



**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.



Welcome to Sentara Health Plans Claims Brush-up

2nd Quarter 2026

Agenda

1. How to Submit A Claim
2. Avoiding Common Claim Errors
3. Corrected Claims
4. Reconsiderations
5. Provider Portals (Availity Essentials & Sentara Health Plans)
6. Billing Updates & Important Reminders

7.

Q&A

How to Submit A Claim

Claims can be submitted either:

Electronically

Submit claims electronically through a clearinghouse that is compatible with Availity.

Claims can be submitted online through Availity.

OR

Paper

Paper claims are submitted via mail:

Medical

P.O. Box 8203

Kingston, NY 12402

Behavioral Health

P.O. Box 8204

Kingston, NY 12402

Avoid Common Claim Errors

Top 10 Common Claim Errors that will cause a claim to deny:

1. Correct member name
2. Correct date of birth
3. Member ID number
4. Providers offering multiple services and multiple provider setups
5. Rendering/Individual NPI – Box 24J (bottom shaded portion)
6. Taxonomy code – Box 24J (top shaded portion)
7. Billing/Group NPI – Box 33a
8. Services requiring pre-authorization can be found on sentarahealthplans.com/providers.
9. Coordination of Benefits (COB) Sentara Health Plans as secondary carrier.
10. Non-Participating Providers

[Provider Toolkit | Providers | Sentara Health Plans](#)

Corrected Claims



A “re-billed” or “corrected claim” is a claim being resubmitted by the provider to correct or change a previous submission for the same patient, date of service and/or procedures.

Submission of Corrected Claims

Submission Instructions

Electronic corrections are accepted in a claim file through a clearinghouse or software vendor. Claims sent through a clearinghouse or software vendor must have a seven- frequency code in the CLM05-3 segment of the 2300 loop of the 5010 A1 837 professional guides. If a claim is resubmitted without the “resubmit” code, the claim will be denied as duplicate. Providers should contact their software vendor or clearinghouse with questions about how to send this code.

Sentara Health Plans accepts the following corrections electronically:

- Patient payment
- Service periods/dates
- Procedure/service codes
- Charges
- Units/visits/studies/procedures
- Hospitalization dates
- Name or ID number of the referring provider
- Provider ID
- Wrong member ID number or birth date

Corrected Claims Submission of a Previously Billed Claim

UB-04 Claims

- ☐ Bill type is a key indicator to determine whether a claim has been previously submitted and processed.
- ☐ The first digit of the bill type indicates the type of facility.
- ☐ The second digit indicates the type of care provided.
- ☐ The third digit indicates the frequency of the bill.
- ☐ Billing type is important for interim billing or a replacement/resubmission bill.
- ☐ “Resubmission” should be indicated in block 80 or any other unoccupied block of the UB-04

CMS-1500 Claims

- ☐ Claims submitted for correction require a “7” in box 22.
- ☐ Claims that need to be voided require an “8” in box 22.
- ☐ Enter the original claim number of the claim you are replacing in the right side of item 22.

[Provider Toolkit | Providers | Sentara Health Plans](#)

Reconsiderations

At Sentara Health Plans, a claim payment reconsideration is a provider's request to review the original processing of a claim. It does not involve changes to the claim itself but assesses whether the initial decision was accurate.

Submission of Reconsiderations

If a claim is not processed as expected, providers should follow the reconsideration process outlined in the Provider Claim Reconsideration Procedure on the website; [Appeals & Reconsiderations | Providers | Sentara Health Plans](#). This process is distinct from appealing an adverse benefit determination (before a claim is submitted). Reconsideration focuses on how the claim was processed, without modifying the original claim.

Submission Instructions

To submit a reconsideration:

- Complete the **Provider Reconsideration Form**
- Attach any supporting documentation
- Instructions for submission are located on the **Provider Reconsideration Form**.
- Government Programs reconsiderations can be submitted online through Sentara Health Plans reconsideration portal.

