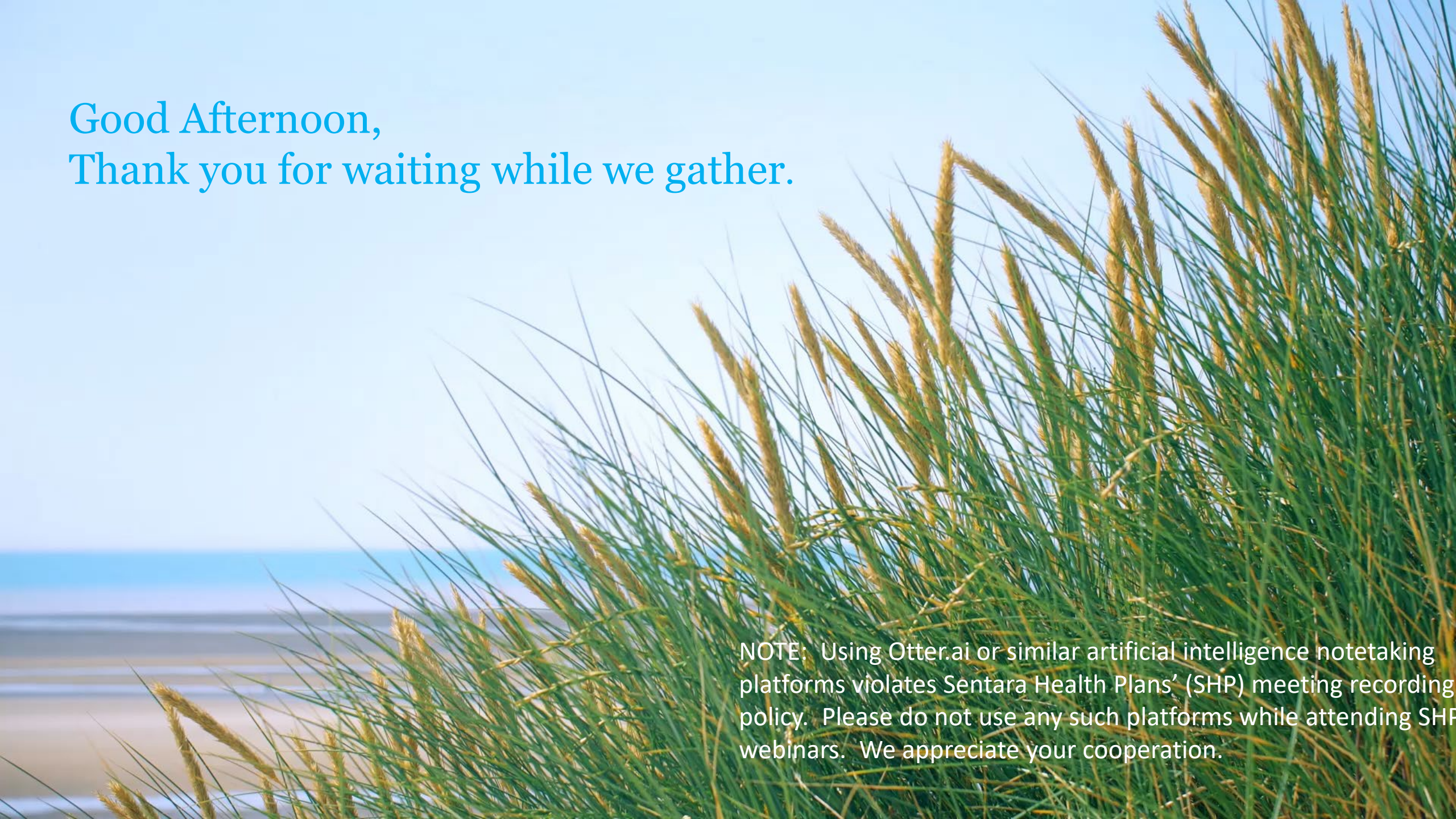
Good Afternoon,
Thank you for waiting while we gather.
NOTE: Using Otter.ai or similar artificial intelligence notetaking platforms violates Sentara Health Plans' (SHP) meeting recording policy. Please do not use any such platforms while attending SHP webinars. We appreciate your cooperation.

