Provider Orientation YR2026

COMMUNITY HEALTH PLAN of Washington™
The power of community

Agenda

- Welcome
- Land Acknowledgement
- About CHPW
- Apple Health (Medicaid)
- Apple Health Exchange (AHE)
- Medicare Advantage D-SNP
- Cascade Select
- Claims & Billing
- Provider/Member Appeals
- Provider Responsibilities
- Utilization Management
- Case Management
- Provider Training & Tools
- Pharmacy
- Provider Information & Resources
- Closing Remarks

Welcome!

This orientation program will provide you with key information regarding Community Health Plan of Washington (CHPW).

You will be introduced to several resources and key contacts to help serve your needs as a valued provider.

We are here to help….

Please feel free to contact CHPW's Customer Service for assistance at:

- Apple Health (Medicaid) **1-800-440-1561**
- Medicare Advantage D-SNP **1-800-942-0247**
- Cascade Select **1-866-907-1906**

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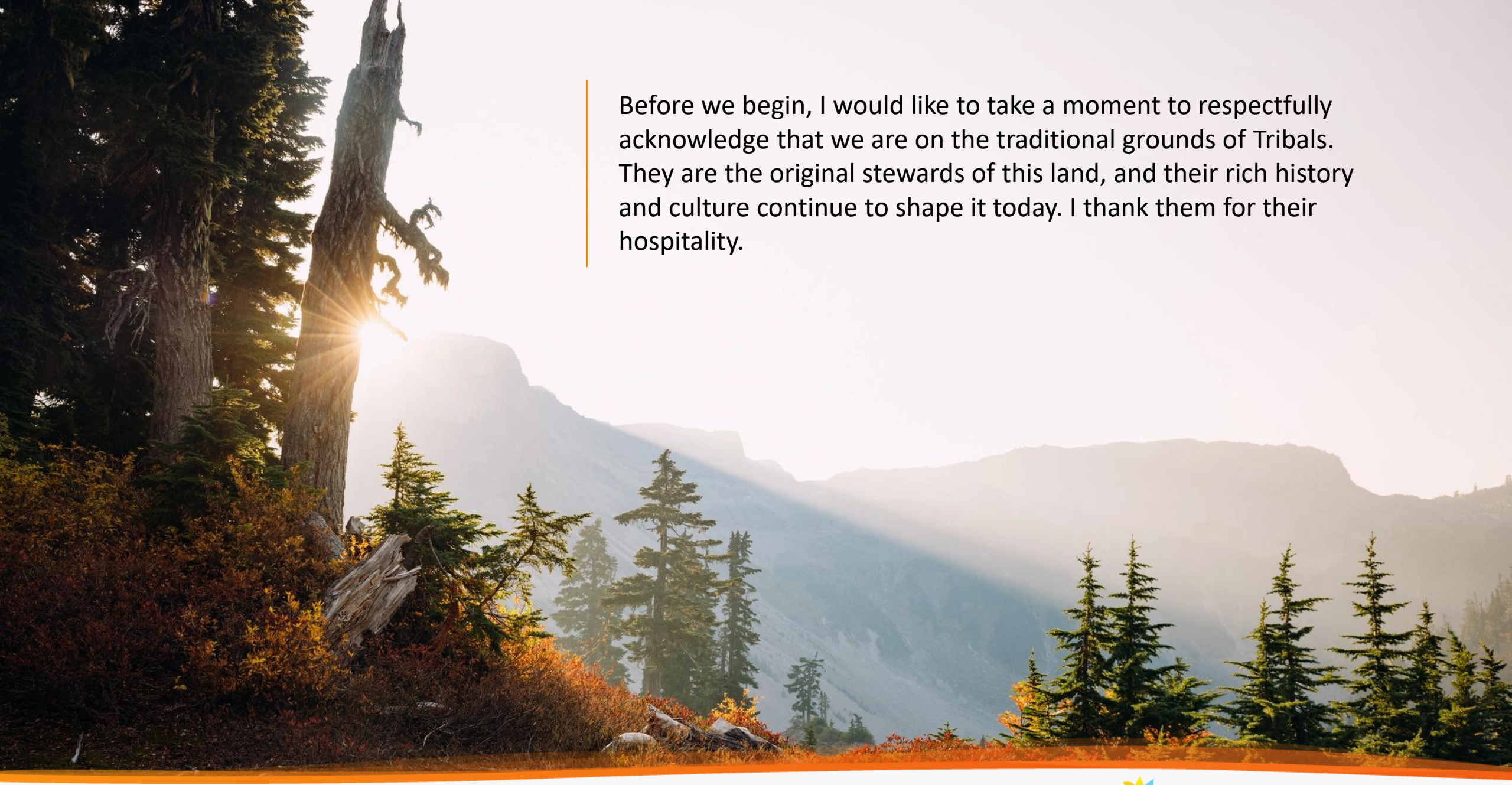
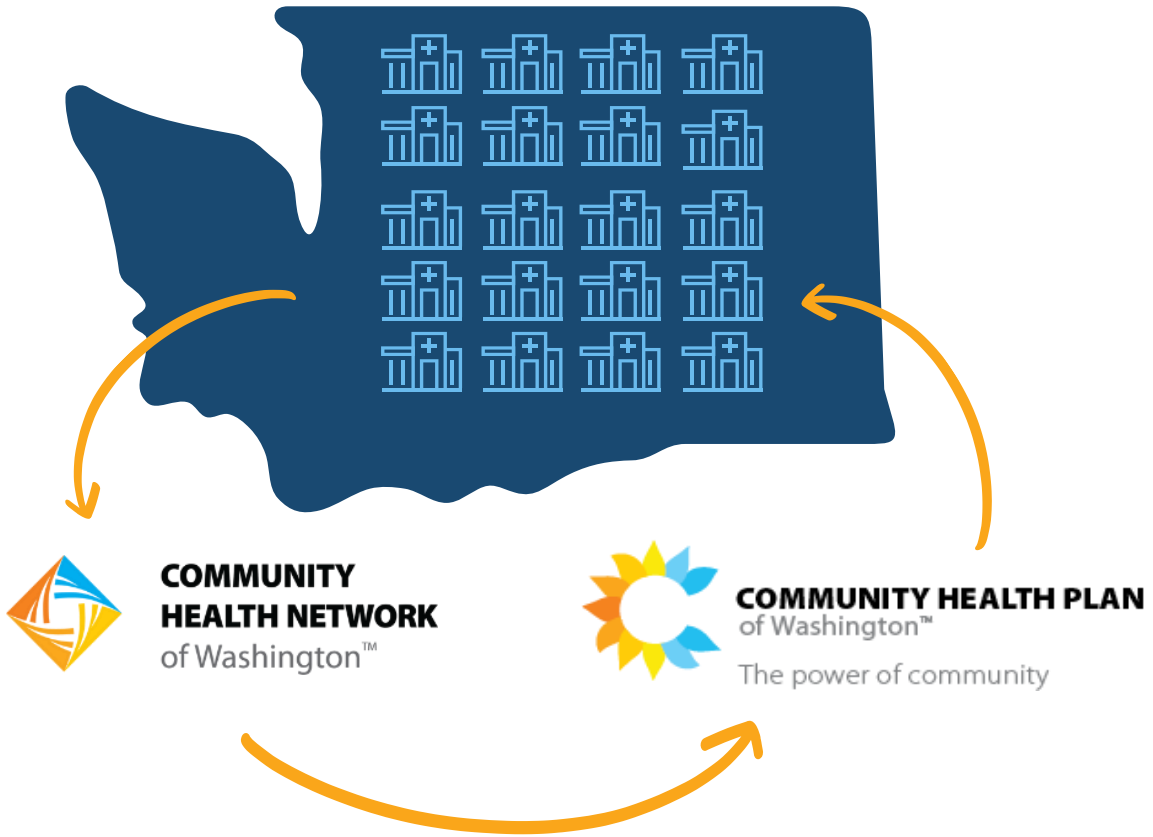