Additional Considerations

- **Incomplete Submissions:** Missing or incomplete information may result in the original decision being upheld.

Provider Reconsideration Form

A [Provider Reconsideration Form](#) is required for medical and behavioral health claims. One form is to be submitted for each claim being reconsidered. Missing or incomplete information may result in the original decision being upheld.

It is important to fill out the form in its entirety with accurate documentation on the form which begins with completion of the top of the form.

Member and Claim Information (all fields are required)	
Member ID:	Member Name:
Date of Service:	Claim Number:
Provider Information (all fields are required)	
National provider identifier (NPI):	Tax identification (EIN):
Provider name:	Telephone:
Provider contact name:	

“Provider Portals”

(Availity Essentials & Sentara Health Plans)

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:

- ❑ 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”**

Billing Updates & Important Reminders



Carefully Review All Claims Before Submission

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

HEALTH INSURANCE CLAIM FORM

IMPOSED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 1970

1. **INSURER**

INSURANCE ☐ MEDICARE ☐ MEDICAID ☐ OTHER ☐

NAME (Last Name, First Name, Middle Initial)

ADDRESS (No. Street)

CITY

STATE

ZIP CODE

TELEPHONE (Include Area Code)

2. **INSURED'S NAME** (Last Name, First Name, Middle Initial)

3. **INSURED'S ADDRESS** (No. Street)

CITY

STATE

ZIP CODE

TELEPHONE (Include Area Code)

4. **INSURED'S POLICY GROUP OR PLAN NUMBER**

5. **INSURED'S DATE OF BIRTH** (MM DD YY)

6. **OTHER CLAIM IS** (Designated by NUCC)

7. **INSURED'S POLICY GROUP OR PLAN NAME**

8. **INSURED'S HEALTH BENEFIT PLAN**

9. **INSURED'S OR AUTHORIZED PERSON'S SIGNATURE** (I authorize payment of medical benefits to the undersigned physician or supplier for services described below)

10. **DATE OF SERVICE** (MM DD YY)

11. **PROCEDURAL SERVICES OR SUPPLIES** (If space is insufficient, attach separate sheet)

12. **DIAGNOSIS** (ICD-9-CM)

13. **RENDERING PROVIDER'S NAME**

14. **INSURED'S ID NUMBER** (For Program in Item 1)

15. **INSURED'S NAME** (Last Name, First Name, Middle Initial)

16. **INSURED'S ADDRESS** (No. Street)

CITY

STATE

ZIP CODE

TELEPHONE (Include Area Code)

17. **INSURED'S POLICY GROUP OR PLAN NUMBER**

18. **INSURED'S DATE OF BIRTH** (MM DD YY)

19. **OTHER CLAIM IS** (Designated by NUCC)

20. **INSURED'S POLICY GROUP OR PLAN NAME**

21. **INSURED'S HEALTH BENEFIT PLAN**

22. **INSURED'S OR AUTHORIZED PERSON'S SIGNATURE** (I authorize payment of medical benefits to the undersigned physician or supplier for services described below)

23. **DATE OF SERVICE** (MM DD YY)

24. **PROCEDURAL SERVICES OR SUPPLIES** (If space is insufficient, attach separate sheet)

25. **DIAGNOSIS** (ICD-9-CM)

26. **RENDERING PROVIDER'S NAME**

DENIED

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](#)

Did You Know!

- **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.
- **Payment Policies** are in Availity under Payer Space, [Essentials Registration & Support | Availity](#)
- **Updated Authorization Request Forms**

REMINDER: Providers are still using authorization request forms with the Optima Logo. Please remind providers that the authorization request forms have been updated for all LOBs, the most recent have been the commercial forms. Providers are still using forms with our Optima logo.

