Provider News

November 2026



Sentara®
Health Plans

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Sentara Health Plans news

The Great American Smokeout: Helping members take the first step toward quitting tobacco

Each November, the American Cancer Society's Great American Smokeout® encourages tobacco users to take the first step toward quitting and begin their journey toward a tobacco-free life. Tobacco use remains a leading cause of preventable disease and death, increasing the risk of heart disease, stroke, lung disease, and cancer.

Healthcare providers play an important role in tobacco cessation by routinely screening for tobacco use, advising patients to quit, and connecting them to available resources and support. Counseling and evidence-based cessation treatments can significantly improve a patient's chances of successfully quitting.

Sentara Health Plans offers members Stay Smokeless for Life, a free tobacco cessation resource that includes educational videos, downloadable toolkits, quit-planning worksheets, tobacco cessation tips, information on cessation medications, relapse-prevention tools, and other educational materials to help patients navigate the challenges of quitting tobacco.

Encourage members who are considering or preparing to quit tobacco to visit the Sentara Health Plans **Stay Smokeless for Life resource** for free tools, educational resources, and support designed to help them take the next step toward a tobacco-free life.

Sources:

Sentara Health Plans. Stay Smokeless for Life. https://www.sentara.com/en/health-plans/members/health-and-wellness/prevention-and-wellness/stay-smokeless-for-life

American Cancer Society. Great American Smokeout®. https://www.cancer.org/cancer/risk-prevention/tobacco/great-american-smokeout.html

Partnering with case management to support your patients

At Sentara Health Plans, we work as your partners in care. Our case management team reinforces the plan of care you establish and helps ensure your patients receive what they need at the right time and in the right setting. Everything we do aligns with and supports your clinical direction.

We help monitor complex health needs, close care gaps, and keep patients engaged between visits with your practice. We also guide members so they know how to make the most of their appointments by helping them understand what to prepare, what to ask, and how to follow through on your recommendations.

Through early identification of high-risk situations, we work to reduce avoidable hospitalizations and help resolve barriers that can interfere with progress. We connect patients with resources, provide education, and offer ongoing support that complements the care you deliver.

Clear and consistent communication is central to an effective partnership. Identifying the assigned case manager, establishing defined communication channels, and sharing timely updates through a designated liaison all strengthen coordination and support improved outcomes.

Case management participation is voluntary and available to all Sentara Health Plans members. We look forward to continuing to work alongside you by reinforcing your care plan, supporting your patients, and partnering to improve health outcomes.



Pre-payment review reminder

To help ensure accurate and timely claim processing, Sentara Health Plans conducts pre-payment reviews on selected claims. During these reviews, providers may be asked to submit medical records and supporting documentation to validate billed services.

Pre-payment reviews include both administrative and clinical validation. Reviews may assess whether documentation supports the services billed, applicable coverage requirements, provider eligibility, required identifiers, timeliness, and other program-specific requirements. Claims may remain pending while requested documentation is being reviewed. The review is based on the documentation submitted for the billed service and required program elements.

Providers are encouraged to respond promptly to documentation requests to ensure records are complete and support the services billed. For detailed information regarding the pre-payment review process, documentation requirements, and reconsideration rights, please refer to the Sentara Health Plans Pre-Payment Review Policy available on the Provider Portal under the Program Integrity section.

How providers can help members maintain healthy vision

Providers play an important role in educating members about eye health and preventive care. Encourage members to follow these recommendations to reduce their risk of vision loss and support lifelong eye health.

Encourage comprehensive eye exams

Many common eye diseases, including glaucoma, diabetic retinopathy, and age-related macular degeneration, often develop without noticeable symptoms. Regular comprehensive dilated eye exams can help detect these conditions early, when treatment is most effective.

Promote the use of sunglasses

Recommend sunglasses that block 99% to 100% of both UVA and UVB rays. Proper eye protection from ultraviolet (UV) radiation can help reduce the risk of long-term eye damage.