Before we begin, I would like to take a moment to respectfully acknowledge that we are on the traditional grounds of Tribals. They are the original stewards of this land, and their rich history and culture continue to shape it today. I thank them for their hospitality.

Our Founding & Governance Structure Provide Unique Connection to Community

- Founded and governed by Community Health Centers (CHCs) more than 30 years ago.
- Our local staff and Board are part of the fabric of the communities we serve.
- Our integration with CHCs allows us to work hand-in-hand to increase access to care, focus on whole-person health, and improve health outcomes for Washingtonians.



Community Health Plan of Washington

Our coverage provides a continuum of care for your patients

CHPW is dedicated to serving patients across **three** health plans to provide consistent, quality service to your patients as they move from Apple Health to Individual & Family Plans to Medicare Advantage D-SNP.

COMMUNITY HEALTH PLAN of Washington™
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APPLE HEALTH (MEDICAID)

COMMUNITY HEALTH PLAN of Washington™
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MEDICARE ADVANTAGE

COMMUNITY HEALTH PLAN of Washington™
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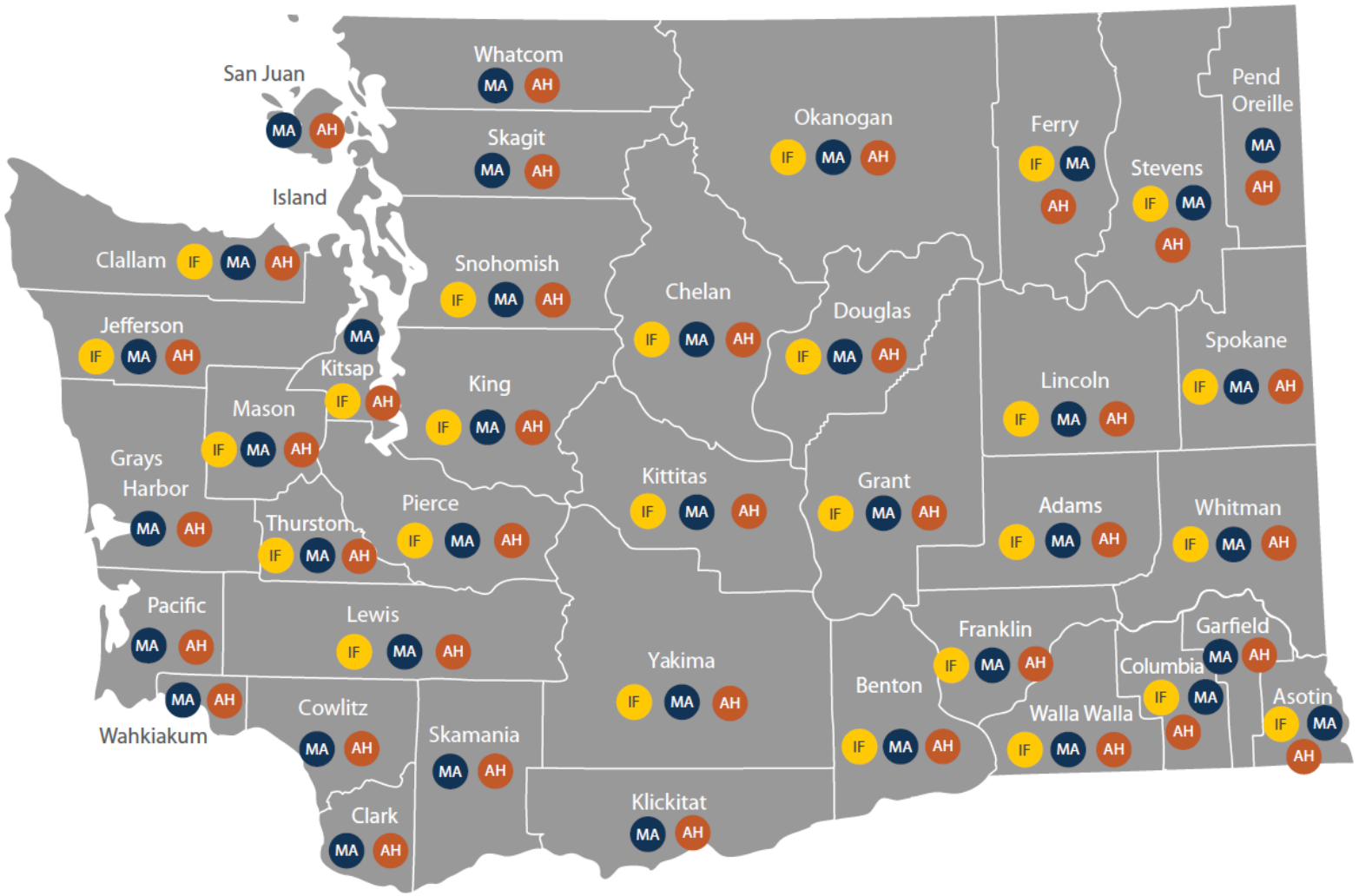
INDIVIDUAL & FAMILY PLANS