Authorization Turnaround Times & Important Reminders

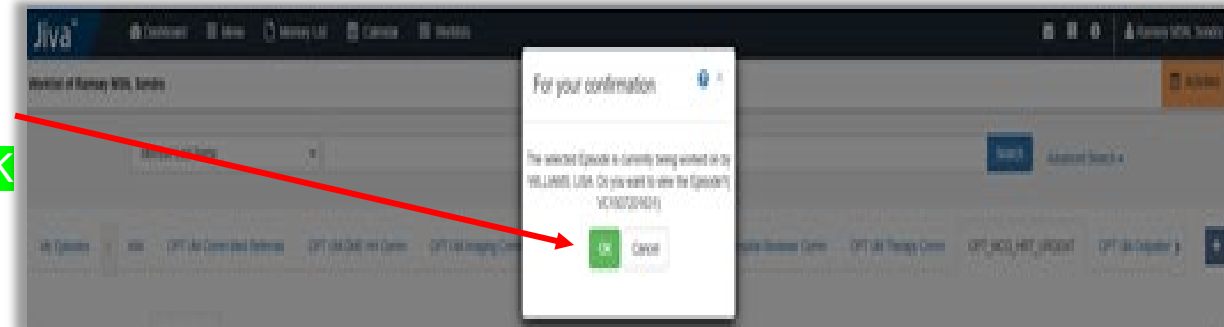
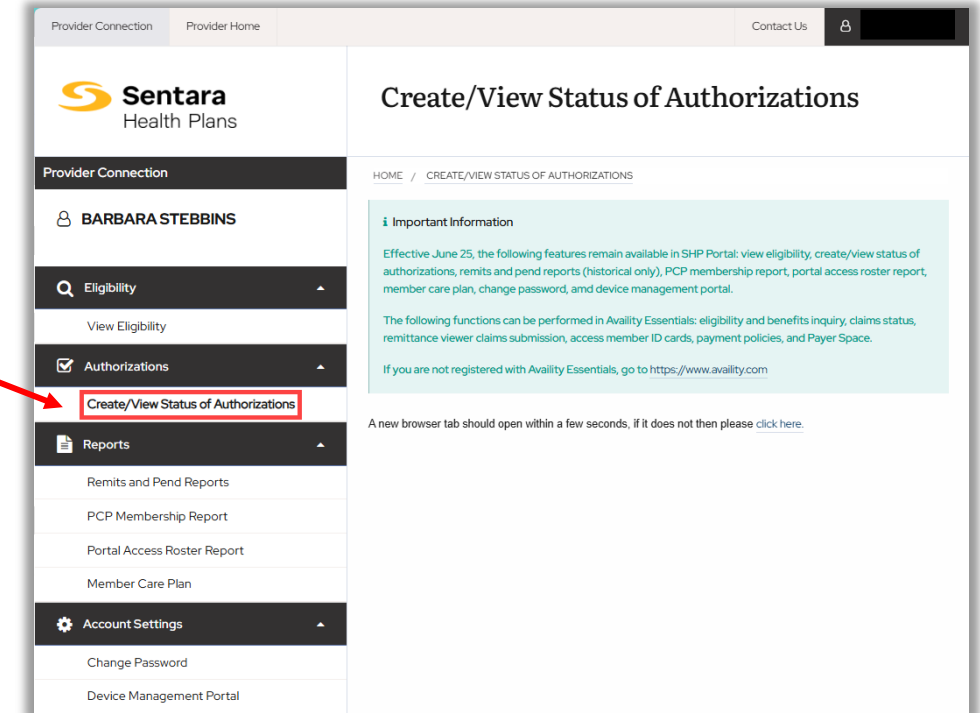
Once you have submitted your authorizations the **turnaround times** for your request to be completed are as follows:

- Non-emergent – 14-day turnaround time
- Urgent requests – 72-hour turnaround time
- Government Programs- 7-day 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.



