

Provider Updates



Dear Provider,

This week, we are sharing the following provider updates — see below to learn more.

- [Erroneous Rejections](#)
- [Revised Provider Reconsideration Form Now Available – Avoid Rejections](#)
- [Billing 837 Files for Medicare D-SNP Members](#)
- [Balance Billing Inquires](#)
- [Refining the Review Process for ARTS Authorization Requests](#)
- [Multi-factor Authentication Tool Change](#)
- [Authorization Updates](#)
- [Upcoming Educational Opportunities](#)

Erroneous Rejections

It has been identified that claims submitted December 18, 2025, through February 12, 2026, for Sentara Health Plans Medicaid, Medicare, and commercial members were erroneously rejected returning the message “Member Not Identified.” This problem has been corrected.

Availity has reopened these claims and will begin to return responses to either resubmit claims or submit patient information. With this fix, rejections that returned the response “Missing or Invalid SubscriberID” should be considered valid.

Revised Provider Reconsideration Form Now Available – Avoid Rejections

In October 2025, Sentara Health Plans announced availability of the redesigned [Provider Reconsideration Form](#) to improve efficiency and ensure accurate routing of all requests. The updated form includes additional fields that capture key details, allowing us to correctly identify the request type and route it to the appropriate team. These enhancements support faster processing and better alignment with current operational guidelines.

To avoid delays and take full advantage of these enhancements, please replace any saved or printed versions of the old form and begin using the [updated form](#) immediately. Beginning on **March 1**, reconsiderations that are submitted with the incorrect reconsideration form will be rejected.

To avoid delays caused by incorrect routing, please ensure the member, claim, and provider information sections are filled in accurately and completely.

Billing 837 Files for Medicare D-SNP Members

Claim submissions for Dual Eligible Special Needs Plan (D-SNP) claims must align with this guideline for accurate processing:

- If the member has primary Medicare and secondary Medicaid with Sentara Health Plans, only one 837 should be submitted. Our system will automatically generate both claims from a single 837 submission.
- Only include additional payer information if the member has primary commercial coverage with Sentara Health Plans, in addition to Medicare and Medicaid.
- Submission of two 837 files for D-SNP claims may cause delays and/or incorrect processing.

Balance Billing Inquires

Please note that balance billing inquiries should not go to the contactmyrep email or directly to Clarity. All balance billing inquiries need to be emailed to shpbappeals@sentara.com. After the

email is received, we will be able to send a copy of the claim and EOB/EOP along with the request to negotiate.

Refining the Review Process for ARTS Authorization Requests

As part of our ongoing commitment to clinical excellence and member-centered care, Sentara Health Plans Behavioral Health Utilization Management (SHP BH UM) is refining our review process for Addiction and Recovery Treatment Services (ARTS) authorization requests. These enhancements are designed to support more precise alignment of services with member needs while continuing the high standards of review we have always followed.

What's Changing?

When conducting initial reviews for the start-of-care, our ARTS review specialists will continue to assess clinical documentation using the ASAM 3.0 criteria. If it appears that the requested level of care may not be the most appropriate based on the information provided, the reviewer will reach out directly to the provider to discuss the case. This collaborative conversation may result in:

- Voiding the current request and submitting a new request for a more clinically appropriate level of care
- An increase or decrease in the units and length of stay for the authorization, if agreed upon by the provider, in the best interest of the member

These steps are intended to ensure that members receive the most effective and appropriate care, tailored to individual needs and consistent with the Department of Medical Assistance Services' (DMAS) coverage and medical-necessity requirements for ARTS services.

DMAS Expectations of ARTS Providers

DMAS requires ARTS providers to adhere to all DMAS policies, the ARTS Provider Manual, and their contracts with Medicaid Managed Care Organizations (MCOs) and the Behavioral Health Services Administrator (BHSA). Providers must verify member eligibility, obtain required authorizations, maintain complete and timely clinical documentation—including Individualized

Service Plans (ISP) and discharge plans—and render only covered services within their scope of practice and licensure.

Attendance Monitoring and MCO Notification

DMAS further requires ARTS providers to notify the member's MCO when a member is not **attending the minimum service hours required for ASAM Levels 2.1, 2.5, and 3.1**, as outlined in the ARTS Provider Manual. When members fall below required participation thresholds, providers must alert the MCO promptly to support care coordination, assess barriers to engagement, and determine whether clinical reassessment or a change in level of care is warranted.

Providers must continue to coordinate care with other treating professionals, involve members in person-centered treatment planning, and notify the MCO or BHSA of significant clinical events and critical incidents as required.