Support blood sugar management

For members with diabetes, maintaining healthy blood sugar levels is essential for reducing the risk of diabetic retinopathy and other diabetes-related eye complications. Regular eye exams should be part of their diabetes care plan.

Remind members to give their eyes a break

Encourage the 20-20-20 rule: Every 20 minutes, look at something approximately 20 feet away for at least 20 seconds. This simple habit can help reduce digital eye strain.

Discuss family eye health history

Many eye diseases and conditions have a hereditary component. Understanding a member's family eye health history can help identify those at increased risk and may support earlier screening and intervention.

Reinforce proper contact lens hygiene

Members who wear contact lenses should wash their hands thoroughly before handling lenses, disinfect lenses as directed, and replace them according to their eye care professional's recommendations to reduce the risk of infection.

Encourage a healthy weight

Overweight and obesity increase the risk of conditions such as diabetes, which can contribute to vision loss. Encourage members to discuss weight management strategies with their healthcare provider if needed.

Promote protective eyewear

Protective eyewear should be worn during sports, home improvement projects, yard work, and other activities that could result in eye injury. Appropriate eye protection can significantly reduce the risk of preventable eye injuries.

Recommend a healthy diet

A diet rich in fruits, vegetables, and dark leafy greens may support eye health. Fish that contain omega-3 fatty acids, such as salmon, tuna, and halibut, may also provide vision-related health benefits.

Encourage tobacco cessation

Smoking increases the risk of age-related macular degeneration, cataracts, and optic nerve damage. Encouraging members to quit smoking or avoid starting can help protect both vision and overall health.

Source: Centers for Disease Control and Prevention (CDC), Vision Health Initiative. Tips to Prevent Vision Loss. https://www.cdc.gov/vision-health/prevention/index.html

Help us advance health equity

In alignment with The National Committee for Quality Assurance (NCQA) standards and regulatory requirements, Sentara Health Plans collects certain demographic information from our network providers.

We encourage you to consider sharing details such as race, ethnicity, and languages spoken. This information plays an important role in helping us identify gaps in care and develop initiatives that reduce health disparities across the communities we serve.

Providing this information is voluntary, and you may choose whether to share it with Sentara Health Plans.

To submit or update your demographic information, please use the Provider Update Form or Delegated Update Form available at this **link**.

Cultural competency training

Sentara Health Plans embraces and promotes cultural humility as a foundational approach to the delivery of services. Delivering culturally competent care means providing services that are respectful, inclusive, and responsive to every individual. This includes individuals with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, pregnancy-related conditions, and those of all sexes and gender identities—encompassing sex characteristics (including intersex traits), sexual orientation, gender identity, and sex stereotypes.

To support this commitment, Sentara Health Plans encourages all providers to participate in cultural competency training. A valuable resource is available through Think Cultural Health, a training program developed by the U.S. Department of Health & Human Services. Providers can access this program via the Sentara Health Plans **Provider Education page**.

Providers have the flexibility to complete any cultural competency course that best fits their needs. After completing training, please complete the online **Cultural Competency Attestation Form**, or submit an update through the **Provider Update Form** (under the "Other" checkbox). The provider directory will indicate which providers have completed Cultural Competency training.



Proper corrected claims submission

A corrected claim is a replacement of a previously submitted claim that requires changes or corrections to the charges, clinical or procedure codes, dates of service, or member information. A claim is being resubmitted by the provider to correct or change a previous submission for the same patient, date of service, and/or procedures. Please ensure that the appropriate claim lines reflect the original claims submission exactly. **Claims should not be split when correcting the original claim.**

We have recently updated the "Corrected Claim Submission of a Previously Billed Claim" section in the provider manuals for all Sentara lines of business, located on our **website**. Please review this information to learn more about submitting corrected claims via the UB-04 and CMS 1500 forms to avoid denials of improperly submitted claims.

Expanding access to care with mid-level practitioners

Timely access to care is an important component of providing high-quality healthcare services. One strategy providers may consider to improve appointment availability and increase patient access is the effective utilization of mid-level practitioners. Mid-level practitioners, including nurse practitioners and physician assistants, can help practices improve appointment availability, reduce wait times, and expand access to care for Sentara Health Plans members.