2nd Quarter Let's Talk Behavioral Health

May 12, 2026

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.

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Agenda

1. **Behavioral Health Contracting: “LTSS Inititatives”-** *Kresha Garland, PsyD, CBT, LGBH Director, Behavioral Health Contracting, LTSS & SCAs*

2. **Attendance Requirements for ARTS** – Amy Croft, Manager, Behavioral Health Care Management - Government

3. **Provider Support: “What Providers Need to Know” (***Billing Reminders, 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

Sentara® Health Plans

Behavioral Health Contracting

❖ *Behavioral Health Network Closure*

Behavioral Health Contracting
Behavioral Health Network Closure

Sentara Health Plans (SHP) carefully reviews each individual request for participation and considers the geographic locations a provider serves, the provider's scope of services, and the adequacy of the current SHP provider network. SHP has determined that our network has a sufficient number of behavioral health providers to meet the needs of our members.

Given the current status of the SHP provider network, Requests For Participation (RFP) received from providers who are interested in joining our network will not be processed at this time. Your request will be added to the behavioral health provider waiting list, and we will reach out should there be any changes in our network needs.

We monitor our network on an ongoing basis. We will keep your information on file for up to 1 (one) year. Duplicate submissions of Requests For Participation are not needed, as we will reach out should there be any changes in our network needs.

Behavioral Health Contracting

❖ *Employee Assistance Program (EAP)*

Behavioral Health Contracting

Employee Assistance Program (EAP)

Sentara Health Plans (SHP) is pleased to announce that we will be increasing the rate for Employee Assistance Program (EAP) services from $85 per session to $95 per session, beginning July 1, 2026. This rate increase will be applied to all current in-network participating providers enrolled in the Commercial line of business and who are participating in the administration of EAP services.

This adjustment reflects our continued commitment to supporting high-quality care, strengthening our provider network, and ensuring sustainable access to EAP services for our members. All impacted in-network participating providers have been notified accordingly. We value the partnership of our providers and appreciate their ongoing dedication to delivering timely, effective, and compassionate support.

Behavioral Health Contracting

❖ *LTSS Contracting*

Behavioral Health Contracting

LTSS Contracting

To better align contracting services across the health plan, Sentara Health Plans, Inc. (SHP) has decided to discontinue our partnership with our current vendor partner, HEOPS, for the administration of our Long-Term Services and Supports (LTSS) contract. On **Wednesday April 1, 2026,** SHP implemented direct contracting with our eligible LTSS provider partners with a contract effective date this plan year of **Thursday October 1, 2026.**

LTSS providers that would like to apply for partnership as an LTSS provider within the Sentara Health Plans (SHP) network, please visit the Sentara website via the following link Join Our Network | Providers | Sentara Health Plans where the Request For Participation (RFP) form can be obtained for submission. **The timeframe for submission of RFPs by all LTSS providers is Wednesday, April 1, 2026, and will end on Saturday, October 31, 2026, this plan year. If you are currently contracted with SHP for the administration of other services, you must submit an RFP by Saturday, October 31, 2026, for review of your eligibility to provide LTSS services this plan year.**

Eligible LTSS providers will receive outreach from a Contract Manager with next steps regarding training. **Completion of the training session is required prior to contract execution with SHP. ALL eligible LTSS providers are required to complete an application for initial credentialing. This includes those eligible LTSS providers with a current SHP agreement. The credentialing process can take between 30 (thirty) to 60 (sixty) days.** ALL LTSS providers **must be enrolled in the PRSS portal before an offer of partnership with SHP can be extended, if eligible.** Please visit the following link to initiate the enrollment process https://virginia.hppcloud.com/ProviderEnrollment/EnrollmentCreate .

Any LTSS provider who has not submitted an RFP, opts not to apply for partnership, or has not been approved for partnership; your affiliation in the SHP network will end on **Wednesday, September 30, 2026,** and you will **no longer be eligible to service SHP members**.

Behavioral Health Contracting
Update Your Contact Information

To ensure you receive important correspondence from our team, we ask that all providers keep their contact information updated.

