Doing business with Sentara Health Plans



Sentara® Health Plans

10/27/2026

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Purpose of the guide

This guide is designed to orient providers on best practices to successfully conduct business with Sentara Health Plans.

Note: The Sentara Health Plans Provider Manual—a more extensive resource—is your trusted source for the health plan's policies and procedures.

PRSS enrollment

Medicaid fee-for-service and Managed Care Organization (MCO) network providers need to enroll through Provider Services Solution (PRSS) to satisfy and comply with federal requirements in the 21st Century Cures Act. All providers must revalidate enrollment at least every five years. It is important that you complete your revalidation before the due date to avoid disenrollment. Please refer to the Sentara Health Plans Medicaid Provider Manual and visit the Department of Medical Assistance Services (DMAS) website for more information about the Medicaid Enterprise System (MES).

Member rights

The Member Rights and Responsibilities document assures that all Sentara Health Plans members are treated in a manner consistent with our mission, goals, and objectives. The Member Rights and Responsibilities ensure that members are aware of their obligations and responsibilities upon joining Sentara Health Plans and throughout their membership with us. Each Sentara Health Plans product has specific Member Rights and Responsibilities and members are mailed information on where to locate their Rights and Responsibilities at the time of enrollment.

The Member Rights and Responsibilities are similar for all Sentara Health Plans products but have slight variations based on the product and its membership. Please review the Sentara Health Plans Provider Manual specific to the line of business, commercial, Medicaid and Medicare Dual-Eligible Special Needs D-SNP on the website.

Health plan obligations

Sentara Health Plans obligations are found in your provider agreement.

Provider obligations

Provider obligations are found in your provider agreement.

Joining the network and credentialing overview

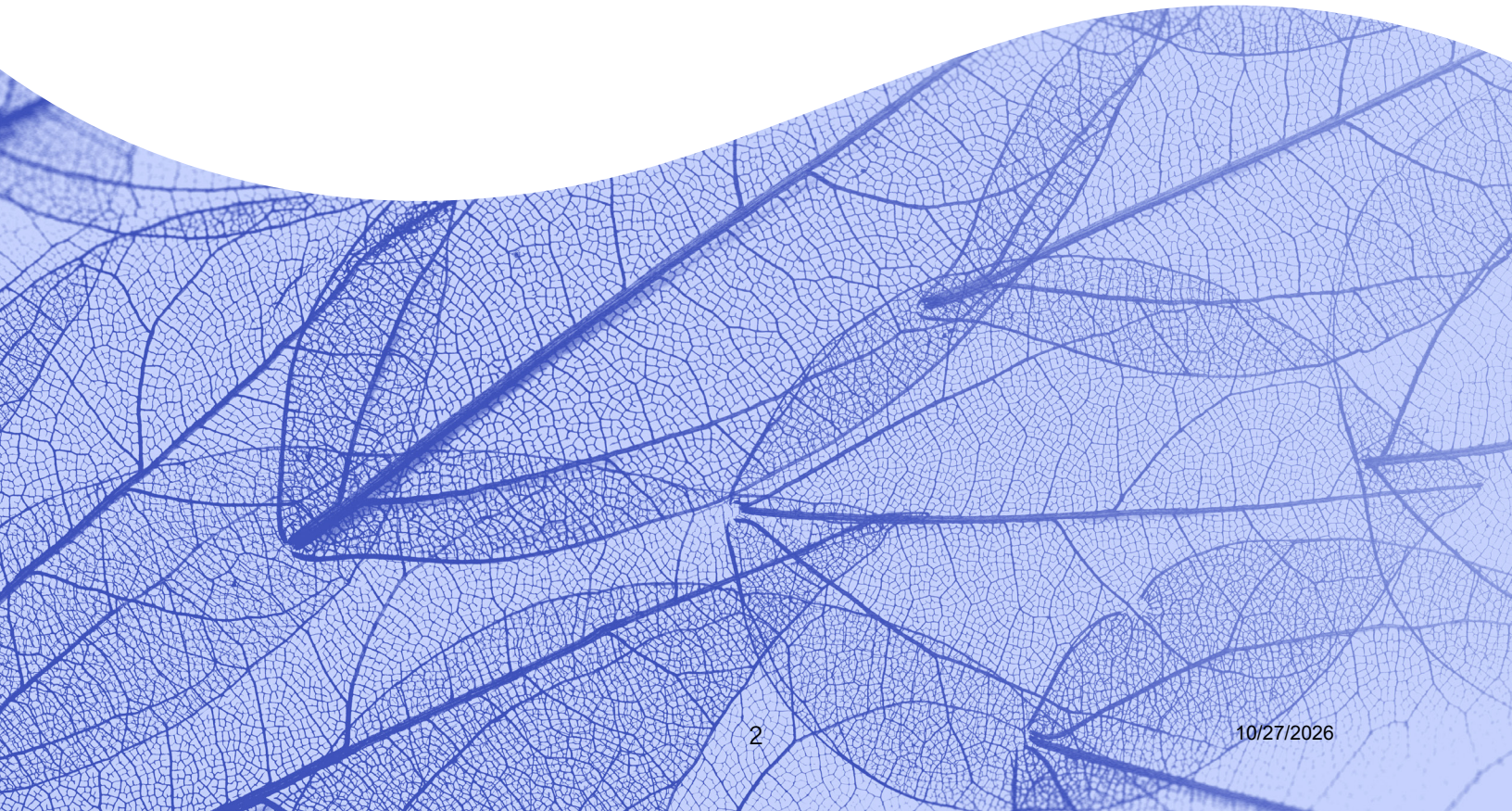
Non-contracted providers, group practices, or facilities that have not joined Sentara Health Plans will need to complete the Request for Participation form on the Sentara Health Plans website under Join Our Network.