Physician assistants and advance practice registered nurses, including licensed nurse practitioners, clinical nurse specialists, certified nurse midwives, and certified registered nurse anesthetists may contract with Sentara Health Plans to provide covered services consistent with applicable state laws and scope-of-practice requirements.

To be eligible for reimbursement from Sentara Health Plans, Nurse Practitioners and Physician Assistants must:

- Be participating with Sentara Health Plans through an active Provider Agreement, either directly or through a participating group.

  Note: Only Nurse Practitioners may be directly contracted without a supervising physician participating in the same practice. Sentara Health Plans does not contract with standalone Physician Assistants, Clinical Nurse Specialists, Certified Nurse Midwives, or Certified Registered Nurse Anesthetists.
- Practice within the scope of their licensure and meet any applicable supervision requirements.
- Provide covered services and obtain required authorizations when applicable.

Utilizing qualified mid-level practitioners can help practices increase appointment capacity and improve timely access to care for Sentara Health Plans members.



Combine a well-child visit with flu prevention

The American Academy of Pediatrics (AAP) in updated recommendations urges that all children age six months and older be vaccinated to prevent influenza (flu). The updated guidance comes after a severe flu season.

The AAP and other medical societies are making evidence-based vaccine recommendations for the populations they serve.

For the 2026-27 flu season, the AAP recommends:

- Influenza vaccination for children without medical contraindications ages six months and older.
- Any licensed influenza vaccine product that is appropriate for age and health status; AAP does not prefer one product over another.
- The number of influenza vaccine doses recommended for children remains unchanged in the 2026–2027 influenza season and depends on the child's age at first dose administration and influenza vaccination history.
- Influenza vaccine should be offered to children as soon as it becomes available, especially to those recommended to receive two doses. The recommended dose(s) ideally should be received by the end of October for optimal protection before the influenza season.
- Influenza vaccination is recommended for pregnant individuals to benefit both them and their infants.
- Influenza vaccination of a breastfeeding parent provides protection to both the parent and the infant and is safe.
- Influenza immunization of immunocompromised patients is updated to align with evidence-based recommendations from other groups and professional societies.

Source:

Diseases, C. O. I. (2026). Recommendations for Prevention and Control of Influenza in Children, 2026–2027: Policy Statement. PEDIATRICS. https://doi.org/10.1542/peds.2026-078778



Medicaid updates

Important federal Medicaid eligibility changes—effective October 1

New federal legislation, House Resolution 1 (H.R. 1), will introduce significant changes to Medicaid eligibility requirements that may affect members' ability to qualify for or maintain Medicaid coverage.

What providers need to know

The new requirements will be implemented between **October 1, 2026, and January 1, 2027**, and are expected to affect more than 500,000 Virginians currently enrolled through Medicaid Expansion[1]. While certain exemptions and waivers may apply, some members could lose coverage if they do not meet the new eligibility requirements.

Why this matters

Loss of Medicaid coverage can create barriers to timely access to care and may negatively affect members' ability to manage chronic conditions and receive preventive services. Members who lose coverage may delay seeking care, increasing their risk for preventable hospitalizations and poorer health outcomes. Additionally, higher rates of uninsured individuals can increase uncompensated care and place greater demand on health care resources across Virginia.

Key federal Medicaid changes

Effective October 1, 2026

- New eligibility rules will limit full-benefit Medicaid coverage for some **non-U.S. citizen adults**.
- Eligibility requirements for children and individuals who are pregnant or within 12 months postpartum will not change.

[1] **dmas-enrollment-report-2026-09.xlsx**

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Beginning January 1, 2027

- Medicaid Expansion members will undergo eligibility reviews every six months.
- Some Medicaid Expansion members will be required to meet **new Medicaid work requirements** to maintain coverage.

