Medicare Providers

# Medicare Advantage Non-renewal Provider Guide

Sentara® Health Plans

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# Medicare Advantage Non-renewal Guide

Sentara Health Plans has made the decision to non-renew our contract with the Centers for Medicare and Medicaid Service (CMS) for our Medicare Advantage Prescription Drug (MAPD) plans in North Carolina and Florida. Our Medicare D-SNP, partial D-SNP Medicaid, individual, and commercial plans in Virginia are not impacted by this decision.

## How long is the "run out" period for providers?

Sentara Health Plans has CMS requirements that includes a "run out" period to ensure providers and members can resolve any claims, reconsiderations, and appeals.

Providers are allowed one year from December 31, 2025, to submit claims for services provided to Sentara Health Plans members through December 31. Our members will also have appeals rights for any service and/or payment denials. You will also have your reconsideration rights as a provider. This expiration date will be December 31, 2026.

## Provider call center

Sentara Health Plans will maintain our provider services center for providers and will be able to support any issue that arises.

Medicare Provider Services: **1-800-927-6048**

Medicare Appeals and Grievances: **1-855-813-0349**

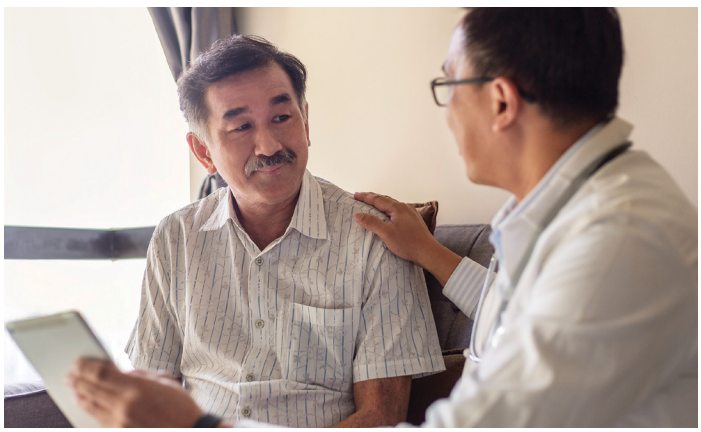
Medicare fax: **1-800-289-4970**

## Continuity of care

For members in an inpatient setting during this transition period, still admitted under an approved inpatient admission, Sentara Health Plans will be responsible for that admission through discharge. For skilled nursing facilities and rehabilitation admissions, Sentara Health Plans will cover through December 31. After that time, coverage will be transferred to the member's new plan.

## Utilization management

Authorizations and clinical care management services for members will transition to their new carrier of choice on January 1, 2026. For outpatient services through December 31, 2025, Sentara is responsible, and providers are expected to request prior auth for services rendered through December 31.



There are no changes in your current claims' submission process. Sentara Health Plans will be processing claims per our provider's contract. Under your contract, there is a period available to submit claims for services rendered up until December 31, 2025. For non-participating providers, we will provide a 365-day run out from date of service to submit claims.

## Timely filing

Sentara Health Plans allows 365 days for initial timely filing from the service date for all claims.

## Corrected claims

Corrections on paper may be submitted via U.S. mail using the same address shown for original claim and reconsideration submissions.

**CMS 1500:** Corrected claims submitted on a paper CMS 1500 form should include the original claim number and submission code **7 in field 22** to prevent misidentification of the corrected claim as a duplicate submission. Until further notice, corrected claims submitted on a CMS 1500 form can also be submitted electronically (without attachments) through the Sentara Health Plans portal.

**UB04:** The bill type should end in **7** with the original claim number showing in **field 80** to prevent misidentification as a duplicate submission.

**Claims Submission:**
Electronic Submissions - We accept claims through any clearing house that can connect through Availity, Veradigm (Payerpath/Allscripts), or Change Healthcare.

**Mail paper claims to:**

- Medical Claims:
  PO Box 8203
  Kingston, NY 12402-8203
- Behavioral Health Claims:
  PO Box 8204,
  Kingston, NY 12402-8204

Medical Providers may submit corrected claims online through the Sentara Health Plans portal by selecting **Medical Claims**, selecting the claim in question, and choosing the **Correct Claim** option. You may make corrections online to CPT code, diagnosis, billed charges, quantity, and/or place of service.

Consistent with Health Insurance Portability and Accountability Act (HIPAA) requirements, please submit corrected claims in their entirety following these guidelines:

- Make the changes in your practice management system, so the corrections print on the amended claim. Please do not make handwritten corrections on the claim.
- Send the entire corrected claim (even line items that were previously paid correctly). The corrected claim will be compared to the original claim and all charges for that date of service. Any partially corrected claim will be denied.
- Provider and patient information must be included on the claim.

**Physician claims:** Enter 7 in electronic field 12A or box 22 of the paper CMS-1500 form.

**Facility claims:** UB Type of Bill should be used to identify the type of bill submitted as follows:

- XX5 Late charges only
- XX7 Replacement of previous bill (corrected claim)
- XX8 Void/cancel previous claim

## Reconsiderations/appeal

Sentara Health Plans will provide the timeframe to file a provider reconsideration/appeal as stated in your provider's remittance. This applies for both participating and non-participating providers.

For participating providers, Sentara Health Plans will accept appeals submitted in writing within 365 days from the date of service for claims appeals.

For more information, please review the following resources:

- **Medicare Appeal Procedure**
- **Provider Claim Reconsideration Procedure**
- **Overview of the Appeal, Reconsideration, and Contestment Processes**

## Provider portal

Please review the **matrix** to learn which features will be available in each portal.

**View Claim Status and Submit Reconsideration Online** –

- Register for the Availity Essentials portal to perform the available features.
- Register for the Sentara Health Plans portal to perform the available features.

## Advising Your Patients

While the selection of a new plan is the patient's responsibility, they may come to you for guidance. Sentara Health Plans encouraged our members to review their options for new Medicare coverage by calling **1-800-MEDICARE (1-800-633-4227)** 24 hours a day, 7 days a week or visiting **medicare.gov**. They were also instructed to keep the notification letter because it will serve as proof that they have a special right to buy a Medigap policy or join a Medicare plan.

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