



Good Afternoon.
Thank you for waiting while we gather.

NOTE: Using Otter.ai or similar artificial intelligence notetaking platforms violates Sentara Health Plans' (SHP) meeting recording policy. Please do not use any such platforms while attending SHP webinars. We appreciate your cooperation.



1st Quarter Let's Talk Behavioral Health

February 10, 2026

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Agenda

- 1. Behavioral Health Contracting: “What’s New in 2026”**- *Kresha Garland, PsyD, CBT, LGBH Director, Behavioral Health Contracting, LTSS & SCAs*
- 2. Overview of ARTS / ASAM Review Process Updates**- *Cindy Hobbs, RN, MS, MBA- Director, Behavioral Health UM*
- 3. Provider Support: “What Providers Need to Know”** (*Billing Reminders, DMAS Updates, Authorization Updates and Important Reminders*) - *Network Education Team*
- 4. Q & A**



Sentara Health Plans - Let's Talk Behavioral Health

“Behavioral Health Contracting: What’s New in ‘2026”

Kresha Garland, PsyD, CBT, LGBH
Director, Behavioral Health Contracting, LTSS & SCAs

February 10, 2026

Behavioral Health Contracting

❖ Contract Manager Engagement Meetings (CMEM)

Contract Manager Engagement Meetings (CMEM)

This year, the Behavioral Health (BH) Contracting team has implemented '***Contract Manager Engagement Meetings (CMEM)***'. CMEMs have been implemented to build and retain trust within the provider community, ensure that we are not only meeting but exceeding the needs of our provider partners as well as acting on the feedback and outcomes generated. The meetings are facilitated by the BH Contract Managers in partnership with their aligned Network Educators for their assigned region.

While these meetings will typically focus on contract performance, this is also an opportunity for our provider partners to communicate any areas of concern, bring forth any challenges, and highlight any initiatives they may be implementing to assist our members in the mental health community by fostering collaboration, improving service delivery, and enhancing overall patient outcomes.

Outreach is made at random to providers and meetings are scheduled, based on provider availability by each Contract Manager for a ***minimum of 45 minutes***. Those providers that would like to initiate a request to have a CMEM scheduled, please contact your assigned Contract Manager, and they will be happy to follow-up with you accordingly.

Behavioral Health Regional Contract Managers

❖ Tidewater Region:

- Janaki Smith, email: jxsmith@sentara.com
- Kimberly Harold-Jacobs, email: kbharold@sentara.com

❖ Central Region:

- April Lonon, email: adlonon@sentara.com
- Melanie Issacs, email: mlkallam@sentara.com
- Patrice Woody, email: pjwoody@sentara.com

❖ Northern and Winchester:

- April Lonon, email: adlonon@sentara.com
- Patrice Woody, email: pjwoody@sentara.com
- Randy Hoffman, email: rchoffma@sentara.com

❖ Charlottesville/ Western Region:

- Randy Hoffman, email: rchoffma@sentara.com

❖ Roanoke/Alleghany Region:

- Kim Ratliff, email: kdratli1@sentara.com

❖ Southwest Region:

- Kim Ratliff, email: kdratli1@sentara.com

❖ Kentucky/West Virginia/Tennessee:

- Kim Ratliff, email: kdratli1@sentara.com

❖ All other states:

- Randy Hoffman, email: rchoffma@sentara.com

Behavioral Health Contracting

- ❖ Network Closure***
- ❖ Behavioral Health Waitlist***

Behavioral Health Contracting – Network Closure

Unfortunately, at this time we have determined that our health plan has enough Behavioral Health providers in all our service locations for the following provider types and services: ***Applied Behavioral Analysis (ABA), Addiction and Recovery Treatment Services (ARTS), and Mental Health Services (All)***, and requests received from providers who are interested in joining our network will not be honored at this time. We monitor our network on an ongoing basis and will keep your information on file for up to 1 (one) year. ***This does not include requests received from practitioners such as LCPs, LMFTs, LPCs, etc.*** as we will continue to follow standard processing procedures for any of these requests received.

Participating provider requests to add any new services (not currently contracted) to their current and/or new locations are *not being honored at this time*. Please note that services administered to SHP members on an in-network (participating) basis for any of these services will be ***denied for reimbursement and no retro-effective date*** will be authorized for these services.

Participating provider ***requests to add currently contracted services*** to new lines of business and/or new locations ***are being accepted*** and will follow standard processing procedures.