How providers can help

Providers are encouraged to discuss these upcoming changes with Medicaid members during office visits and reinforce the importance of maintaining current information with Virginia Medicaid. Members should be encouraged to:

- Keep their mailing address, phone number, and email address up to date and report changes within 10 days.
- Read and respond promptly to all Medicaid letters, emails, and text messages.
- Watch for information regarding eligibility reviews and work requirements.
- Check regularly for updates from Virginia Medicaid and the Virginia Department of Medical Assistance Services (DMAS).

Member assistance resources

Members with questions or who need language assistance services or large-print documents may:

- Call Cover Virginia at **1-855-242-8282**
- TTY: **1-888-221-1590**
- Email: **covervirginia@dmas.virginia.gov**
- Use the live chat available through **DMAS resources**

Qualified hospitals should also be aware that the Hospital Presumptive Eligibility portal is scheduled to incorporate the updated citizenship and noncitizen eligibility rules on October 1, 2026, followed by federal work requirement eligibility rules, exemptions, and exceptions on January 1, 2027. Updated HPE provider manuals and training slides are available through the **DMAS Hospital Presumptive Eligibility Information webpage**.

Action needed

Providers should encourage Medicaid Expansion members to verify their contact information now and remain alert for future communications regarding eligibility reviews and work requirements that begin in 2027.

Additional resources:

- **Virginia Medicaid**
- **DMAS Provider Resources**
- **Medicaid Work Requirement Information**
- **Cover Virginia Resources**



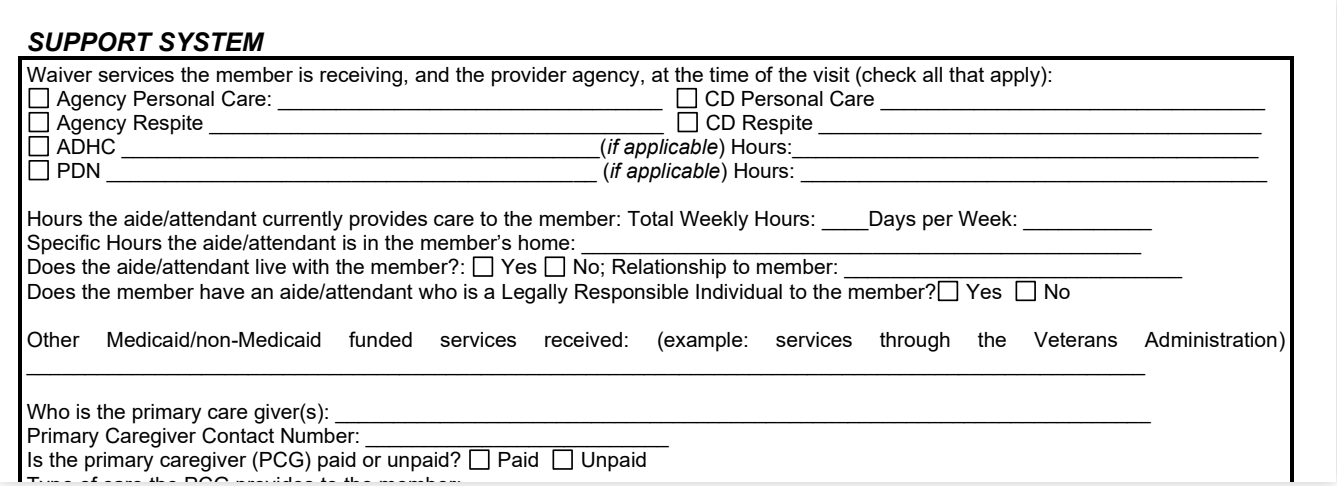
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Reminder: LRI requirements and updated DMAS 99 form

DMAS defines a Legally Responsible Individual (LRI) as a parent or legal guardian of a minor or the member's spouse. Personal care services provided by an LRI must be extraordinary in nature and above and beyond the care the individual is otherwise obligated to provide.

As a reminder, reimbursement for LRI-provided personal care services is limited to 40 hours per week. When an LRI provides assistance for multiple eligible children, reimbursement may be available for up to 40 hours per week for each child. Additionally, respite services are not available when there is a paid LRI providing personal care/ assistance.