To submit a request to be credentialed providers must confirm their Council for Affordable Quality Healthcare (CAQH) application is current and attested before submitting a credentialing request.

To submit a request to be credentialed with Sentara Health Plans, providers must complete a **Provider Update Form** on the plan website.

Credentialing Overview

The goals of the Sentara Health Plans credentialing/recredentialing policy are to ensure quality care and patient safety by utilizing credentialing and recredentialing standards outlined by the National Committee for Quality Assurance (NCQA), CMS, Sentara Health Plans policies and applicable state regulations. For more information please refer to the provider manual and the Credentialing Program Description on the website.



Billing while credentialing is pending

According to VA Law § 38.2-3407.10:1 of the Code of Virginia, Sentara Health Plans may reimburse providers for services rendered during the period in which their credentialing application is pending. An application is considered pending once the application has been deemed complete/clean by Sentara Health Plans to advance within the credentialing process. Reimbursement for services rendered during the pending application period is contingent upon approval of the provider's credentialing application by Sentara Health Plans credentialing committee and subsequent provider record configuration in the Sentara Health Plans claims system. However, no services shall be provided to a Sentara Health Plans member until a completed credentialing application has been received by Sentara Health Plans. Claims for these services must be held until the provider has received notification of credentialing approval and the provider agreement is signed by Sentara Health Plans.

The Provider agreement must be fully executed for the claims to be processed. If a Sentara Health Plans provider agreement is not signed and/or the provider does not meet all credentialing requirements, Sentara Health Plans is not required to reimburse claims as a network provider and the provider should not seek any reimbursement for services provided to the member from the time of application to final notice of the credentialing decision. Please review the entire process in the provider manual on the **website**.



Provider access and member care

Access to care

Access to care is recognized as a key component of quality care. As a condition of participation, providers must provide covered services to members on a 24- hour per day, 7-day per week basis, in accordance with Sentara Health Plans' standards for provider accessibility. This includes, if applicable, call coverage or other backup, or providers can arrange with an in-network provider to cover patients in the provider's absence. Providers may direct the member to go to an emergency department for potentially emergent conditions, and this may be done via a recorded message.