Behavioral Health Contracting - Waiting List

The '***Behavioral Health Contracting Waiting List***' is a list that is utilized to track the names of those **non-participating** providers who have been denied a Request For Participation (RFP) in a service(s) that are not immediately available either due to network adequacy and/or oversaturation of that service or provider type in the SHP network.

The waiting list is also utilized to track requests received from **participating** providers to add any new services (not currently contracted) to their current and/or new locations as they are also not being honored at this time.

Please note that services administered to SHP members on an in-network (participating) basis for any of these services will be **denied for reimbursement and no retro-effective date will be authorized** for these services. There is **no guarantee** as to if or when RFPs in these services will be honored, and requests are processed based on the order in which they are received as well as network need.

Behavioral Health Contracting

❖ Medicaid Behavioral Health Services Redesign

Right Help Right Now

Medicaid Behavioral Health Services Redesign



DMAS (Department of Medical Assistance Services) in coordination with the Department of Behavioral Health and Developmental Services (DBHDS), the Department of Health Professions (DHP), and DMAS health plans, launched a two-year project (July 2024-June 2026) employing an integrated and comprehensive approach to address rate, service, and workforce/provider roles for Medicaid. The project seeks to redesign DMAS' youth and adult legacy services: *Intensive In-home (H2012)*, *Therapeutic Day Treatment (H2016)*, *Mental Health Skill Building (H0046)*, *Psychosocial Rehabilitation (H2017)*, and *Targeted Case Management (H0023)*.

Medicaid Behavioral Health Services Redesign – Things to Know

Please visit the Department of Medical Assistance Services (DMAS) where you will find the most recent updates regarding Behavioral Health Services Redesign: Public Postings, General Information, and Provider Open Office Hours.

DMAS invites behavioral health providers to join their Provider Office Hours dedicated to Behavioral Health Redesign. These sessions provide an opportunity for providers to ask questions and clarify policies regarding the new services (Community Psychiatric Support and Treatment, Coordinated Specialty Care, Mental Health Clubhouse Services and policy changes to Mental Health Case Management) that will be implemented on 07.01.26. DMAS subject matter experts will be available during this time to address your questions. Please visit the DBHDS and DMAS websites for additional information for a narrative regarding Medicaid Behavioral Health Services Redesign:

DMAS: <https://www.dmas.virginia.gov/for-providers/benefits-services-for-providers/behavioral-health/medicaid-behavioral-health-services-redesign/>

DBHDS: <https://dbhds.virginia.gov/community-services-division-reorganization>

Medicaid Behavioral Health Services – Update Your Contact Information



KEEP YOUR CONTACT INFORMATION UPDATED

TO MAKE SURE YOU RECEIVE IMPORTANT CORRESPONDENCE
FROM THE DEPARTMENT

Behavioral Health Contracting



Overview of ARTS / ASAM Review Process Updates

Cindy Hobbs, RN, MS, MBA- Director, Behavioral Health UM



Introduction to Updated Review Process

Refined Authorization Reviews

Updated review process aligns with DMAS and ASAM 3rd edition criteria for clinical excellence and member-centered care.

Enhanced Provider Communication

New protocols strengthen communication between providers and SHP BH UM and CM to improve care coordination.

Documentation and Compliance

Adjustments in documentation requirements support compliance with DMAS standards and reduce administrative burden for providers.

Focus on Member-Centered Care

Process improvements aim to match services to individualized treatment needs and promote recovery and safety.



Why the Review Enhancements Were Implemented

Motivation for Enhancements

The update focuses on clinical precision, compliance, and aligning with the intent of ASAM services to improve care quality.

Reducing Inappropriate Placements

Enhancements aim to lower inappropriate level-of-care placements through careful individual assessments.

Strengthening Provider Collaboration

Improved communication and partnership between providers and ARTS Review Specialists fosters better outcomes.

Streamlined Authorization Workflow

Enhanced authorization processes support timely decisions and clearer expectations for providers.



Key Modifications to ARTS Initial Review Protocols

Collaborative Case Review

Reviewers now engage providers directly for real-time dialogue when care levels seem misaligned with clinical needs.

Enhanced Workflow Steps

New workflow includes voiding and resubmitting requests or modifying care units when clinically justified.

Improved Communication Benefits

Open communication reduces avoidable denials and ensures shared understanding of clinical needs.

Commitment to Quality Care

Updates reinforce regulatory compliance and person-centered care supporting effective treatment planning.

Regulatory Responsibilities Under DMAS Policy

Compliance with Regulations

Providers must adhere to the ARTS Provider Manual, Medicaid rules, MCO contracts, and licensing standards thoroughly.