Effective October 1, 2026, providers should use the updated DMAS 99 form and ensure LRI caregivers are accurately identified, documented, and reported. The revised form includes questions regarding whether the aide/ attendant is an LRI, the aide/attendant's relationship to the member, and whether the primary caregiver is paid or unpaid.



SUPPORT SYSTEM

Waiver services the member is receiving, and the provider agency, at the time of the visit (check all that apply):
☐ Agency Personal Care: _____ ☐ CD Personal Care _____
☐ Agency Respite _____ ☐ CD Respite _____
☐ ADHC _____(*if applicable*) Hours:_____
☐ PDN _____ (*if applicable*) Hours: _____

Hours the aide/attendant currently provides care to the member: Total Weekly Hours: ____Days per Week: _____
Specific Hours the aide/attendant is in the member's home: _____
Does the aide/attendant live with the member?: ☐ Yes ☐ No; Relationship to member: _____
Does the member have an aide/attendant who is a Legally Responsible Individual to the member?☐ Yes ☐ No

Other Medicaid/non-Medicaid funded services received: (example: services through the Veterans Administration)
_____

Who is the primary care giver(s): _____
Primary Caregiver Contact Number: _____
Is the primary caregiver (PCG) paid or unpaid? ☐ Paid ☐ Unpaid

We encourage providers to review the resources below to help ensure accurate documentation, reporting, and compliance with current DMAS requirements.

Resources

- **DMAS Legally Responsible Individual (LRI) Guidance**
- **Updated DMAS 99 Community-Based Care Member Assessment Form**
- **CCC Plus Waiver Provider Manual Update – Extraordinary Care Requirements**
- **DMAS Bulletin: HCBS Waiver Amendments and LRI Updates**

Welcoming Baby℠ program

Welcoming Baby is Sentara Community Plan's incentive-based prenatal and postpartum care program for our members. It includes:

- Pregnant members from conception
- Birth
- Postpartum care for up to 12 months
- Watch Me Grow℠ child outreach to babies from birth to 15 months

What do your patients receive from this program?

- One-on-one supportive services from a certified community health worker (outreach representative) and a maternity case manager and/or behavioral health maternity care coordinator
- Screening and referral to maternity case manager/ care coordinators for care planning and goal setting
- Management of high-risk conditions
- Education and community referrals for identified needs
- Family planning, long-acting reversible contraception (LARC), and birth spacing education
- **Baby showers** (virtual and in person)
- Access to breast pumps
- **Maternal/child education series classes** (virtual)
- Referrals to parenting, breastfeeding classes, and lactation services
- Hospital tours (virtual and in person)
- Timeliness of care incentives

Welcoming Baby Outreach Team:
8 a.m. to 5 p.m., Monday-Friday.

- Phone: **1-844-671-2108 (TTY: 711)**
- Email: **welcomingbaby@sentara.com**

Timeliness of prenatal and postpartum care

Our members are encouraged to seek timely and consistent prenatal and postpartum care with their providers. Through the Welcoming Baby program, members receive reminders, education, and incentives if they receive their first prenatal visit within 42 days of enrolling with Sentara Community Plan (or within their first trimester). Members also receive reminders, education, and are eligible for an incentive if they receive their timely postpartum provider visit (within 7-84 days of giving birth). Complete our **OB Registration Form for Medicaid Members** and submit supporting documents to help us improve the timeliness of prenatal care.

OB registration program: Early identification of pregnancy

- Providers are eligible to receive a $25 incentive for referring pregnant patients to Sentara Health Plans' Welcoming Baby Program upon identification of pregnancy for Medicaid members.
- Providers must complete the **OB Registration Form for Medicaid Members** and fax it to Outreach at **1-804-799-5117**, and submit a claim using the code **G9001**.
- Providers can also email the form to **welcomingbaby@sentara.com**.

