Provider Manual Chapter 13: Complaints, Grievances, and Appeals
- eLearning: Complaints, Grievances and Medical Necessity Reviews: Learn The Process

Members' Rights and Responsibilities

- Jefferson Health Plans/Health Partners Plans members have the right to know about their Rights and Responsibilities. Exercising these rights will not negatively affect the way they are treated by our participating providers or other state agencies.

- It is your obligation and duty as one of our providers to comply with these standards and uphold our Members' Rights.

- Members also have responsibilities, including the duty to work with their health care service providers.

- A comprehensive statement of Member Rights and Responsibilities provided can be found here: Provider Manual Chapter 15: Member Rights & Responsibilities

Fraud, Waste and Abuse (FWA)

Special Investigations Unit (SIU)

- **We prohibit all illegal and/or unethical conduct by members, employees, and providers.** Our Special Investigations Unit (SIU) proactively addresses questionable activity and investigates referrals of illegal and unethical conduct. Investigative findings are forwarded to state and/or federal law enforcement agencies for appropriate legal action upon a substantiated finding of fraudulent conduct.

- Examples of illegal and unethical conduct:
  - Providers up-coding claims or submitting claims for services not provided
  - Providers providing false statement to obtain credentials (MediCheck)
  - Providers paying members incentives for patronage
  - Pharmacist paying provider kickbacks for referrals
  - Members selling membership cards or allowing others to use their membership ID numbers to obtain services
  - Members selling obtained through the program
  - Members obtaining medication services or equipment not medically necessary for their conditions
  - Employees selling Jefferson Health Plans/Health Partners Plans information
  - Employees accepting money or gifts in exchange for manipulating some part of Jefferson Health Plans/Health Partners Plans system

For more information, please visit the Fraud, Waste and Abuse page on our website: Fraud, Waste & Abuse Information

FWA False Claims Act

- The False Claims Act is the most important tool U.S. taxpayers have to recover the billions of dollars stolen through fraud by U.S. government contractors, including providers, every year.

- Under the False Claims Act, those who knowingly submit or cause another person or entity to submit false claims for payment of government funds are liable for three times the government's damages, plus civil penalties. DOJ has increased False Claims Act (FCA) penalties to $11,665 - $23,331 per false claim, effective June 2020.

- If you wish to report fraud or suspicious activity, please call the Special Investigation Unit Hotline at 1-866-477-4848.

FWA False Billing & Procedural Neglect

- False Billing
  - Services already paid for or never rendered
    - Upcoding: Billing to increase revenue instead of billing to reflect actual work performed
    - Unbundling: Billing for each procedure separately instead of using grouping that is to be billed together
  - Forging physician signatures when such signatures are required for obtaining reimbursement

- Procedural Neglect
  - Perform medically unnecessary procedures
  - Falsified diagnoses to justify additional tests or overstated treatments

7 Fundamental Compliance Program Elements

1

Written Policies, Procedures, and Standard Code of Conduct

- Articulate the organization's commitment to comply with all applicable requirements and standards under contract.
- These policies and procedures are updated or reviewed on an annual basis or when regulation changes.

2

Establishment of Compliance Office and Compliance Committee

- We have a full-time Compliance Officer for our Health Partners Plans Medicaid, Health Partners Plans CHIP, Jefferson Health Plans Medicare Advantage, and Jefferson Health Plans Individual and Family Plans lines of business.
- There is a compliance committee dedicated to ensuring our compliance and ethics run effectively.

3

Effective Training and Education

- The goal is to ensure our providers are well trained and educated on various Health Partners Plans Medicaid and Health Partners Plans CHIP laws and regulation requirements.
- The trainings are provided upon hire and annually.
- Major required trainings are for Fraud, Waste, and Abuse; Compliance and HIPAA.

7 Fundamental Compliance Program Elements

4

Effective Lines of Communication

- It is important that employees, providers, subcontractors, and employees know that we have a 24-hour hotline to report compliance issues, including misconduct violating Fraud, Waste, and Abuse (FWA), Compliance, HIPAA, or Human Resources laws and regulations.
- **Reporting channels include:**
  - Compliance Hotline (Anonymous) : 1-866-477-4848
  - EthicsPoint Online Reporting Tool: (Anonymous)
  - Compliance email: compliance@Jeffersonhealthplans.com
  - Fraud, Waste, and Abuse:
    - Special Investigations Unit Hotline:1-866-477-4848
    - Email: SIUtips@Jeffersonhealthplans.com

5

Well-Published Disciplinary Guidelines

- We have well established policies and procedures regarding our disciplinary actions for noncompliance, FWA and improper misconduct.

7 Fundamental Compliance Program Elements

6

Effective System for Routine Monitoring and Auditing

- We conduct external monitoring and auditing of providers' and subcontractors' compliance with various laws and regulations regarding:
  - Medicaid and CHIP regulations
  - CMS requirements
  - State and federal laws and regulations
  - Contractual agreements

7

Prompt Response to Compliance Issues

- We have procedures in place to address compliance, FWA and HIPAA issues for reported offenses. Providers and subcontractors are instructed to report such issues through our compliance hotline at 1-866-477-4848.
- In doing so, providers are protected by the non-retaliation and whistleblower policy.
- Additional training on Fraud, Waste and Abuse can be found on our website.