Documentation and Clinical Records

Clinical records like ISPs, progress notes, and discharge plans must be accurate, timely, and person-centered.

Eligibility and Authorization

Maintaining up-to-date eligibility verification and securing required authorizations before service delivery is mandatory.

Care Coordination and Communication

Providers must promptly notify MCOs about clinical changes or incidents to ensure safety and treatment integrity.





Monitoring Member Participation and Required MCO Alerts

Attendance Monitoring

Providers must track member attendance to ensure compliance with service-hour requirements and therapeutic goals.

MCO Notification Process

Prompt alerts to MCOs enable care coordination to address participation barriers and assess need for clinical reassessment.

Care Coordination and Support

Collaboration between providers and MCOs fosters tailored re-engagement strategies to enhance member safety and treatment progress.

Documentation and Compliance

Thorough documentation of attendance and communication ensures regulatory compliance and supports treatment continuity.



Expectations for Collaboration With Member Health Plans

Care Coordination Importance

Effective care coordination ensures smooth transitions, better treatment adherence, and enhanced member safety during critical times.

Provider Communication Responsibilities

Providers must maintain timely communication with MCOs, verify benefits, submit records, and participate in consultations.

Clinical Event Notification

Providers are required to promptly notify MCOs and BHSA of significant clinical events for proper risk management.

Documentation and Compliance

Thorough documentation of care coordination supports regulatory compliance and reflects person-centered best practices.



Strengthening Ongoing and Person-Centered Discharge Planning

Continuous Discharge Planning

Discharge planning begins at intake and evolves throughout the care episode for seamless member transitions.

Person-Centered Goals

Plans are integrated into ISP with realistic, person-centered goals reflecting individual progress.

Detailed Documentation

Providers document follow-up, referrals, appointments, and coordination to support safe transitions.

Promoting Continuity and Recovery

Active discharge planning reduces relapse risk and strengthens community support linkages for stability.



Submitting Complete and Clinically Relevant Documentation

Dimension 1: Substance Use Documentation

Include evidence of recent substance use, withdrawal symptoms, and detox history to support clinical relevance.

Dimension 2 & 3: Medical and Psychiatric Details

Document current health conditions, medication adherence, psychiatric diagnoses, behavioral health history, and cognitive function.

Dimension 4 & 5: Motivation and Relapse History

Record motivation levels, treatment engagement, relapse patterns, triggers, and coping mechanisms for targeted care planning.

Dimension 6: Environmental and Support Assessment

Assess living environment, recovery supports, housing stability, and barriers to treatment access comprehensively.



How Providers Can Support Effective Reviews and Member Care

Complete and Timely Documentation

Providers must submit thorough and timely clinical documentation aligned with ASAM criteria to support authorization requests.

Collaborative Communication

Transparent engagement with ARTS Review Specialists ensures accurate level-of-care decisions and reduces administrative delays.

Care Coordination and Transition Support

Active monitoring, discharge planning, and care coordination improve member support and recovery outcomes.

Regulatory Awareness and Resource Use

Providers should stay informed on regulations and use resources like ASAM guides and training to enhance care.



Provider Support: “What Providers Need to Know”

*(Billing Reminders, DMAS Updates, Authorization Updates
and Important Reminders)*



Provider Portals

Availity Essentials and Sentara Health Plans Portal

Availity Essentials

[Essentials Registration & Support | Availity](#)

- Eligibility & Benefits – **Member ID Card View**
- Claims Submission
- Claims Status
- Remittance Viewer
- Payer Space
 - Access helpful resources such as payment policies, views our newsletters and important updates/announcements.
- Connect to the Sentara Health Plans Portal to conduct transactions not yet available in Availity Essentials.
- Connect to vendor portals:
 - Avalon
 - Evolent
 - OncoHealth
 - Sentara Health Plans Portal
 - Surescripts



Sentara Health Plans Portal

[Provider Connection | Sentara Health](#)

- Create authorizations
- View status of authorizations

Reconsiderations submission

- To submit reconsiderations for **Medicare** and **Medicaid** lines of business, login or register: [Sentara Health Plans Provider Portal | Login \(payertransactions.com\)](#)

2026 New Features to be added to our Availity Essentials

Portal will include: [Essentials Registration & Support | Availity](#)

- Authorization requests, attachments, inquiry and dashboard
- Claims attachments
- Claim corrections
- Claim reconsiderations
- Other Health Insurance (OHI) reverification

Additionally, we have made improvements effective in :

- ❑ For Medicaid and Medicare lines of business, we added access to the primary care provider (PCP) roster and advance balance reports under the payer space application tab.
- ❑ Increased the look back period for claim status from 12 months to 24 months from the date of the request.
- ❑ Enhanced eligibility and benefits by providing:
 - Additional benefit information including group ID and group name
 - Additional coordination of benefits (COB) information

**Availity Essentials
Portal “2026”**

Reimbursement for Services Rendered While Credentialing is Pending

It is recommended that providers wait to provide services to Sentara Health Plans members until they are informed that their credentialing application is accepted as complete/clean. This may take up to 30 days of receipt of your application.