Appointment access standards– Medicaid

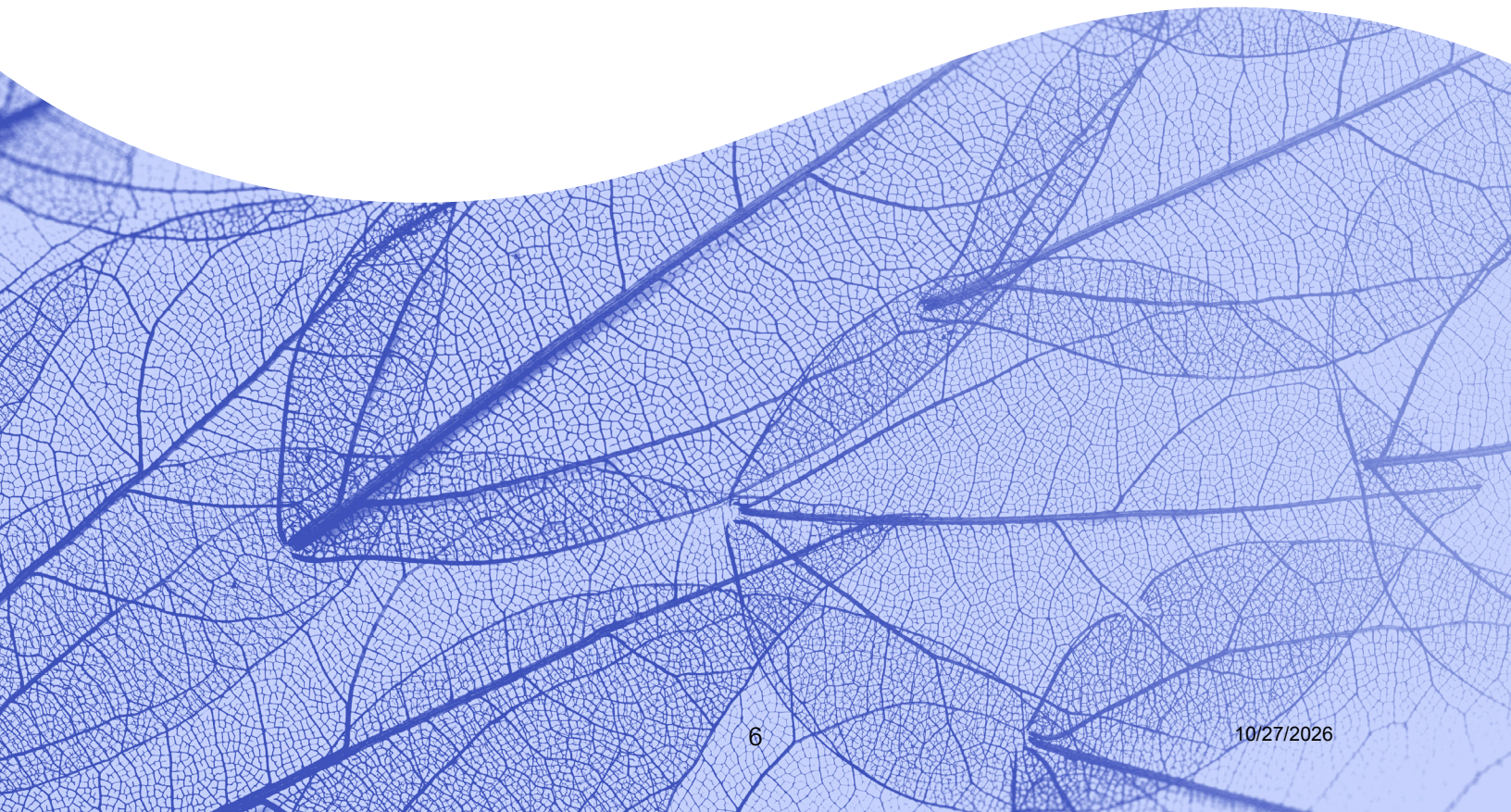
Service	Sentara Health Plans Medicaid Standards
Emergency services, including crisis services (medical and behavioral health)	Emergency appointments and services, including crisis services, must be made available immediately upon the member's request. Follow-up to crisis services must be made within 24 hours of Sentara Health Plans being notified of the crisis services utilization.
Non-life-threatening behavioral health emergency	Within six hours or directed to emergency care.
Urgent appointments (medical and behavioral health)	Within 24 hours of the member's request.
Regular and routine primary care services	Regular and Routine, primary care service appointments must be made within 30 calendar days of the member's request. Standard does not apply to appointments for routine physical examinations, for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every 30 days, or for routine specialty services like dermatology, allergy care, etc.
Maternity care – first trimester	Within seven calendar days of request.
Maternity care – second trimester	Within seven calendar days of request.
Maternity care – Third Trimester	Within three business days of request.
Maternity care – high-risk pregnancy	Within three business days of high-risk identification to Sentara Health Plans or a maternity provider, or immediately if an emergency exists.
Postpartum	Within 60 days of delivery.
Behavioral health services (initial and follow-up routine)	Must be made available as expeditiously as the member's condition requires and within no more than five business days from Sentara Health Plans' determination that coverage criteria are met.
LTSS	Must be made available as expeditiously as the member's condition requires and within no more than five business days from Sentara Health Plans' determination that coverage criteria are met.
Specialty Care Service	Within 30 calendar days of the member's request.