Behavioral Health Contracting
Any Questions

Sentara®

Overview of ARTS / ASAM Review Process Updates

Amy Croft, Manager, Behavioral Health Care Management - Government

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.

Documenting Attendance

Required for All ASAM 2.1, 2.5, and 3.1 Extension Requests
All extension requests must clearly include the following:

Attendance and Scheduling
- Number of sessions attended per week
- Type of sessions attended (e.g., group, individual, family, skills)
- Total number of sessions scheduled per week

Weekly Service Hours
- Total clinical hours per week
- Confirmation that minimum ASAM service hour requirements are met
- A clear weekly total when multiple service types are provided

Missed Sessions (if applicable)
- Number of sessions missed
- Reason(s) for missed sessions (e.g., illness, transportation barriers, member refusal)
- Outreach and engagement efforts to address attendance concerns

Attendance information must be documented under **Section 1: Describe how the member is progressing under the current treatment plan**.

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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 Baby℠ 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*

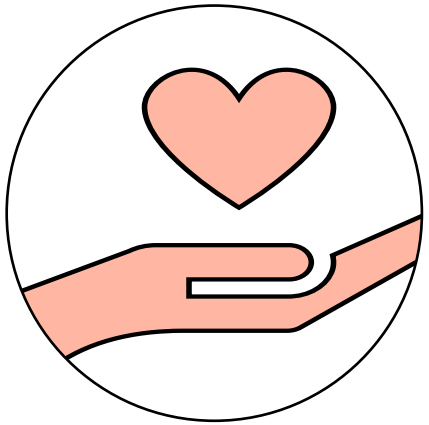
When you submit a referral in Epic, Sentara Health Plans will route it and document the outcome in the patient's chart.

✓ *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

Billing Updates, Authorization Updates & Reminders

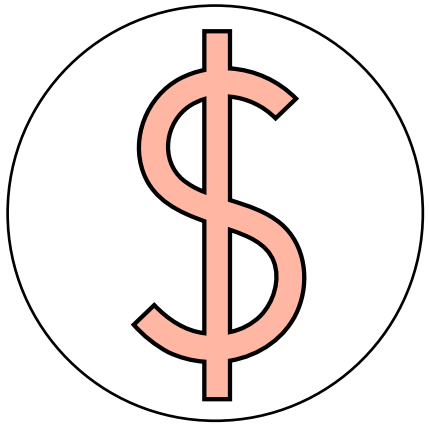


Balance Billing Inquires

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.



Telehealth Audio Only – Modifer 93

Effective May 1, 2026, Sentara Health Plans will no longer require Modifier 93 on audio only telehealth services codes 98008-98015 for synchronous, time-based medical decision-making. Modifier 93 is typically used to indicate audio-only real-time service.

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.**

Additional Considerations

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

Provider Reconsideration Form

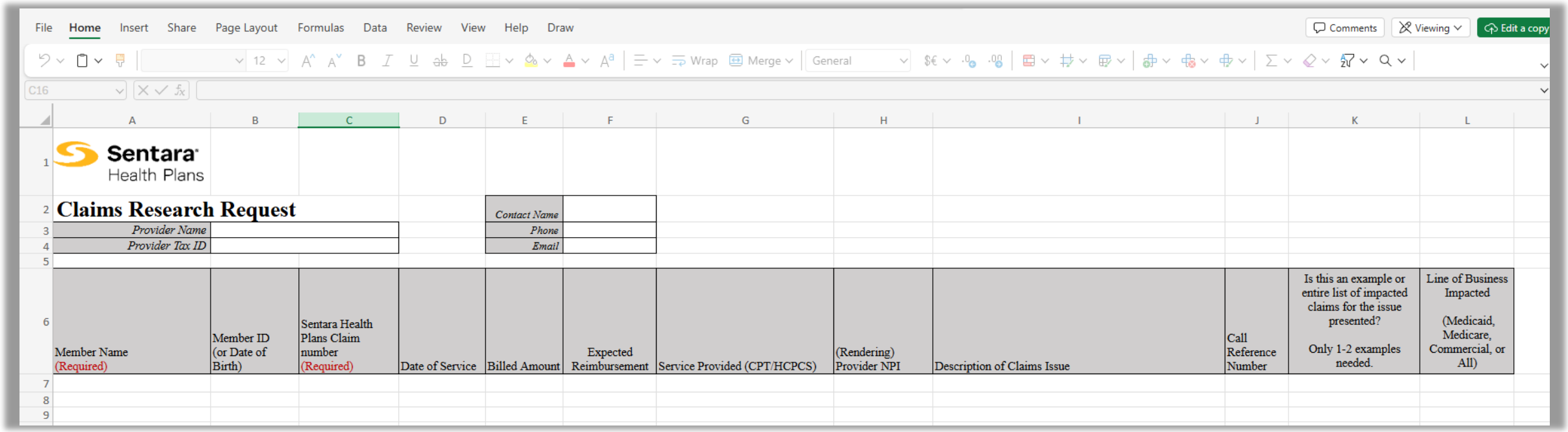
A Provider Reconsideration Form is required for medical and behavioral health claims. One form is to be submitted for each claim being reconsidered. Missing or incomplete information may result in the original decision being upheld.