MA Provider Self-Audit Protocol

- The DHS Medical Assistance Provider Self-Audit Protocol allows providers to disclose any overpayments or improper payments:
  - 100 Percent Claim Review
  - Provider-Developed Audit Work Plan for BPI Approval
- Intended for MA providers that participate in both the fee-for-service and managed care environments.
- The protocol provides guidance to providers on the preferred methodology to return inappropriate payments to DHS.
- Providers also have the option for conducting an audit via the DHS Pre-Approved Audit Work Plan with Statistically Valid Random Sample (SRVS)

Recipient Restriction Program

Health Partners Plans Medicaid

- The Recipient Restriction is a program of DHS's Bureau of Program Integrity (BPI), also referred to as "lock-in" program (requirement of DHS).
  - Participants are Health Partners Plans Medicaid members only.
  - It identifies patterns of misutilization of benefits.
  - Recipients may be restricted to a physician, a pharmacy, or both (physician and pharmacy) upon BPI approval.
  - For more information on the Recipient Restriction Program, contact the pharmacy department: 215-991-4300 or email PharmacyRecipientRestriction@JeffersonHealthPlans.com.

What's New?

Behavioral Health Update

- Beginning January 1, 2026, members enrolled in our **Health Partners Plans CHIP, Jefferson Health Plans Medicare Advantage and Jefferson Health Plans Individual and Family Plans** will receive their behavioral health benefit through Optum Behavioral Health.

- **Member benefits/coverages will not change with this transition.**

- Magellan will continue to provide BH services for Health Partners Plans Medicaid

Blood Pressure Resource Guide

Hypertension is one of the most common chronic conditions among the patient population we serve. Controlling high blood pressure is an important step in preventing other adverse health outcomes like heart attacks, stroke, kidney disease, and other serious conditions.

We have created a guide that can serve as a foundation for your office to:

- Learn more about the Controlling Blood Pressure (CBP) measure
- Understand how you can impact your QCP incentive
- Discover how we can support you and your care team

Visit Disease and Medication Management to view the Blood Pressure Resource Guide.

Regulatory Reminders

- As a contracted provider, there are several requirements that must be completed annually. If you have not already done so, please complete these items by the end of the year.

D-SNP Model of Care Training

This training ensures providers understand the specialized care and services offered to dual-eligible beneficiaries.
Attestation link

2025 Access and Availability Survey

Survey to determine if Medicaid/CHIP providers are meeting the access, appointment, and telephone availability standards
aasurvey@jeffersonhealthplans.com

ADA Compliance Attestation

Per federal and state regulations, all participating Medicaid/CHIP providers are required to attest that their practice locations meet the requirements set forth by the Americans with Disabilities Act (ADA).

*Additionally, please visit our Webinars page for other upcoming trainings.

Questions

Please use the Slido Q&A panel for any questions.

For additional questions, please email: providereducation@jeffersonhealthplans.com

Please take a moment to complete the post-webinar survey. Your feedback is greatly appreciated.

Upcoming webinars

Register at: hpplans.com/webinars

Thank You for Attending

Appendix

Plan Contacts and Resources

Provider Services Helpline 888-991-9023 9:00-5:00 pm	Medical Providers	Prompt 1
	Pharmacies	Prompt 2
	Join our Provider Network	Prompt 3
	Member Services	Prompt 4

Additional Resources	Utilization Management	866-500-4571
	Care Coordination	866-500-4571
	eviCore Radiology auths, PT/OT/ST and other expanded services	888-693-3211
	ECHO Health – electronic funds transfer and remittance advice	888-834-3511
	Quality Management	215-991-4283
	Skilled Nursing Facilities and Rehabilitation	215-991-4395 Fax: 215-991-4125
	Health Partners Plans CHIP Magellan Behavioral Health	800-424-3702
	Jefferson Health Plans Medicare Magellan Behavioral Health	800-424-3706

Plan Contacts and Resources

Providers	https://www.healthpartnersplans.com/home/providers/
Provider Manual	https://www.healthpartnersplans.com/home/providers/tools-and-resources/provider-manual/
Provider Portal	https://www.healthpartnersplans.com/home/providers/provider-portal/
Training & Education	https://www.healthpartnersplans.com/home/providers/training-and-education/
Provider Directories	https://www.healthpartnersplans.com/home/providers/tools-and-resources/provider-directory/
Formularies	https://www.healthpartnersplans.com/home/providers/tools-and-resources/formularies/
ECHO Health	http://www.echohealthinc.com/
Claims	https://www.healthpartnersplans.com/home/providers/eligibility-and-claims/
Contracting	Contracting@jeffersonhealthplans.com

Home Health Services and Non-Emergent Transportation Facsimile

Home Care and Home Infusion	Fax: 267-515-6633 (Jefferson Health Plans Medicare Advantage)
	Fax: 215-967-4491 (Health Partners Plans Medicaid, Jefferson Health Plans Individual and Family Plans)
Durable Medical Equipment (DME)	Fax: 267-515-6636 (Jefferson Health Plans Medicare Advantage)
	Fax: 215-849-4749 (Health Partners Plans Medicaid, Jefferson Health Plans Individual and Family Plans)
Shift Care/Medical Daycare	Fax: 267-515-6667
Non-emergent Transport	Fax: 267-515-6627

Additional Content

- Provider Tools and Resources (Slides 9-10)
- Product ID Cards and 2025 Product Information (Slides 11-20)
- Claims (Slides 28-35)
- Credentialing (Slides 35-39)
- Quality Management Department Contact Information – slide 47
- Additional Prior Authorization Information: Submissions, Pharmacy, Transportation (Slides 53-56)
- Home Care Documentation Requirements (Slide 60)
- Shift Care Additional Information (Slide 65)
- Additional HHAeXchange Information (Slide 69)
- Skilled Nursing Facility (SNF) Additional Information (Slide 78,80)
- Non-Discrimination Policy slide 91
- Fraud Waste and Abuse (FWA) (Slides 95 – 103)
- Plan Contacts and Resources (Slides 111-113)