Appointment access standards– Commercial

Service	Sentara Health Plans Commercial Standards
Emergency appointments, including crisis services	Must be made available immediately upon the member's request.
Urgent appointments	Must be made within 24 hours of the member's request.
Routine primary care	Must be made within 14 calendar days of the member's request. Standard does not apply to appointments for routine physical examinations; for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently; or for routine specialty services like dermatology, allergy care, etc.
Maternity care – first trimester	Must be made within seven calendar days of request.
Maternity care – second trimester	Must be made within seven calendar days of request.
Maternity care – third trimester	Must be made within seven calendar days of request.
Maternity care – high-risk pregnancy	Must be made within three days of high-risk identification or immediately if an emergency exists.
Postpartum	Within 60 days of delivery.
Preventive care	Within 60 days of member's request.
Routine behavioral health/ substance use disorder initial visit	Within 10 business days.
Routine behavioral health/ substance use disorder follow-up visit	Within 14 calendar days.
After-hours care	As a condition of participation, providers must provide covered services to members on a 24-hour per day, 7-day per week basis.
Specialty Care Service	Within 30 calendar days of the member's request.

Appointment access standards– Medicare

Service	Sentara Health Plans Medicare Standards
Urgently needed services or emergency	Must be made immediately.
Services that are not emergency or urgently needed, but the member requires medical attention	Must be made within seven business days.
Routine and preventive care	Must be made within 30 business days.





Managing care gaps

To ensure optimal, timely service for our members and close gaps in patient care, we encourage following the protocol below:

- Use appropriate documentation and correct coding.
- Maintain appointment availability for patients with recent emergency department visits.
- Explain the importance of follow-up appointments to your patients.
- Contact patients who do not keep initial appointments and reschedule them as soon as possible.
- Encourage follow-up visits via telehealth when appropriate to the principal diagnosis.
- Submit claims and encounter data promptly.

Visit the Close Care Gaps section on our **website** to learn more and review the Comprehensive Care Gap Documentation Guide-All Measures.

Provider training requirements and recommendations

Required annually

Model of Care – Providers are required to review the Model of Care Provider Guide (MCPG) within 30 days of their initial orientation date as a newly contracted provider and by January 31 each subsequent year. Attestation is required and will be recorded by provider (practice/facility) name, tax identification number (TIN), and email address. Out-of-network providers must review the MCPG when they sign the requisite Single Case Agreement (SCA).

Encouraged

- Fraud, Waste, and Abuse
- Cultural Competency
- Trauma-informed Care
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

Learn more by visiting the Provider Education section on our **website** and reviewing the provider manual.