Apple Health (Medicaid)	Medicare Advantage Dual Special Needs Plans (D-SNP)	Cascade Select (Individual & Family Plans)
Serving all counties in WA State		*Serving all counties in WA State*

CHPW Service Area



AH

Apple Health
(+ Apple Health Expansion)
All Counties

MA

Medicare Advantage
Dual Special Needs Plan
(HMO D-SNP)
(Medicare/Medicaid Members)
All Counties

IF

Individual & Family
Cascade Select
26 Counties

Provider Relations Team

Zane Switzer – zane.switzer@chpw.org
Greater Columbia &
Adams, Skamania, Klickitat Counties

Heather Gregory – heather.gregory@chpw.org
Spokane, North Central
Provider Networks: MultiCare, Providence/Swedish

Janelle Taasan – janelle.taasan@chpw.org
N. Sound, Pierce, King
Provider Networks: UW, PeaceHealth

Carmen Ballmann – carmen.ballmann@chpw.org
Great Rivers, Salish, Thurston, Mason, Southwest
Provider Networks: Virginia Mason/Franciscan, Proliance and DME

Contact for Escalated Issues:
Jae Switzer – Manager, Provider Relations
Jae.Switzer@chpw.org or 206 408-4750

Apple Health Medicaid

- About Apple Health- Medicaid
- Apple Health Expansion
- Plan Benefits
- Alternative Treatments
- Circumcision Benefit
- Early Periodic Screening Diagnosis & Treatment (EPSDT)
- Infant-Early Childhood Mental Health (IECMH) Assessments
- ChildrenFirst Well-Child Rewards
- Member Rewards
- Contact Guide – Apple Health (Medicaid)

COMMUNITY HEALTH PLAN of Washington™

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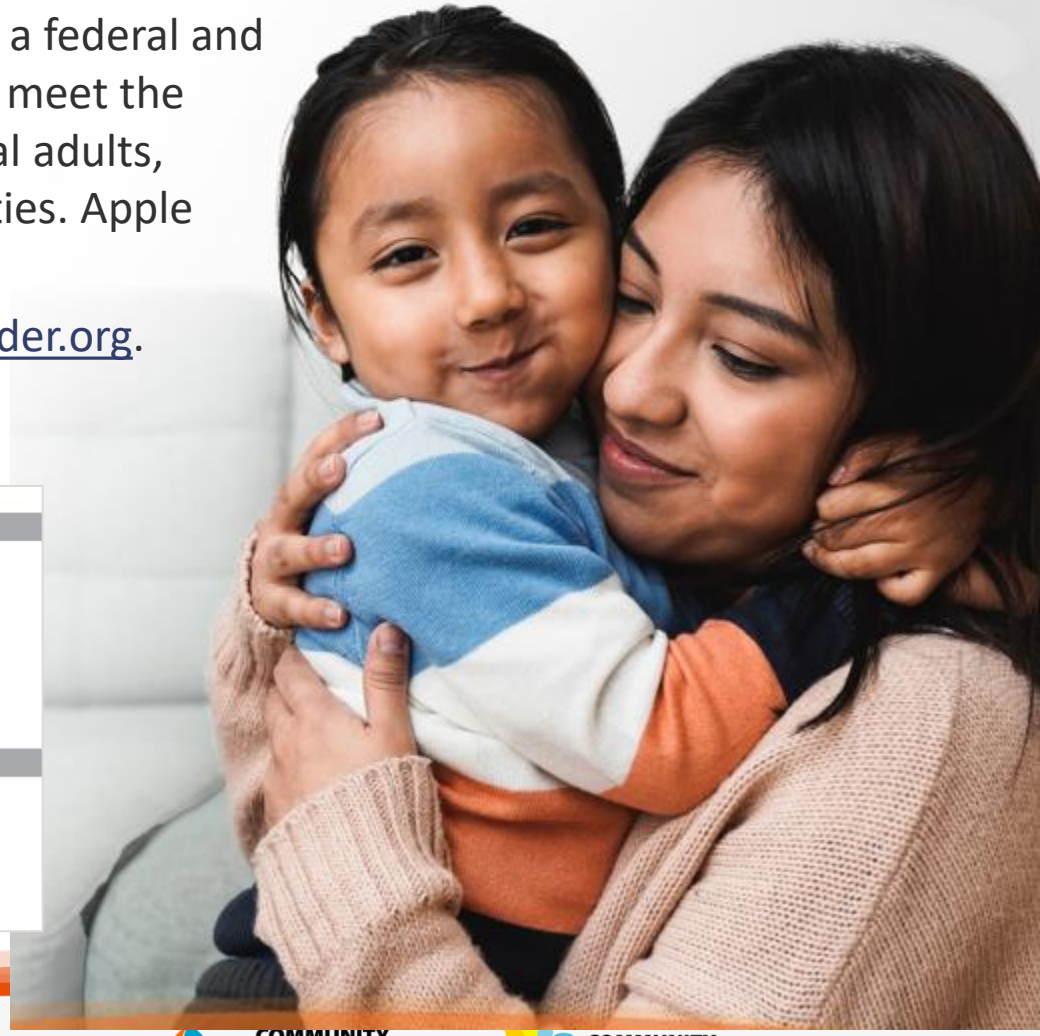
About Apple Health (Medicaid)

Washington Apple Health is the Medicaid program in Washington State.

In the State of Washington, Medicaid is called Apple Health. Medicaid is a federal and state government health coverage program available to individuals who meet the income and resource limits. Apple Health provides coverage to individual adults, families and children, pregnant individuals, and individuals with disabilities. Apple Health eligibility depends on income and life situation.