Providing services to Sentara Health Plans members during this period will carry the risk of non-reimbursement if credentialing requirements are not met or the provider agreement is not signed and fully executed.

If you provide services to Sentara Health Plans members while your credentialing application is pending, please hold claims until you have been notified that your credentialing application has been fully approved.

For further information see page 9 in the provider manual.

[Provider Manuals and Directories | Providers | Sentara Health Plans](#)

Member Experience





Welcoming Baby

Welcoming BabySM is an incentive-based program that provides Sentara Health Plans Medicaid members with a variety of clinical and personal resources and ongoing support during and after pregnancy. Providers will be given an incentive of \$25 for submitting the OB Registration and sending over the members that are pregnant and their clinicals.

Medicaid members now have access to view the following online:

- frequently asked questions
- maternal health benefits
- education and events and resources

The Sentara Health Plans health and wellness page now provides a link to our maternal health programs:

- Welcoming Baby for Medicaid members
- Partners in Pregnancy for commercial and Medicare members

Welcoming Baby:

[Welcoming Baby | Medicaid | Sentara Health Plans](#)

Maternal health:

[Maternal Health Benefits | Medicaid | Sentara Health Plans](#)

Tobacco Cessation Referrals

You can refer patients to the state tobacco quitline directly through Epic.

Quit Now Virginia and **Quitline NC** offer:



- *Free, 24/7 counseling*
- *Support for patients ages 13+*
- *Help quitting tobacco or nicotine, including vaping*
- *Free nicotine replacement therapy, based on patient assessment*



When you submit a referral in Epic, Sentara Health Plans will route it and document the outcome in the patient's chart.

✓ For detailed instructions, see the [Epic Tip Sheet](#) under the **How To** section of the [Provider Toolkit](#).

Where to go for care



As part of Sentara Health Plans' continued efforts to ensure our members access the right level of care at the right time, we want to educate our providers to the many alternatives available to members for receiving care for urgent or non-life-threatening conditions outside of the Emergency Department. Please review the flyer at this link for assistance in referring Sentara Health Plans Medicaid members, [SHP_MD_MEM_FL_240038 Where to Go for Care \(Oct 2024 update\)_Web.pdf](#)

DMAS Updates/Follow-up

DMAS Updates/Follow-up

Clarification on Intellectual and Developmental Disability Targeted Case Management and FAMIS - January 30, 2026

Telehealth Services Supplement Update - January 5, 2026

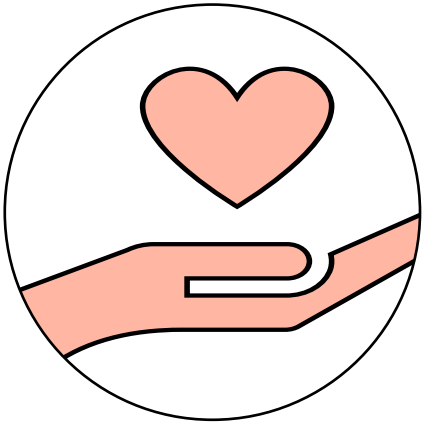
Update to Emergency Medicaid Supplement - January 26, 2026

Update to Chapter II of the Hospice and Nursing Facilities Provider Manual - January 6, 2026

Update to Pharmacists as Providers (PAP) Supplement in Pharmacy Manual - January 6, 2026,

[**Memo & Bulletin Library | MES \(virginia.gov\)**](#)

Billing Updates, Authorization Updates & Reminders



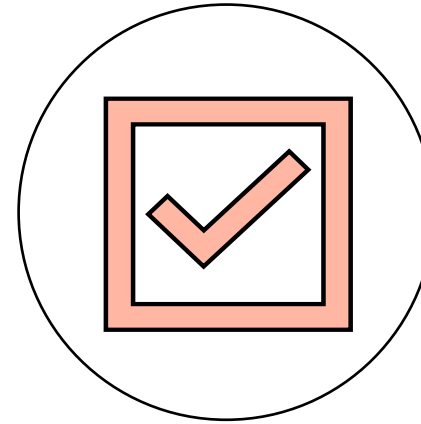
Balance Billing Inquires

Balance billing inquiries should not go to the contactmyrep email or directly to Clarity. All balance billing inquiries need to be emailed to shpbbappeals@sentara.com. By doing this, we will be able to send a copy of the claim and EOB/EOP along with the request to negotiate.