Early and periodic screening, diagnostic, and treatment (EPSDT)

All of our Sentara Community Plan members, from birth to age 20, are eligible for EPSDT services to include annual wellness checkups with their providers, pediatricians, primary care providers, or general practitioners. Children can receive comprehensive health screenings and developmental assessments, vision, dental, and hearing services, as well as medically necessary services as identified.

At Sentara Community Plan, the Watch Me Grow, Infant and Child Wellness program, screens children at birth through 15 months, and other Sentara Community Plan children in the home, for any health needs and ensures access to care. Children identified with additional needs are referred to our internal high-risk pediatric case management for further assessment and follow up. Parents are provided with education on timely well-child visits and immunizations to include oral health care and vision care.

Maternal/child dental health care

At Sentara Community Plan, members are educated on dental care during and after pregnancy, and how to care for their baby's teeth, including fluoride treatment. Education is provided through a partnership with Cardinal Cares Smiles. Members are encouraged to contact a dental provider through **DentaQuest.com** or by calling **1-888-912-3456**.

Maternal Community Health Education Series

Sentara Health Plans is thrilled to announce the completion and launch of our new Maternal Community Health Education Series, created to empower, inform, and support parents and caregivers throughout their journeys. This initiative is part of Sentara Health Plans' commitment to improving maternal and family health outcomes in our communities.

Our comprehensive series covers a wide range of essential topics, from prenatal care and childbirth to postpartum support and newborn care. Our goal is to ensure every parent and caregiver has access to reliable information and helpful resources, making a positive impact on the well-being of families across the region.

Please explore the links below, share, and help spread the word:

- **Sentara Health Plans - Welcoming Baby Education and Events**
- **YouTube Channel: Welcoming Baby | Sentara Health Plans**

Changes to gender dysphoria coverage

This notice is to inform providers that DMAS will no longer cover gender-affirming procedures, including certain drugs/hormones, for children under the age of 18 enrolled in Medicaid and children under the age of 19 in the Children's Health Insurance Program (CHIP). Providers may continue to deliver these services, but these services will no longer be covered by DMAS. These restrictions also prohibit states' use of the federal Medicaid EPSDT pathway to provide coverage of these services to children under 18.

Changes to services

In accordance with **2026-16508 (91 FR 52406)**, impacted members enrolled in fee-for-service or a managed care organization will no longer be able to receive the following services for dates of service beginning on or after October 13, 2026. Prohibited services will not be covered with dates of service on or after October 13, 2026, regardless of an active prior authorization/service authorization.

In alignment with the rule, gender-affirming procedures encompass the following when used to align a child's physical appearance or body with an asserted identity that differs from the child's sex and are now prohibited:

- Puberty-suppressing medications (GnRH agonists/puberty blockers).
- Gender-affirming hormone therapy (estrogen or testosterone for secondary sex characteristic development).
- Surgical procedures including mastectomy, vaginoplasty, and related gender-related surgeries.