Member identification



Sentara Health Plans

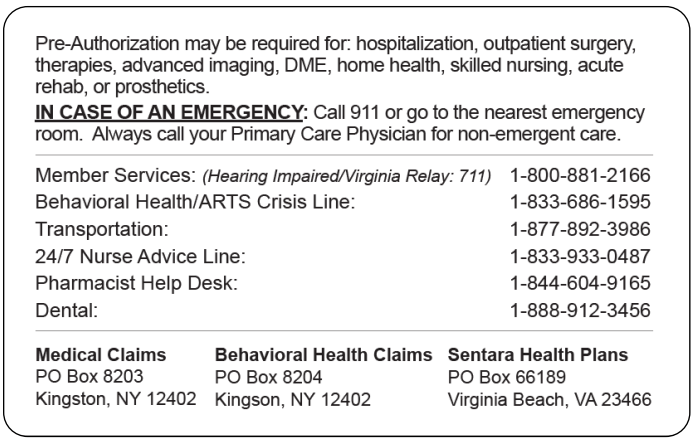
SENTARA COMMUNITY PLAN

Member Name: JOHN DOE
Member Number: 9999999
Group Number: SCP
Medicaid/Rx ID: 999999999999
PCP Name: JANE DOE
PCP Phone: 123-456-7899
Member Effective Date: 01/01/24

RxBIN: 003858
RxPCN: MA
RxGRP: SHPMDCD

CardinalCare Virginia's Medicaid Program

*Detailed plan information at sentarahealthplans.com



Pre-Authorization may be required for: hospitalization, outpatient surgery, therapies, advanced imaging, DME, home health, skilled nursing, acute rehab, or prosthetics.

IN CASE OF AN EMERGENCY: Call 911 or go to the nearest emergency room. Always call your Primary Care Physician for non-emergent care.

Member Services: *(Hearing Impaired/Virginia Relay: 711)*	1-800-881-2166
Behavioral Health/ARTS Crisis Line:	1-833-686-1595
Transportation:	1-877-892-3986
24/7 Nurse Advice Line:	1-833-933-0487
Pharmacist Help Desk:	1-844-604-9165
Dental:	1-888-912-3456

Medical Claims	**Behavioral Health Claims**	**Sentara Health Plans**
PO Box 8203	PO Box 8204	PO Box 66189
Kingston, NY 12402	Kingson, NY 12402	Virginia Beach, VA 23466