Applications can be completed and submitted at: www.wahealthplanfinder.org.



CHPW Apple Health (Medicaid) Member ID:

Note: *Member ID images are examples; the actual ID cards can list specific regions, or specific plan names.*

COMMUNITY HEALTH NETWORK of Washington™ COMMUNITY HEALTH PLAN of Washington™

About Apple Health (Medicaid)

CHPW provides comprehensive medical coverage, so members can get and stay healthy.

Services covered by Apple Health:

- Primary care like regular checkups
- Vaccinations/immunizations
- Allergy medication
- Labs and X-rays
- Medical supplies
- Women's health
- Support for chronic conditions
- Transgender health services
- Cancer treatment
- Health management services

This is only a **partial list** of covered services/benefits. To learn more about Apple Health benefits, **download our Member Handbook and CHPW Plan Benefits**:

CHPW Member Covered Services Handbook
CHPW Apple Health Plan Benefits

Note: The benefit lists included above is for general information only and does not guarantee Apple Health will cover the service. It is important to verify member eligibility, benefits and services.

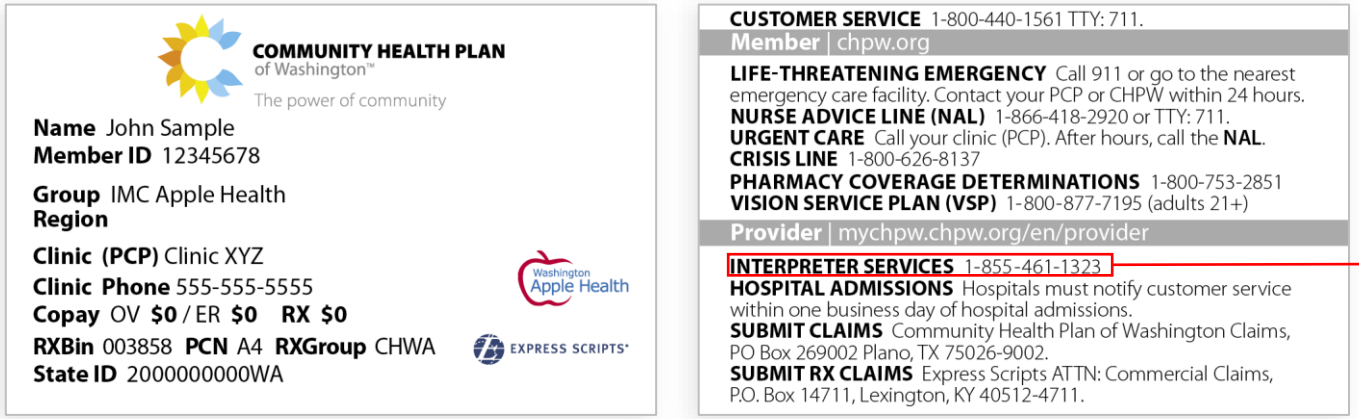
For more information on benefits, you can contact CHPW's customer service department 800 440-1561.

About Apple Health Expansion

Washington Apple Health Expansion is a newer state-wide program available to people age 19 or older with certain immigration statuses. Eligible members include those who do not qualify for other Apple Health programs based on their immigration status. Apple Health Expansion is designed to mirror to the extent possible the services provided to individuals enrolled in Apple Health (Medicaid) managed care. Due to program funding, the number of people who can enroll in Apple Health Expansion is limited. The enrollment cap is currently met.

Applications can be completed and submitted at: www.wahealthplanfinder.org.

CHPW Apple Health Expansion Member ID:



Interpreter services phone number

Note: *Member ID images are examples; the actual ID cards can list specific regions, or specific plan names.*

Vision Benefit

CHPW offers no-cost frames and basic lenses to adult members (21+)

https://www.vspdirect.com/find-a-doctor

This benefit includes:

- Routine eye exams for adults are covered through VSP
- Routine coverage includes **one eye exam every 24 months**
- Access to VSP's large, **trusted network of providers**
- Free glasses (frames* and basic lenses) **every 24 months**

For more information about vision benefits for CHPW members, including eye care for kids, visit our Vision page.

Alternative Treatments

Number of visits per year -

Benefit	Members under age 21	Members age 21+
Acupuncture	Up to 20 visits per year	Up to 20 visits per year
Chiropractic	Covered directly by Apple Health	Up to 20 visits per year
Massage*	Up to 20 visits per year	Up to 20 visits per year

Note that this is a **combined** 20 visit benefit. For example, a 24-year-old member could use this benefit for 10 massage visits, 5 chiropractic visits, and 5 acupuncture visits.

**Massage visits are based on session length of 30 minutes. A one-hour massage would count as two visits. Optional tipping is not included in coverage.*

Billing guidelines for alternative treatments can be found here:
Alternative Treatments Billing Guidelines

For more information contact Customer Service – 800 440-1561

Circumcision Benefit

Coverage Criteria

- CHPW covers up to $200 toward non-medically necessary circumcision for each child. (Medically necessary circumcisions are covered by the state.)
- Non-medically necessary circumcision is optional, not required.
- Benefit applies to children under 18.
- Each child assigned male at birth in the family is eligible.
- Open network: The doctor performing the procedure doesn't have to be contracted with CHPW; they just need to be willing to bill CHPW.
- Any charges above $200 are member's responsibility.

Early Periodic Screening Diagnosis & Treatment (EPSDT)

EPSDT requires a periodic well-child checkup with the members primary care provider (PCP). HCA's expectations for the recommended frequency of checkups align with the American Academy for Pediatrics (AAP) Bright Futures Periodicity Schedule, including:

Infancy					
1st week	1 month	2 months	4 months	6 months	9 months

Early Childhood						
12 months	15 months	18 months	24 months	30 months	3 years	4 years

Middle Childhood and Adolescence
One checkup every calendar year for ages 5 through 20 years

Note: EPSDT services do not apply to 19- and 20-year-olds who are on Apple Health Expansion. For information on well exam services that are covered under Apple Health Expansion for 19- and 20-year-olds, see the Physician's Related Services/Health Care Professional Services Guide.