Coordination With Members' Health Plans

Under DMAS policy, ARTS providers are required to collaborate with the member's health plan to ensure safe, coordinated, and cost-effective care. This includes verifying benefits, submitting requested clinical documentation promptly, participating in care-coordination activities, and supporting transitions across levels of care.

Discharge planning is an essential component of the ISP and must outline realistic, person-centered steps for connecting the member to appropriate follow up services and supports. Discharge planning should occur throughout the entire episode of care.

To further strengthen care coordination and promote timely, clinically appropriate transitions, continuation of stay requests must include updated discharge planning details—including completed referrals, provider names, levels of care, and scheduled appointment dates and times. Providers must be able to demonstrate active, ongoing discharge planning for each member.

What We Need From You

To support quality-focused reviews and timely authorization decisions, please submit complete and clinically relevant documentation aligned with each ASAM dimension. *Providers must also indicate the total number of sessions the member attended during the most recent authorized*

period. Refer to the [Sentara Health Plans Network Status Operations Update](#) for additional guidance.

Documentation Guidance by ASAM Dimension

Dimension 1: Acute Intoxication and/or Withdrawal Potential

- Evidence of current or recent substance use
- Withdrawal symptoms and severity
- Detox history and protocols

Dimension 2: Biomedical Conditions and Complications

- Medical history and current physical health status
- Co-occurring medical conditions
- Medication lists and adherence

Dimension 3: Emotional, Behavioral, or Cognitive Conditions and Complications

- Psychiatric diagnoses and symptoms
- Behavioral health history
- Cognitive functioning and risk factors

Dimension 4: Readiness to Change

- Member's motivation and engagement
- Stage of change assessment
- Treatment goals and willingness

Multi-factor Authentication Tool Change

Sentara is transitioning our multi-factor authentication tool from Cisco Duo to Microsoft Authenticator. **For enrollment support, please call 757-857-8190 or 855-306-2252 and select option 6.**

Authorization Updates

[Visit our website](#) to view the most recent authorization updates.

Upcoming Educational Opportunities

New Provider Orientation

This webinar is for newly contracted providers, new hires, or anyone seeking a refresher on how to successfully conduct business with Sentara Health Plans. We will offer guidance on how to find solutions for common questions or challenges without contacting provider services.

To register, please visit sentarahealthplans.com.

Lunch & Learn: Provider Website Tour – Provider Orientation Part 2

Join Us for an Interactive Lunch Hour Website Tour

Take a break and join us for an informal, yet informative, session designed to make navigating our provider website simple and efficient. During this hour, you'll discover how to:

- Navigate our provider portal with confidence
- Access and utilize self-help resources
- Find guidance and tools to successfully conduct business with us
- Get answers quickly on your own- without having to call for assistance

Bring your questions and curiosity. We're here to help you get the most out of our resources.

To register, please visit sentarahealthplans.com.

Claims Brush-up

Join us for a for a 30-minute interactive session, designed to keep you informed about important health plan changes. This session offers key insights into evolving claims activity, recent operational updates, and process enhancements that influence your daily workflows.

During this webinar, you will:

- Gain a clear understanding of emerging claims trends and how they may affect your practice
- Learn about new operational updates that help to simplify tasks and improve overall efficiency
- Review essential process changes that support timely, accurate claims submissions
- Participate in a live Q&A with a member from our expert team to get the clarity you need

Whether you're new to claims management or a seasoned professional, this session will help you stay informed, compliant, and prepared for what's next.

To register, please visit sentarahealthplans.com.

Provider Quality Learning Collaborative

The March 4 session is designed for general practice, pediatric providers, and their staff that are interested in reducing preventable admissions, specifically in patients diagnosed with diabetes, congestive heart failure, and asthma/COPD. Medical Directors Allison L. Raines, DO, MBA, MPH, FACEP, and Valerie Bowman Hicks, MD, FAAP, will provide an overview of our disease management programs and review how we can partner using our care management teams and resources provided by the health plan. Our quality and risk management teams will review best practices for medical records and risk code documentation. We will reserve time for an open forum so participants can ask questions and discuss their successes and barriers in these areas.

We encourage all providers and their staff interested in discovering new workflow ideas to improve care gap performance to attend our April 1 session. You will hear a provider's journey in using their electronic medical record (EMR) "ticketing" system to electronically schedule patient nurse visits for blood pressure rechecks and lab appointments for elevated A1c results. Our quality team will also introduce a new resource on developmental screening best practices. Time will be reserved for an open forum discussion and Q&A.

To register for either session, please visit sentarahealthplans.com.

Sincerely,
Sentara Health Plans

[Register for upcoming provider webinars](#)

[View current policy and operations changes](#)