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Permitted exceptions

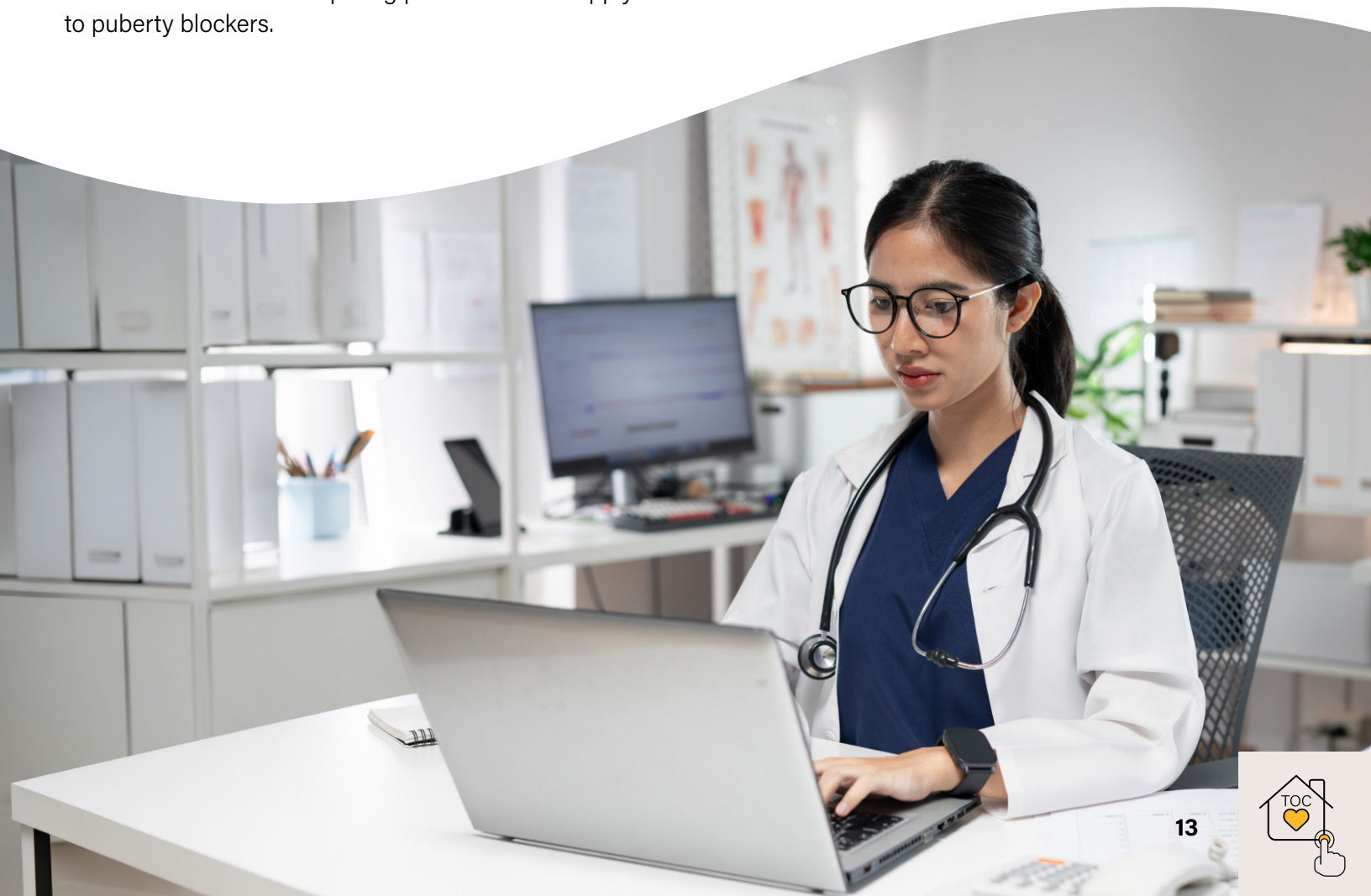
- Medically verifiable disorders of sexual development (e.g., congenital conditions affecting sexual anatomy or function).
- Procedures performed for purposes other than aligning a child's physical appearance or body with an asserted gender identity.
- Treatment of complications — infections, injuries, diseases, or disorders — caused by or exacerbated by prior gender-affirming procedures (including pharmaceutical interventions).
- Mental health services and psychotherapy for gender dysphoria.

Gender-affirming hormone tapering period

Coverage is permitted for members who are already receiving gender-affirming hormone therapy as of October 13, 2026, to continue that hormone therapy for up to six months. The Centers for Medicare & Medicaid Services (CMS) does not consider the six-month period a clinical guideline; treating providers may recommend a shorter timeline. This tapering period does not apply to puberty blockers.

Managed Care Organizations (MCOs) contracted with Virginia DMAS will not create or enforce additional coverage criteria. Please contact MCOs at the contacts listed below for MCO-specific billing guidance for managed care members.

If you have authorization questions or need assistance, contact Sentara Community Plan at **757-552-7474** or **1-800-229-8822**. Thank you for your prompt attention and continued participation in providing high-quality care for our members.