Documentation for a well-child checkup

Providers must document in the patient's medical record that each required element of the well-child checkup was done at the visit and what the findings were.

Each well-child checkup consists of specific elements, though how the element is completed depends on the age of the child

For more information go to:

EPSDT Screening FAQs
EPSDT HCA Program Billing Guide Links

Infant-Early Childhood Mental Health (IECMH) Assessments

Changes to Apple Health policies regarding mental health assessments for children from birth through age five.

In April 2021, the Washington State Legislature passed 2HB1325. The bill made changes to Apple Health policies regarding mental health assessments for children from birth through age five.

This set of new policies is currently referred to as Mental Health Assessment for Young Children (MHAYC).

The changes include:

Enhanced reimbursement, including:

- Reimbursement for up to five sessions for assessment, if necessary
- Reimbursement of provider travel costs for assessments conducted in home or community settings

Requirement to use the DC:0-5™ diagnostic classification system

Infant-Early Childhood Mental Health (IECMH) Assessments

When is provider travel eligible for reimbursement?
Provider travel is eligible for reimbursement under a specific and limited set of circumstances.
The provider must be traveling for:

- The purpose of conducting a mental health assessment ***(CPT code 90791, 90792 or H0031 ONLY)***
- For a child from birth through the age of five ***(up till their 6th birthday)***
- For a session that is conducted in the child/family's home or in a community setting ***(POS 03/ School; 04/Homeless Shelter; 12/Home or 99/Other Place of Service ONLY)***

How will MHAYC provider travel be reimbursed for providers serving children enrolled with Community Health Plan of WA?
Providers will utilize this form: ➔ MHAYC Provider A-19 Form

To complete the A19, each line/entry must include:

- The Service Date of the diagnostic assessment
- The ProviderOne client ID
- Addresses of starting and ending point
- Miles from starting point to ending point
- Mileage rate (prepopulated on A19)
- Submit invoices to invoice@chpw.org

Infant-Early Childhood Mental Health (IECMH) Assessments

All invoices will be validated to claims per eligibility requirements for reimbursement as outlined here. No invoice will be paid without an **adjudicated claim**.

Invoices must be submitted no later than **60 days** from an adjudicated supporting claim.

More information & resources:

- RCW 74.09.520
  - Billing for MHAYC
  - Resource Guidance for Infant-Early Childhood Mental Health Services
- DC 0-5 Crosswalk
- Infant-Early Childhood Mental Health Workforce Collaborative – IECMH-WC Webpage

For questions, please contact: provider.relations@chpw.org

Member Rewards Programs

ChildrenFirst™ Rewards

Support for keeping families healthy

CHPW Apple Health members can earn **gift card rewards** for prenatal, postpartum, and well-child checkups through our ChildrenFirst™ Program. **Gift cards can be used at Amazon, Safeway/Albertsons, or Target.**

Learn about CHPW Prenatal, Postpartum and Well-Child rewards HERE.

Member Rewards Programs

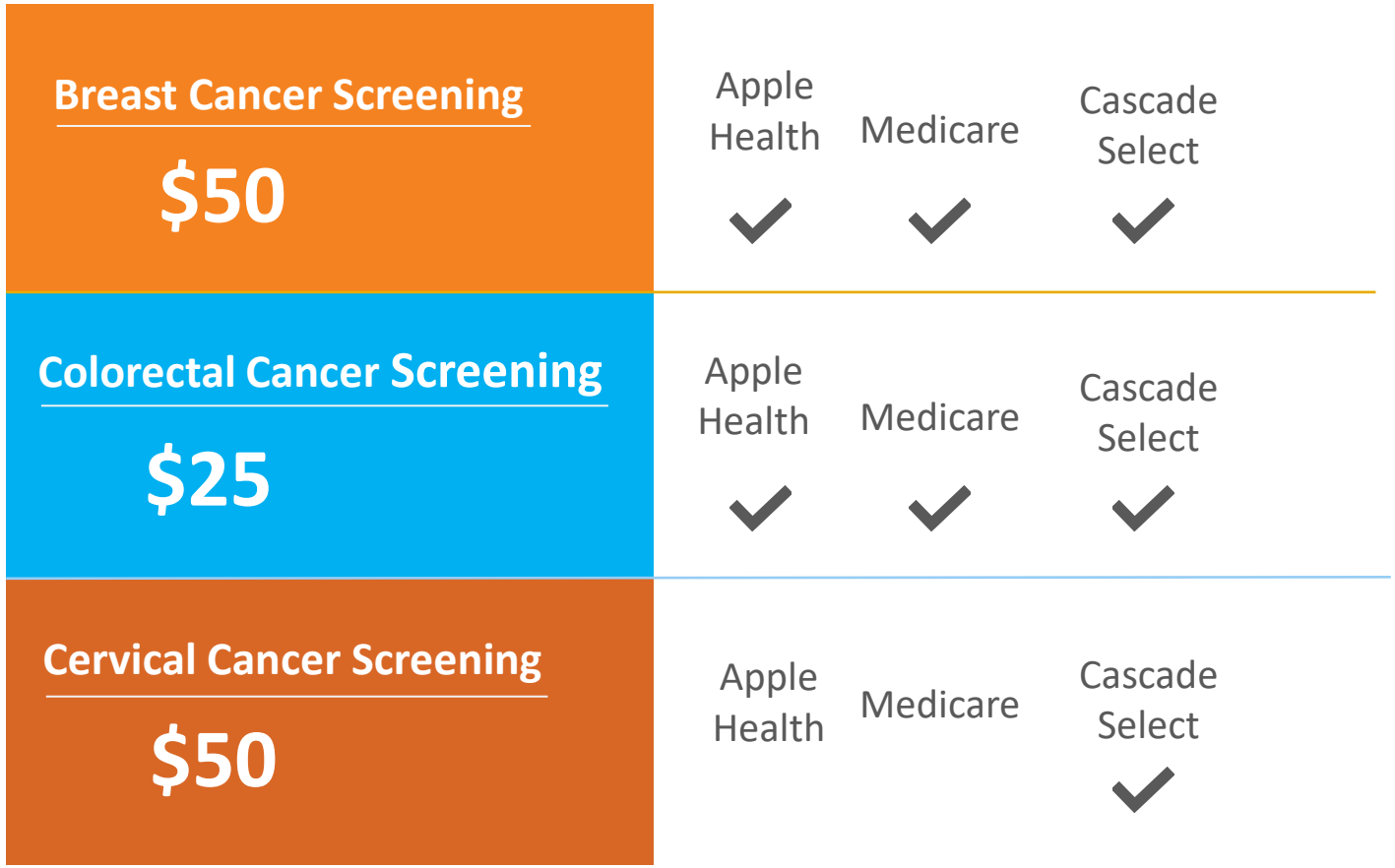
MemberFirst™ Rewards

CHPW rewards our adult members for looking after their own health.