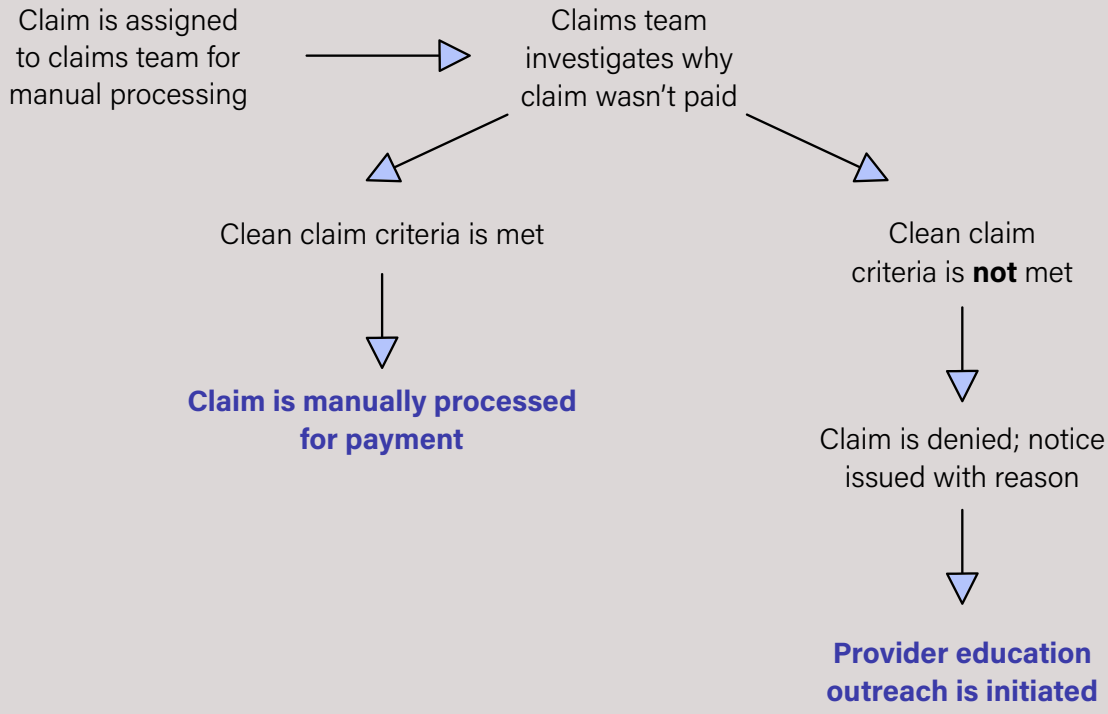
Billing and payments

By entering into a provider agreement, you have agreed to accept payment directly from Sentara Health Plans. This constitutes payment in full for the covered services you render to members, except for copayments, coinsurance, deductibles, and any other monies listed in the "Patient Responsibility" portion of the remittance advice. You may not bill members for covered services rendered or balance bill members for the difference between your actual charge and the contracted amount. In cases where the copayment is greater than the allowed amount for services rendered, only the allowed amount for the services should be collected. Should you collect more than the allowed amount, you will be expected to refund the member the difference between the two amounts. Please review the Billing and Claims Payments section of the provider manual on the **website**.

Clean claim/auto adjudication diagram



Clean claim criteria not met diagram



Electronic claims, electronic funds and electronic remittance advice

Sentara Health Plans' preferred method for claim submission and payment is electronic. Claims can be submitted through Availity or any clearinghouse that can connect through Availity. The Sentara Health Plans Payor ID number is 54154.

Electronic funds transfer (EFT) is safe, secure, and efficient, as well as less expensive than paper check payments. Funds are typically deposited 48 hours after payments are processed. Clean claims are processed and paid by Sentara Health Plans within an average of seven days when submitted electronically and when payment is made through EFT.

Provider payment processing and electronic remittances advice (ERA) are handled through Zelis Payments Network.

Providers are encouraged to enroll for EFT/ERA. Visit the **website** for the Authorization Agreement Instructions.

All claims must be submitted within the guidelines of the product (see the "timely filing" section in the manual), or they will be denied as a late claim submission.

Claims must be submitted by participating providers

Submit paper claims on the standard CMS-1500 form for professional providers or UB-04 form for facilities.

All claims must be "clean claims."

To process a claim, Sentara Health Plans must have on file a valid W-9 for the provider TIN. Claims submitted without a W-9 may be administratively denied by Sentara Health Plans. Sentara Health Plans may require that any claim submitted without a valid W-9 on file be resubmitted to be processed.

Common reasons for denial of payment

- Errors in member name – hyphenated last names must be submitted correctly
- Incorrect birthday submitted – claims must match the birth date associated with the member ID number

To learn more, review the Claims section of the provider manual or download the Avoiding Common Claim Submission Errors job aid from the online **Provider Toolkit**.

Paper claims must be mailed to:

Medical Claims
PO Box 8203
Kingston, NY 12402-8203

Behavioral Health Claims
PO Box 8204
Kingston, NY 12402-8204

Please review the provider manual on the **website** for additional information.

Reconsiderations, appeals and contestments

Claim reconsideration

A reconsideration—distinct from a claim correction—is a written request submitted by the provider seeking a review of how a claim was processed. It is important to note that a reconsideration does not involve any changes to the original claim. The reconsideration filing deadline is 365 days from the last date of service.

Non-participating Medicare providers have 60 days from the last claim adjudication date to file reconsideration and must also submit Waiver of Liability Statement agreeing not to balance bill regardless of reconsideration outcome.

A **Provider Reconsideration Form** must accompany each claim for reconsideration.

Appeal process

An appeal is a formal request to reconsider and change a previous adverse decision on a prior authorization request. This process occurs before a claim is submitted for payment.

For services rendered, providers have the right to appeal adverse actions after exhausting the Sentara Health Plans reconsideration process. Providers cannot appeal Sentara Health Plans' enrollment or termination decisions to the DMAS Appeals Division.