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Quality improvement

2027 Quality Excellence Award

Sentara Health Plans values quality and safety, especially when coordinating and managing care and safety for our members. Sentara Health Plans has a physician recognition program to promote and salute excellence: the Dr. Melvin T. Pinn, Jr. Quality Excellence Award (QEA).

Founded in 2006, this prestigious award was created to recognize providers for their commitment to quality care and safety. Dr. Pinn advocated for the medically underserved and was a pillar in the community. He received countless awards throughout his career for his many contributions to high-quality and safe patient care.

Sentara Health Plans will continue to annually recognize an outstanding in-network provider who promotes safe clinical practice and delivery of quality care.

Sentara Health Plans members, network providers, provider office staff, Sentara Health Plans employees, and Sentara employees can nominate a physician at any time between January 1 and December 31 each year.

To submit a nomination for the QEA, **click this link** or scan the **QR code**.

QMR corner: CCC Plus waiver services—quality management review

Tips for documenting when more than one LTSS provider is involved.

Long-term Services and Supports (LTSS) providers care for our most vulnerable members, those who meet nursing home level of care. Many of these members prefer to have care in the community. In some cases, Commonwealth Coordinated Care (CCC) Plus members need more than one hands-on community-based LTSS provider to stay safely in the community. It is important that each LTSS provider is aware of the other providers serving our members so that each one serves our members appropriately.

Here are some quality management documentation tips to make sure your medical documentation is complete:

Personal care agencies and service facilitators

- Use the top of the back page of the DMAS-99 form where the various agency types are listed. Use additional notes as needed.

Adult day health care centers

- Use either the DMAS 301 or the DMAS 99 forms (or both) to identify other providers, with additional notes as needed.

Private duty nursing

- Use the DMAS 116 form to identify other service providers and additional notes as needed.

Coordinated care is vital to our members. If you have questions about other LTSS providers, the Sentara care coordinator is a good resource for more information.

Remember, only one LTSS service is provided at a time. Overlapping billing is not allowed. For instance, Adult Day Health Care Centers can bill for services to members from the time the member arrives at the Center until the transport or family takes the member back. Personal or respite care services can only start once the member is in the care of the paid aide or attendant.

Updates

New updates to the CCC Plus Waiver Provider Manuals and new DMAS-99 and DMAS-97AB forms have been published. Always start using new forms immediately. Check the **DMAS-MES portal** for updates, forms, manuals, and bulletins regularly.

Sentara also publishes a **Medicaid Provider Manual** with helpful information.

The Sentara Health Plans Quality Management Review (QMR) team works with DMAS to ensure provider compliance. If you have any questions, contact Sentara Provider Relations at **1-800-229-8822**.



Authorizations, medical policies, and billing

Sentara Health Plans medical and clinical policy updates

Access all current behavioral health, durable medical equipment, imaging, medical, obstetrics, pharmacy, and surgical policies on the Sentara Health Plans **medical policy webpage**.

Visit our **website** to view the most recent authorization updates.

Pharmacy

Pharmacy formulary updates

The Sentara Health Plans Pharmacy and Therapeutics Committee meets at least bimonthly to provide strategic clinical direction on formulary management and clinical programs. Clinical recommendations made by the committee may result in drug formulary placement updates. These updates help ensure that the most clinically appropriate, cost-effective formulary drugs remain accessible and that contractual obligations are maintained.

Formulary updates for our commercial, exchange, FAMIS, Medicaid, and Medicare lines of business can be found on our **website**.

Once on the **Formularies and Drug Lists** page, choose the appropriate line of business. **The Quarterly Pharmacy Changes document(s)** are updated quarterly. Updates are posted a minimum of 60 days before implementation.

Important updates and reminders

Register for our upcoming webinars

Mark your calendars for our upcoming quarterly educational and CME sessions, offered both in person and virtually.

Claims Brush-up

- Wednesday, December 16 – 1 p.m.

Accredited Online Opportunities: Mind & Medicine

Stay connected!
Follow Sentara Health Plans on social media for updates that support your patients and practice.

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