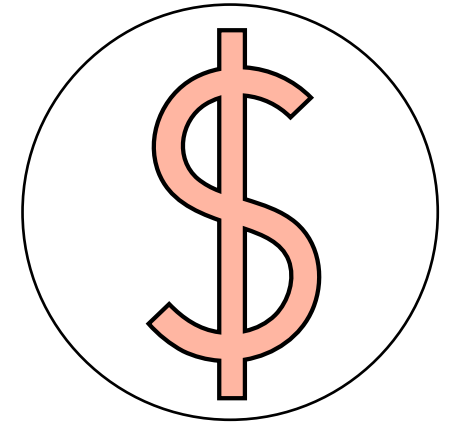
Review All Claims Before Submission

To avoid denials, incorrect payment, and delays in processing claims, it is critical that the rendering provider, date of service (DOS), and services on the authorization match the DOS and services provided on the claim before submission.



Important Reminder About the National Provider Identification for Groups

When requesting an authorization for a provider within a group, please verify that the National Provider Identifier (NPI) on the request matches the NPI listed on the claim for the group (i.e., durable medical equipment, hospital, etc.). The additional step of ensuring NPIs match will help prevent the inappropriate denial of claims.



Billing 837 files for Medicare Dual-Eligible (D-SNP) Member – Reminder

Claim submissions for D-SNP claims must align with this guideline for accurate processing:

If the member has primary Medicare and secondary Medicaid with Sentara, **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 DSNP claims may cause delays and/or incorrect processing.

Claims Project Request Template

Please Note: When completing the claims project template, **the claim number MUST** be included. The inclusion of the claim number ensures that the claims project team can work more efficiently to complete your request. The template should not be used to submit open AR claims.

The screenshot shows the Microsoft Excel interface with the 'Claims Research Request' template. The ribbon at the top includes File, Home, Insert, Share, Page Layout, Formulas, Data, Review, View, Help, and Draw. The formula bar shows 'C16' and the active cell is 'C16'. The template includes a header with the Sentara Health Plans logo, a title 'Claims Research Request', and a table for claim details. The table has columns for Member Name, Member ID, Claim Number, Date of Service, Billed Amount, Expected Reimbursement, Service Provided, Provider NPI, Description of Claims Issue, Call Reference Number, and Line of Business Impacted.

Member Name (Required)	Member ID (or Date of Birth)	Sentara Health Plans Claim number (Required)	Date of Service	Billed Amount	Expected Reimbursement	Service Provided (CPT/HCPCS)	(Rendering) Provider NPI	Description of Claims Issue	Call Reference Number	Is this an example or entire list of impacted claims for the issue presented? Only 1-2 examples needed.	Line of Business Impacted (Medicaid, Medicare, Commercial, or All)

Behavioral Health Authorization Fax Numbers and Forms located on Sentara Health Plans website

[Behavioral Health Provider Resources](#) | [Providers](#) | [Sentara Health Plans](#)

Government

For Urgent Requests (ARTS, Inpatient, Crisis, MH PHP/IOP):

Fax Numbers: (844)-348-3719 or (757)-963-9619

BH forms/documents:

- Addiction and Recovery Treatment Services (ARTS) Initial
- Addiction and Recovery Treatment Services (ARTS) Extension
- Addiction and Recovery Treatment Services (ARTS) Peer Support Services Registration
- Community Stabilization Initial (S9482)
- Community Stabilization Continued Stay Service Authorization Request (S9482)
- Mental Health Intensive Outpatient (MH-IOP: S9480) and Mental Health Partial Hospitalization
- Program (MH-PHP: H0035) Initial Service Authorization Form
- Mental Health Intensive Outpatient (MH-IOP: S9480) and Mental Health Partial Hospitalization Program (MH-PHP: H0035) Continued Stay Service Authorization Form
- Residential Crisis Stabilization Unit (RCSU) Continued Stay Service Authorization Request (H2018)

Government

For Non-Urgent BH Outpatient Requests

Fax Numbers: (844)-895-3231 or (757)-963-9620

BH forms/documents:

- Applied Behavior Analysis (ABA) Initial (97155, Et al.)
- Applied Behavior Analysis (ABA) Continued Stay (97155, Et al.)
- Assertive Community Treatment (ACT) Initial (H0040)
- Assertive Community Treatment (ACT) Continued Stay (H0040)
- Behavioral Health Outpatient Services
- Behavioral Health Electroconvulsive Therapy (ECT)
- Functional Family Therapy (FFT) Initial (H0036)
- Functional Family Therapy (FFT) Continued Stay (H0036)
- Intensive In-Home (IIH) Initial (H2012)
- Mental Health Skill Building (MHSS) Initial (H0046)
- Multisystemic Therapy (MST) Initial (H2033)
- Multisystemic Therapy (MST) Continued Stay (H2033)
- Psychosocial Rehabilitation (PSR) Initial (H2017)
- Service Authorization Form CMHRS Continued Stay Service Authorization Request Form
- Therapeutic Day Treatment (TDT) Initial (H2016)

Commercial

For all Urgent and Non-Urgent Commercial Behavioral Health Authorization Requests (Inpatient and Outpatient):

Fax Numbers: (757)-431-7763 or (844)-723-2096

BH forms/documents:

- Behavioral Health Inpatient Authorization Request: Acute Inpatient and Residential
- Behavioral Health Outpatient Authorization Request: Partial Hospitalization Program (Initial and Extension), Intensive Outpatient Program (Initial and Extension), Applied Behavioral Analysis, Electroconvulsive Therapy, Repetitive Transcranial Magnetic Stimulation, Psych Testing, Office Visits
- Behavioral Health Discharge Summary: Notice of discharge from services

Authorization Turnaround Times & Important Reminders

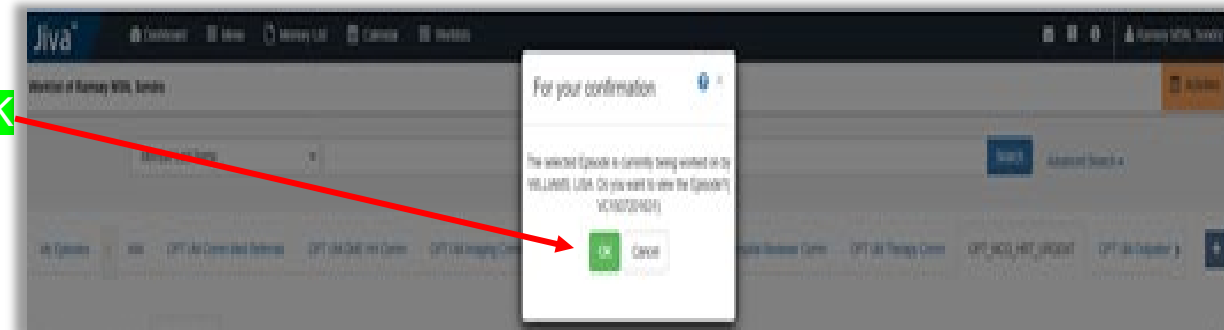
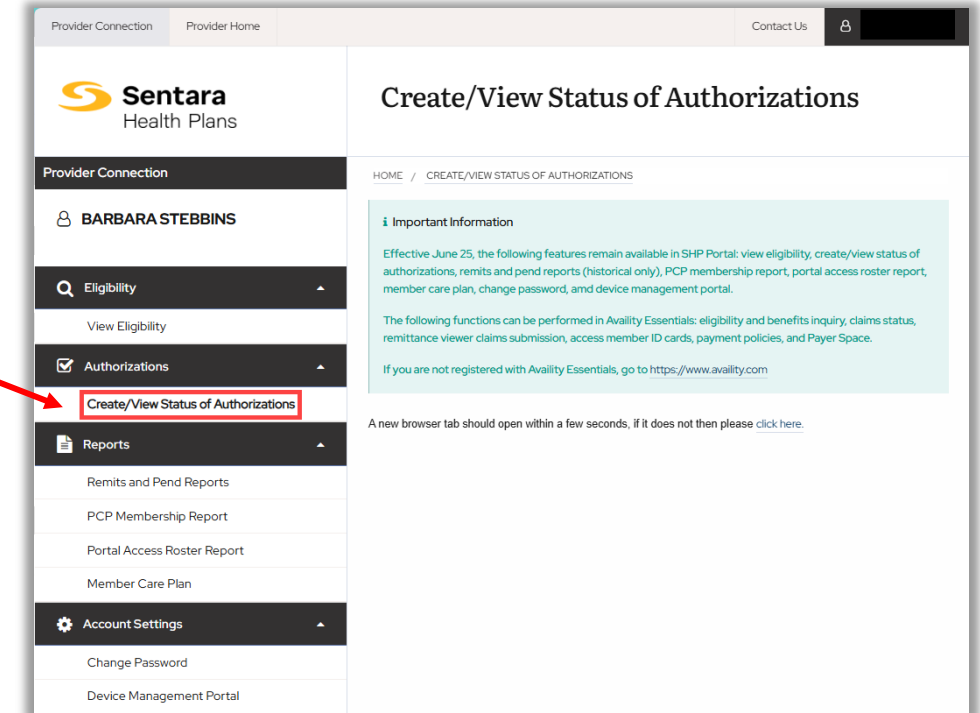
Once you have submitted your authorizations the **turnaround times** for your request to be completed are as follows:

- Non-emergent – 14-day turnaround time
- Urgent requests – 72-hour turnaround time

We ask that you do not contact Provider Services prior to these times. You can check the status of your authorizations through the Sentara Health Plans Provider Portal by going into the Create/View Authorizations which will take you to the JIVA portal where you can view all authorizations for your office or by member.

Important Reminder:

- Please enter information in the contact fields of the authorization (email addresses, name, and phone number) this will enable someone from the utilization management team to contact you if there are any questions.
- When you see messages in your dashboard this means the authorization is incomplete and will need to be completed.
- Please ensure you are finishing the authorization and clicking **OK** for your confirmation. If you do not this prevents the utilization management team from being able to process the request.



Council for Affordable Quality Healthcare (CAQH)

Directory Updates and Attestation

Important Provider Directory Information

To comply with CMS, DHS, and PID requirements for maintaining accurate provider directories as well as the federal No Surprises Act (effective Jan. 1, 2022) Sentara Health Plans (SHP) requires all providers to verify their directory information at least once every 90 days.

SHP uses the Council for Affordable Quality Healthcare (CAQH) portal for all directory updates and attestations.

CAQH will send alerts and contact you by email or phone to confirm that your directory information is current and correct.

Failure to attest every 90 days may result in actions required under CMS guidelines. If attestation for a specific location is not completed within the required timeframe, that location will be temporarily suppressed from the public provider directory until attestation is submitted. Suppression does not indicate that a provider is out of network; however, members will not be able to find that location in directory searches.

Providers must attest that all information in their CAQH profile is accurate for each listed location. Any location without a current attestation will be marked as unverified and suppressed from the directory. To avoid disruptions in directory visibility, providers are strongly encouraged to regularly review and attest to their CAQH profiles.

Access to Care Protocol & Appointment Access Standards

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.

Sentara Health Plans Commercial and Medicare Provider Manual on page 14 and page 15
Sentara Health Plans Medicaid Provider Manual on page 62 and page 63

[Provider Manuals and Directories | Providers | Sentara Health Plans](#)

Doing Business with Sentara Health Plans - [Provider Orientation | Providers | Sentara Health Plans](#)

Report Critical Incidents

A critical incident is defined as any actual, or alleged, event or situation that creates significant risk of substantial or serious harm to the member's physical or mental health and safety or well-being of a member/patient.



Immediately report alleged abuse, neglect or exploitation related critical incidents to appropriate protective services agency: Contact:

Adult Protective Services (APS): (888) 832-3858

Child Protective Services (CPS): (800) 552-7096



Within **24 hours**, Email: criticalincidents@sentara.com; OR fax Critical Incident Report form to Fax: (833) 229-8932 located at [Critical Incident Form 11092021 \(sitecorecontenthub.cloud\)](#) **OR** Call Sentara Health Plans: (757) 252-8400

Provider Changes and Updates 60-Day Notice REQUIRED

Please submit the following changes by completing the Provider Update Form available at:

[Update Your Information | Providers | Sentara Health Plans | Sentara Health Plans](#)

Panel Status/Accepting new patients
Contact information (address, phone, email, etc. – for all locations)
Provider relocation or joining additional practice
Tax ID change (need a new/current W-9)
Name change
Practitioner leaving practice/deceased

Once the form has been submitted, you will receive an automated email notification as an acknowledgement which contains helpful information, including instructions on checking the status of the request.

****Be sure to check your SPAM/JUNK folder if not received.***

The email address listed in the “requestor email” section on the provider update form is where the notification is sent once the request is complete.