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: _____	

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.



Sentara Health Plans

Claims Research Request

Provider Name	
Provider Tax ID	

Contact Name	
Phone	
Email	

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

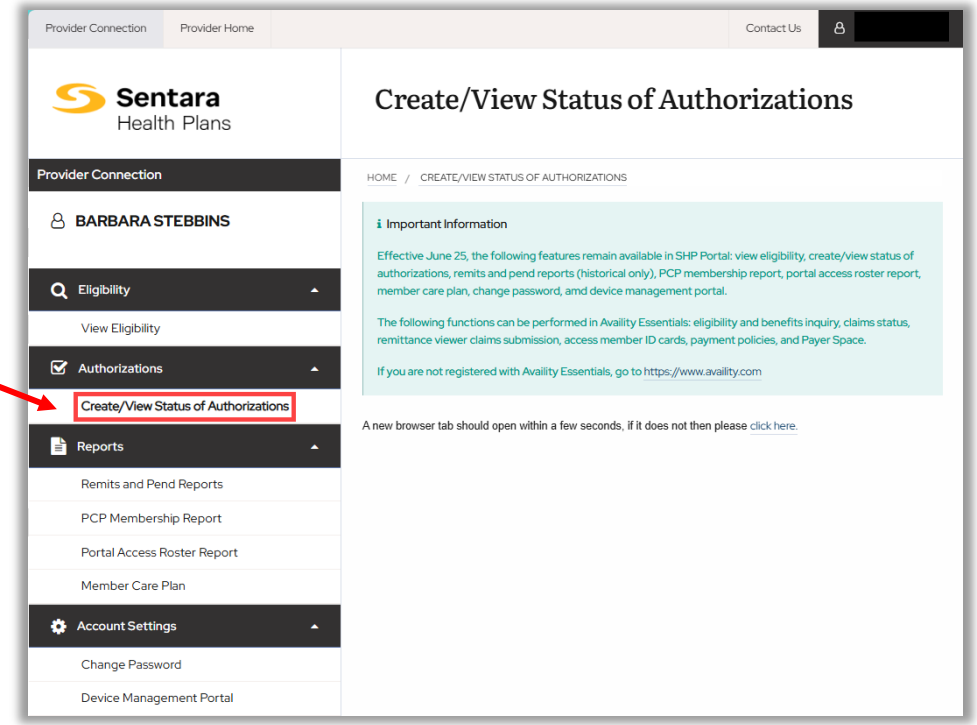
- ***BH forms/documents*:**
  - Behavioral Health Inpatient Authorization Request: Acute Inpatient and Residential
  - Behavioral Health Outpatient Authorization Request: Partial Hospitalization Program (Initial and Extension), Intensive Outpatient Program (Initial and Extension), Applied Behavioral 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:

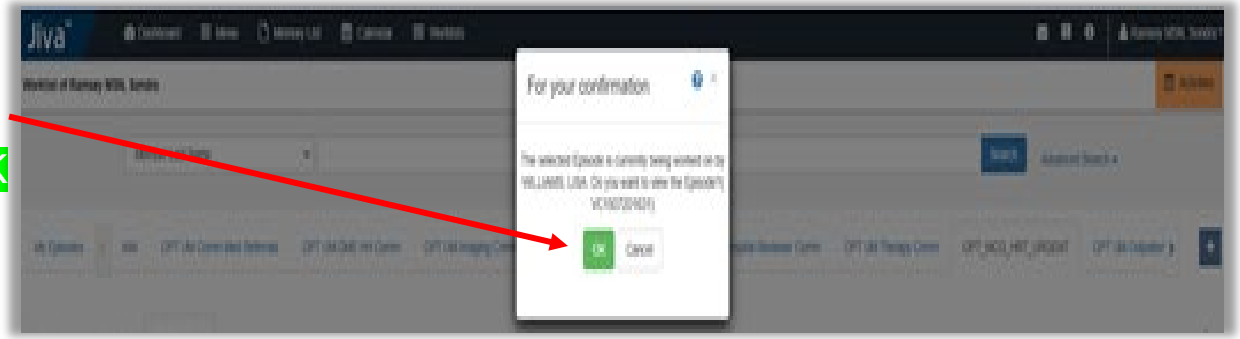
- Non-emergent – 14-day turnaround time
- Urgent requests – 72-hour turnaround time
- Government Programs – 7-day turnaround time

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.



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 Provider Manual on page 108

Sentara Health Plans Medicaid Provider Manual on page 99 and page 100

Provider Manuals and Directories | Providers | Sentara Health Plans

Doing Business with Sentara Health Plans – Provider Orientation | Providers | Sentara Health Plans

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

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

DMAS Updates/Follow-up

New Single Sign-on Requirement for FFS Service Authorization Requests – April 27, 2026

Changes to Member Demographic Updates Requests – May 4, 2026

Retrospective Eligibility and Timeliness of Submission – May 4, 2026

Taxonomy Updates for ARTS Residential Services

To review DMAS updates and follow up please visit

Memo & Bulletin Library | MES (virginia.gov)

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.

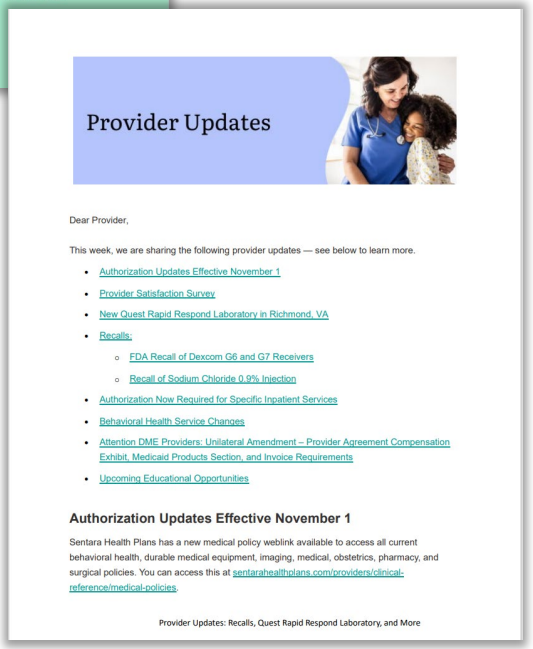
Immediately report alleged abuse, neglect or exploitation related critical incidents to appropriate protective services agency: Contact:

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

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



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.

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)

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, and Retractions | Providers | Sentara Health Plans

Provider Appeals Procedure – Medicare: Appeals, Reconsiderations, and Retractions | Providers | Sentara Health Plans

Provider Appeals Procedure – Medicaid: Appeals, Reconsiderations, and Retractions | Providers | Sentara Health Plans

Provider Reconsideration Procedure: Appeals, Reconsiderations, and Retractions | Providers | Sentara Health Plans

Waiver of Liability Statement:Appeals, Reconsiderations, and Retractions | 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

May 13, 2026 1-2 PM

May 19, , 2026 7-8 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

June 17,2026 1-2 PM

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

July 8,2026 1-1:30 PM

October 7, 2026 1-1:30 PM

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)

May 19, 2026 12-12:30 PM

June 11, 2026 12-12:30 PM

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

June 3, 2026 12-1 PM

July 1, 2026 12-1 PM

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.

Give us your feedback