- Members can earn gift cards for completing certain preventive screenings.
- Eligible screenings vary by type of insurance plan.

Gift cards can be used at Amazon, Safeway/Albertsons, or Target.

*Note: Member fills out an **online form** to attest to completing the screening and request the reward. Providers can help the member fill out the form if needed.*



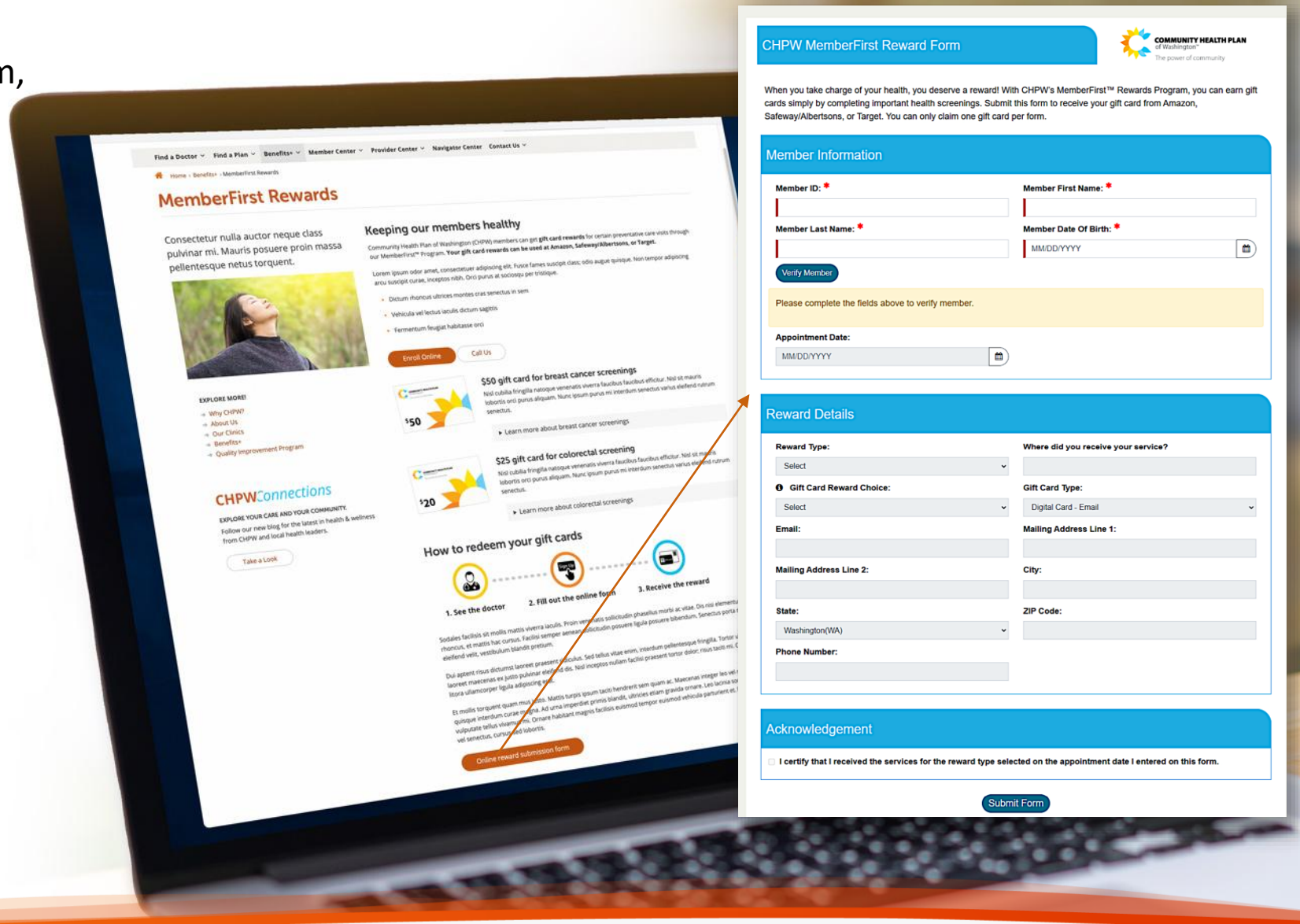
Member Rewards Programs

To benefit from CHPWs Rewards Program, members should:

- Schedule and complete a screening or test.
- Fill out the **online reward submission form**. (*Providers can help the CHPW member do this if needed*.)

Gift card should arrive in 2-3 weeks, once request is approved.

Note: Member must request the reward within 180 days of the preventive screening or test.



Link to online reward form: https://forms.chpw.org/incentives-reward-request

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CHPW Contact Guide – Apple Health (Medicaid)

Washington Apple Health (Medicaid) Customer Services

Plans Serviced

Washington Apple Health

In the State of Washington, Medicaid is called Apple Health.

Medicaid is a federal and state government health coverage program available to individuals who meet the income and resource limits.

Apple Health provides coverage to individual adults, families and children, pregnant individuals, and individuals with disabilities.