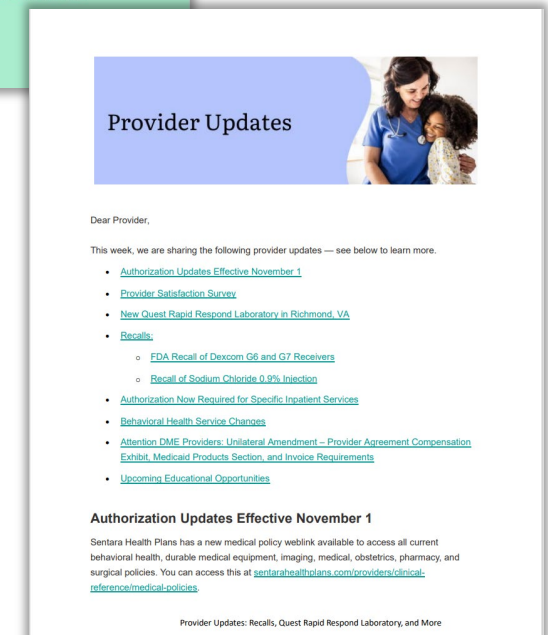
After 30 days from your submission, you can check the status of the request by emailing: pustatus@sentara.com

Please notify your contract manager directly regarding the following changes:

Tax ID change (**requires a new/current W-9**)
Name change

How do we communicate with you?

- providerNEWS
- Provider Emails – (it is important that we have the email address of a point of contact who can share with the staff, i.e., physicians, quality, billing/coding, etc.) **We accept multiple email addresses**
- Website
- Provider Manuals
- Emails to and from your Network Educator (contactmyrep@sentara.com)
- Availity Essentials PayerSpace



Providing the BEST E-mail Address(es)...

- Ensures you receive notification of changes 60 days or more in advance
- Allows you to prepare early
- Allows to you ask questions prior to implementation
- Helps avoid unnecessary denial of claims, claims reprocessing, etc.
- Allows you to participate in provider trainings in advance of changes, when offered

Who Needs to Know?

- Decision maker(s)
- Billers and coders
- Practice administrators/managers
- Quality subject matter experts



Note: If you are the designated recipient, be sure to forward to others as appropriate. Be sure to update your contacts and email addresses when staffing changes occur (including role changes)

The Fair Business Act in Virginia

The Fair Business Practices Act in Virginia establishes minimum fair business standards for health insurance carriers in the state. These standards include timely payment of claims, handling of additional documentation requests electronically, and specific guidance in provider contracts regarding required documentation for claims payment.

As part of this Act and required by state law, Sentara Health Plans is required to gather accurate contact information for our network providers in order to communicate electronically.

Sentara Health Plans has established a form for you to easily update your information. We ask that you complete this form as soon as possible.

If you have any questions on this process, please contact provider services at 1-800-229-8822 or your Network Educator at contactmyrep@sentara.com.

Electronic Communications Email



Look for our Upcoming 2026 Webinars

[Provider Webinars | Sentara Health Plans](#)

New Provider Orientation

February 11, 2026 1PM

February 19, 2026 8 AM

The New Provider Orientation webinar is designed for newly contracted providers and those seeking a refresher. This session offers a comprehensive overview of essential resources, tools, and processes to ensure a successful partnership.

Claims Brush-up

March 11, 2026 1PM

June 17, 2026 1PM

Join us for a for a 30-minute interactive session, designed to keep you informed on the latest claims trends, operational updates, and process changes. This is your opportunity to get quick, essential updates and ask questions directly to our experts

Appeals, Reconsiderations, and Contestment Processes

April 8, 2026 1PM

July 8, 2026 1PM

This training session is designed to help you navigate submission of reconsiderations and appeals. We will distinguish the differences in the appeals submission processes and requirements by plan type as well as introduce the procedures and other related self-help resources available on the provider website

Lunch & Learn: Provider Website Tour

(New Provider Orientation Part 2 & Refresher)

February 12, 2026 12PM

February 24, 2026 12PM

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, utilize self-help resources, Find guidance and tools to successfully conduct business with us. Bring your questions and curiosity! We're here to help you get the most out of our resources!

Provider Quality Care Learning Collaborative

March 4, 2026 12PM

April 1, 2026 12PM

In these webinars, we focus on a specific topic each month. We also highlight any significant changes, review relevant quality or value-based care measures, address areas of opportunity we are focused on, review member support resources, programs and initiatives, and share provider resources to support your care gap closure efforts. We encourage your designated quality subject matter expert(s), key clinical representative(s), and other staff members to join us virtually to learn how you can identify and address care gaps effectively



Let's Talk Behavioral Health

Give us
your
feedback