Please review the **Overview of the Appeal, Reconsideration and Contestment Processes** resource

Mail to:

Medicaid/Medicare

Sentara Health Plans Appeals and Grievances
PO Box 62876
Virginia Beach, VA 23466

- **Medicaid Provider Services**
  Phone: **1-800-229-8822**
- **Medicaid Appeals and Grievances**
  Phone: **1-844-434-2916**
  Medicaid Fax: **1-866-472-3920**
  Email: **memberappeals@sentara.com**
- **Medicare Provider Services**
  Phone: **1-800-927-6048**
- **Medicare Appeals and Grievances**
  Phone: **1-855-813-0349**
  Medicare Fax: **1-800-289-4970**
  Email: **medicareappeals@sentara.com**

Commercial

Sentara Health Plans Appeals and Grievances
PO Box 66189
Virginia Beach, VA 23466

- Email: **commappeals@sentara.com**
- Hand Delivery:
  1300 Sentara Park
  Virginia Beach, VA 23464
- Commercial Fax: **1-877-240-4214**

Contestment process

What is Contestment? An industry term that refers to a dispute with supporting evidence that the health plan's claim recovery effort is erroneous. Contestment must occur prior to a claim adjustment.

Prior authorizations

The preferred method to obtain an authorization is through the secure provider portal.

Prior authorization means an evaluation process that assesses the medical necessity of proposed treatment and checks to see that the treatment is being provided at the appropriate level of care.

Some services require prior authorization before the services are given. Physicians or other providers are responsible for getting prior authorization when required. When prior authorization is required for a service, but not obtained, any denial of benefits will not be the responsibility of the member. Prior authorizations are approved or denied based on current medical practice and guidelines. Decisions are not based on incentives, bonus structures, or intended to result in underutilization of services. Prior authorization is certification by Sentara Health Plans of Medical Necessity and not a guarantee of payment by Sentara Health Plans. Payment by Sentara Health Plans for Covered Services is contingent on the member being eligible for Covered Services on the date the Covered Service is received by the member.

Please review the **provider manual** for additional information.

Authorization Contacts

Commercial Plans

757-552-7540 or **1-800-229-5522**

Government Programs

Medical/Pharmacy: **1-888-946-1167**

Behavioral Programs

1-888-946-1168

Vendor-facilitated services

- **American Specialty Health Network (ASHN):** chiropractor network claims are paid through ASHN; commercial and Medicare D-SNP only; **1-800-848-3555**
- **Community Eye Care (CEC):** a subsidiary of VSP will service all Medicare D-SNP
- **DentaQuest:** only the FIDE-SNP (H4499-001) members; **1-888-650-1274**
- **Modivcare:** transportation vendor for Medicare D-SNP, Medicaid, and commercial
- **MDLive:** virtual visits; commercial, Medicare D-SNP, and Medicaid
- **NationsBenefits:** bathroom safety devices, personal emergency response system (PERS), meals, grocery allowance, and over-the-counter (OTC) product allowance for Medicare D-SNP
- **Nations Hearing:** discounted services for Medicare D-SNP and Medicaid
- **Papa:** in-home support services for things like playing board games, tech help, pet help, gardening, etc. for Medicare D-SNP
- **Vision Services Plan (VSP):** routine vision care; only commercial, Medicare D-SNP, and Medicaid
- **Quest Diagnostic** exclusive independent national laboratory provider and anatomic pathology services: commercial, Medicare D-SNP, and Medicaid



Medical records

"If the service was not documented, it was not done."

Practitioners and providers delivering services to Sentara Health Plans members are expected to maintain and appropriately share member health records in accordance with established professional standards.

Practitioners are required to maintain comprehensive and accurate medical records documenting the care and services provided to Sentara Health Plans members. All communications and records related to a member's healthcare must be treated with strict confidentiality. Unless otherwise authorized by law, records may not be released without the member's written consent, or, in the case of a minor, the consent of their legal guardian (unless the records relate to services for which the minor has consented for themselves in accordance with Virginia law).