Receive answers on the following

- Appeals & Grievances
- Claims Status
- Eligibility Verification
- General Information
- Hospital Notifications
- Member Benefits
- PCP Changes
- Prior Authorization Status

Contact Numbers

Customer Service

Phone (800) 440-1561

TTY/TDD Dial relay 711

Fax: (206) 652-7040

Email: Customercare@chpw.org

Program Contact and Fax Numbers

Community Support Services

Phone: (866) 418-7006 (TTY/TDD Dial relay 711)
Email: CCSRequests@chpw.org

Care Management Services

Phone: (866) 418-7004 (TTY/TDD Dial relay 711)
Email: caremgmtreferrals@chpw.org
Fax: (206) 652-7092

Apple Health Medical Management

Fax: (206) 652-7065 Prior Authorization & Referrals; Mom & Baby Admits

Fax: (206) 652-7067 Prior Authorization for Behavioral Health Services- IMC/BHSO Only

Fax: (206) 652-7078 Inpatient Notification, Admission & Discharge

More on Apple Health Medicaid

- Plan & PCP Selection/ Plan & Clinic Changes
- Auto Assignment Process
- Newborn – Effective Date of Enrollment
- Newborn – PCP Assignment
- Member Eligibility Verification
- Retro Enrollment

CHPW Apple Health-Medicaid Plan

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Apple Health Member Plan and PCP Clinic Selection

Enrollees can select their Plan and Clinic/PCP during the initial enrollment application on WA Healthplanfinder. **Visit wahealthplanfinder.org** or call their Support Center at **1-855-923-4633.**

If the enrollee wishes to apply any changes to their Plan (MCO) selection after they made the selection on the WA Healthplanfinder, member can do so through the Healthplanfinder or Provider One portals.

Note: If a patient expresses the desire to switch to CHPW, you can assist your patient by calling:

- Phone: **866-907-1904 – Monday – Friday from 8:00am to 5:00pm**

For more enrollment information, to CHPW's website page: How to enroll with CHPW

Auto-Assignment Process

If the member did not choose an MCO during the enrollment process via WA Healthplanfinder, the state auto-assigns them to an MCO (one of the 5 listed below). The MCO then will auto-assign the enrollee to a PCP closest to their home.

Washington State Health Care Authority

COMMUNITY HEALTH PLAN of Washington™

MOLINA HEALTHCARE

Wellpoint

coordinated care

UnitedHealthcare Community Plan

- Should the enrollee wish to change the MCO that they were auto-assigned, they can go through WA Healthplanfinder or Provider One and choose another MCO.
- If the enrollee was auto-assigned to CHPW and wishes to change the PCP/Clinic, they can access a PCP/Clinic change form on CHPW's website here: CHPW Online or call CHPW Customer Service at 1-800-440-1561.

Newborn - Effective Date of Enrollment

Newborns whose mothers are enrollees with Community Health Plan of Washington on the date of birth are deemed enrollees and under the same plan as the mother as follows:

- Retrospectively for the month(s) in which the first twenty-one (21) days of life occur and prospectively, beginning the first of the month after the newborn is reported to the Health Care Authority.
- If the newborn does not receive a separate client identifier from the Health Care Authority the newborn enrollment will be only available through the end of the month in which the first twenty-one (21) days of life occur.
- If the mother's enrollment is ended before the newborn receives a separate client identifier from the Health Care Authority, the newborn's enrollment shall end the last day of the month in which the twenty first (21st) day of life occurs or when the mother's enrollment ends, whichever is sooner.

Newborn PCP Assignment

Newborn accounts manually created by CHPW's eligibility department will be assigned to mom's PCP.

Newborn accounts created via state files are put through auto-assign and can be adjusted by submitting a request -

PCP assignment requests can be submitted as follows:

- PDF Form: https://forms.chpw.org/clinic-selection
  - Fax this form to: 206-652-7085
- Online: CHPW PCP Assignment Request
- CHPW Customer Service: 800-440-1561

Prospective Requests: Requests received through customer service, via on-line or fax are checked daily to make sure assignments are processed and completed.

If a newborn request is received through either of these methods, the PCP is updated, and a new ID card is sent to the member. The update should also be seen the following day in HealthMAPS.

Member Eligibility Verification

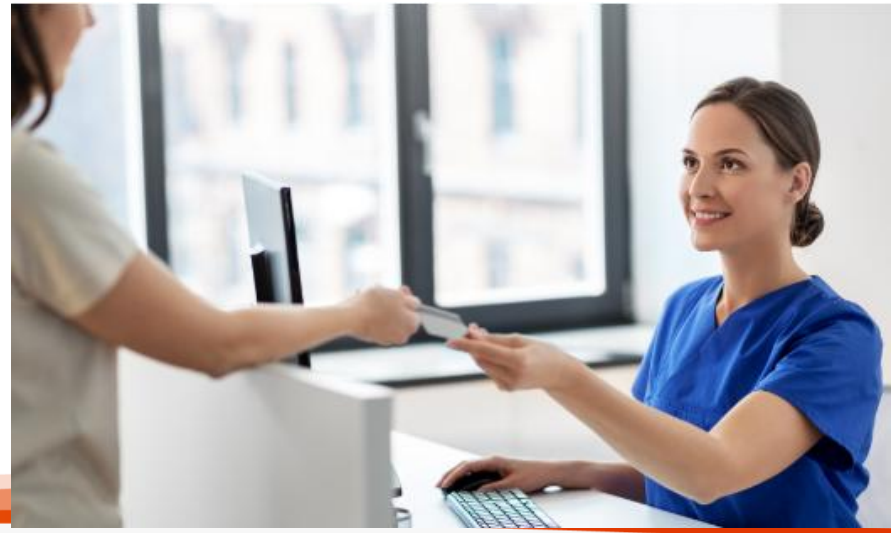
To avoid claims issues or non-payment, it is vital to verify a patient's insurance eligibility before being admitted to any hospital, or treated by a clinic, or medical facility.

Why is routine verification of member/patient eligibility important?

- Prioritizing member eligibility checks promotes proactive collection measures and prevents payment delays.
- Apple Health members can change Managed Care Organization (MCO) Plans Monthly
- CHPW members can change PCP's monthly.

CHPW recommends the following steps to verify member/patient eligibility:

- To verify which MCO the member is enrolled, use ProviderOne via:
  - OneHealthPort - ProviderOne Log In Page
- To verify CHPW member PCP assignment, use HealthMAPS via:
  - OneHealthPort - CHPW Log In Page



Member Eligibility Verification

CHPW Member Assignment FAQs:

Q: If a CHPW member is assigned to a PCP clinic outside of your organization, can the member be seen without a Plan Authorized Referral?