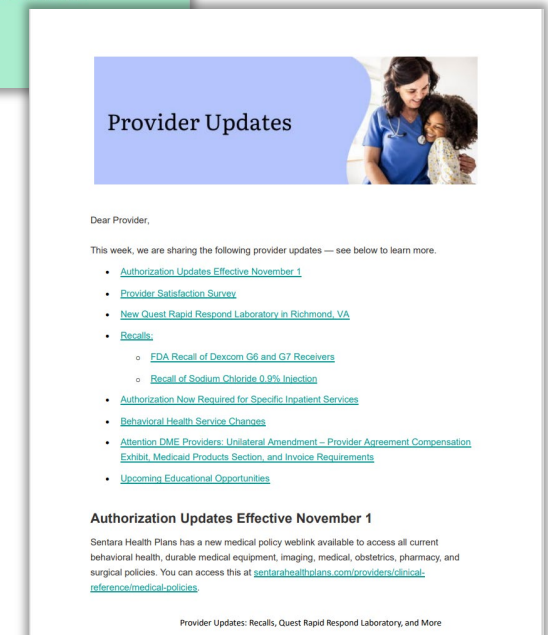
Claims Project Request Template

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.

	A	B	C	D	E	F	G	H	I	J	K	L
1												
2	Claims Research Request											
3	Provider Name				Contact Name							
4	Provider Tax ID				Phone							
5					Email							
6	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)
7												
8												
9												

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.

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



Helpful Links & Key Contacts

Email Addresses & FAQs

Request for Participation Forms: PRVRECRUIT@sentara.com

Provider Update Form Follow-Up: PUStatus@sentara.com

Credentialing Status Follow-Up: SHPCredDept@sentara.com

Recredentialing Status Follow-Up: SHPrecred@sentara.com

Ancillary Credentialing Status Follow-Up: Cred_Org_Apps@sentara.com

Connect With Your Network Educator: contactmyrep@sentara.com

Frequently Asked Questions: [Frequently Asked Questions | Providers | Sentara Health Plans](#)

EFT/ERA Set up

Zelis Payment Network (ZPN): Please call 1-855-496-1571 or visit [Enroll in a Zelis Network or Sign-up for Consolidated e-Payments](#)

Zelis' Sentara's ePayment Center: please call - 855-774-4392, login or register for basic EFT/ERA at // sentarahealthplans.epayment.center
(copy and paste into web browser)

Helpful Links & Key Contacts Continued

Provider Portal Registrations & Support

Availity Essentials: [Essentials Registration & Support | Availity](#). Provider Support contact: 1-800-282-4548

Sentara Health Plans Portal: [Provider Connection | Sentara Health](#). Provider Support contact: providerconnectionsupport@sentara.com

Forms & Resources

Provider Claim Reconsideration Form: [Sentara Health Plans Provider Claim Review Form](#)

Provider Appeals Procedure – Commercial: [Appeals & Reconsiderations | Providers | Sentara Health Plans](#)

Provider Appeals Procedure – Medicare: [Appeals & Reconsiderations | Providers | Sentara Health Plans](#)

Provider Appeals Procedure – Medicaid: [Appeals & Reconsiderations | Providers | Sentara Health Plans](#)

Provider Reconsideration Procedure: [Appeals & Reconsiderations | Providers | Sentara Health Plans](#)

Waiver of Liability Statement: [Appeals & Reconsiderations | Providers | Sentara Health Plans](#)

The Kaiser Collaboration: [Kaiser Permanente Collaboration Flyer](#)

Look for our Upcoming 2026 Webinars

[Provider Webinars](#) | [Sentara Health Plans](#)

New Provider Orientation

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.

Let's Talk Behavioral Health

Stay ahead in the rapidly evolving behavioral health sector with this comprehensive session developed to keep professionals informed, prepared, and ready for what's next. Whether you're a provider, administrator, or stakeholder, this session will equip you with the knowledge and tools to make informed decisions and successfully partner with us.

Appeals, Reconsiderations, and Contestment Processes

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)

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

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



Thank You For Partnering With Sentara Health Plans



Claims Brush-up Survey



CONTACTMYREP@sentara.com