Medical records are essential tools for preserving the continuity, accuracy, and integrity of clinical information. As the primary source of data related to patient care, medical records support not only the treating provider, but also other healthcare professionals involved in coordinating and delivering comprehensive care.

Critical incident reporting

A critical incident is defined as any actual, or alleged, event or situation that threatens or impacts the physical, psychological, emotional health, safety, or well-being of the member. Critical incidents are categorized as either quality of care incidents, sentinel events, or other critical incidents as defined in the provider manual.

Providers must report critical incidents that occur during:

- The provision of services to members in nursing facilities, inpatient behavioral health or HCBS settings, hospital, PCP, specialist, transportation, or other healthcare setting
- Participation in or receipt of mental health services, ARTS, or waiver services in any setting (e.g., adult day care center, a member's home, or any other community-based setting)

Reporting procedures/guidelines

Sentara Health Plans requires all network and affiliated providers to report critical incidents within 24 hours of discovery via the approved **Provider Critical Incident Report Form** found under "Forms" on the Sentara Health Plans website. An initial report of an incident may be submitted verbally within 24 hours but must be followed up with a written report within 48 hours.

If the critical incident includes notifying Adult Protective Services (APS) or Child Protective Services (CPS), the following numbers may be used:

- APS: **1-888-832-3858**
- CPS: **1-800-552-7096**

Notify Sentara Health Plans of a critical incident either by phone, fax, or email within 24 hours of knowledge of the incident. Sentara Health Plans contact information to report a critical incident is located on the **Provider Critical Incident Report Form** found under "Forms" or the "Sentara Health Plans Key Contact Information" at the top of this document.

Please reference the provider manual on our **website** for detailed information.

Definitions

1. **Billed charge:** the actual amount charged by provider for any covered service furnished to a member.
2. **Clean claim:** As defined in the Provider Agreement, will generally be processed and paid by Sentara Health Plans within 30 days of its receipt. Processing delays may occur for claims that require coordination of benefits, code review, or medical review.
3. **Clean/complete application:** when the application has been received, all supporting documents and/or responses have been received and all verifications, primary source or otherwise, have been confirmed.
4. **Corrected Claim:** a corrected claim is a complete replacement of a previously submitted claim that requires changes such as updates to diagnosis codes, procedure codes, modifiers, charges, member information, or provider information. Corrected claims must include all services provided.
5. **Covered services:** those services, drugs, supplies, and equipment for which coverage benefits are available under the healthcare plans. Covered services beneficiaries are given benefits according to the terms and conditions of the health plan.
6. **Copayment:** charges for covered services collected directly by provider from member as payment, in addition to the fees paid to provider by the health plan.
7. **Deductible:** a dollar amount which a member is responsible to pay before the covered service.
8. **Electronic Health Record (EHR):** an electronic record of clinical services rendered by a participating provider to a member.
9. **Fee schedule:** a list of the maximum amounts allowed per unit for covered services.
10. **Medically necessary:** reflecting the services and care provided to members, and are justified by documentation.
11. **Noncovered services:** those healthcare services that are not covered services.
12. **Provider network:** a group of participating providers that, through a contractual relationship, supports some or all products in which members are enrolled.
13. **Quality improvement:** the program is designed to implement, monitor, evaluate, and improve processes within the scope of our health plan to continuously improve the health of our members every day.
14. **Reconsideration:** a reconsideration - distinct from a claim correction - is a written request submitted by the provider seeking a review of how a claim was processed. It is important to note that a reconsideration does not involve any changes to the original claim.
15. **Taxonomy:** a unique 10-character code that designates a healthcare provider's classification and specialization.

Helpful resources

The resources below, and more, can be found at **Providers | Sentara Health Plans**

- Sentara Health Plans Commercial Provider Manual
- Sentara Health Plans Medicaid Provider Manual
- Sentara Health Plans Medicare Dual-Eligible Special Needs (D-SNP) Provider Manual
- Overview of the Appeal, Reconsideration and Contestment Processes

MES Provider Portal

Sentara Health Plans quick reference resources:

- Clinical references
- Authorizations

E-booklets:

- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Provider Guide
- Model of Care

Sentara® Health Plans