- **No,** if the member is assigned to a PCP clinic outside of your organization, a Plan authorized referral is required.

  Note: When PCP-to-PCP referrals/authorizations are not obtained, it will result in claim denials.

Q: If a CHPW member is assigned to a PCP clinic in your organization, are they able to see any primary care provider in your group?

- **Yes,**

  Note: The rendering doctor/provider must be credentialed and issued an effective date by CHPW.

Note:

- CHPW members are assigned to a Primary Care Provider (PCP) Clinic.
- If a CHPW member wants to switch to a different Clinic this can be done using the online Clinic Selection Form or the member can contact Customer Service 800 440-1561.

Retro Enrollment

Retroactive eligibility allows a person applying for Medicaid to obtain coverage prior to the month they applied. The retroactive period is up to 90 days prior to the month the Medicaid application is received as long as eligibility requirements are met.

How will Providers know that a member has been enrolled retroactively?

- Providers should **access ProviderOne** to determine retroactive eligibility.

Authorizations & Inpatient (IP) Notifications for Retro Enrolled Members

- Providers must submit a request for an Authorization or IP Notification ***within 90- days from the date the member was retroactively enrolled with CHPW***. (please indicate on form that member was retro enrolled)
  - Approval will be based on medical necessity.
  - Inpatient notifications will apply even if the member has been discharged from the hospital.
  - Submission of clinical information with the inpatient notification will assist in speeding up the concurrent review process.

Medicare Advantage D-SNP Plans

- About Medicare Advantage
- Enrollment
- D-SNP Plans - 2026
- Service Area
- Member Grocery Benefit
- CMS Approved Chronic Conditions
- Eligibility Verification
- Part D Coverage
- CHPW Contact Guide – Medicare Advantage

www.Medicare.chpw.org

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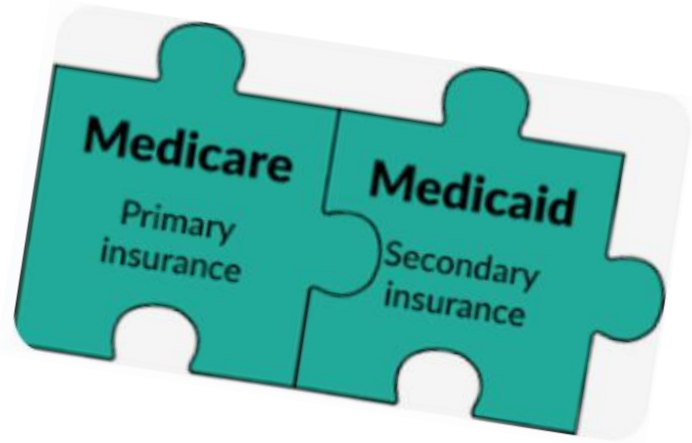
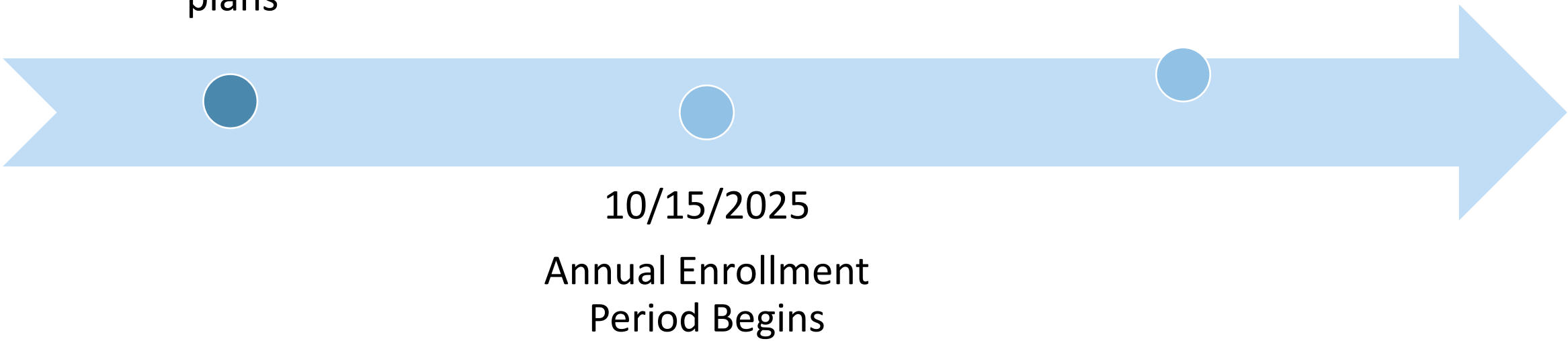
About Medicare Advantage D-SNP

Individuals who are entitled to both Medicare and medical assistance from a state plan under Medicaid can enroll in a Dual Special Needs Plan (D-SNP). States cover some Medicare costs, depending on the state and individual's eligibility.



Timeline of Member Notice and Annual Enrollment Period (AEP)

During AEP, Medicare beneficiaries can change their Medicare coverage for the upcoming year with changes taking affect January 1.



CHPW Medicare Advantage Plans in 2026

Plan Benefit Package Changes

In 2026, CHPW will sunset MA Plan 2, MA Plan 4 and MA Freedom Plan.

CHPW will retain its two HMO Dual Special Needs Plans (D-SNP)

- Dual Complete
- Dual Select

Member Notice of Plan Closure

CMS provides a model document/plan termination letter.

The letter directs members to call 1-800-MEDICARE or visit Medicare Plan Finder to find a new plan. Member can also change to original Medicare.

Dual Special Needs Plans in 2026

In 2026, CHPW D-SNP Plans are:

- Dual Complete
- Dual Select

With Duals plans, some members pay $0 (Dual Complete), while others pay 20% (Dual Select).

The amount a member pays depends on the level of assistance from Medicaid.

Dual Complete and Dual Select Member ID Cards

COMMUNITY HEALTH PLAN of Washington™
MEDICARE ADVANTAGE

MedicareRx Prescription Drug Coverage

Name John Sample **ID** 1234567801
Group CHPW Dual Complete (HMO D-SNP) **Issuer** (80840)

PCP My CHC (123) 456-7890

Copay PCP **$0***/ ER **$0***/ Specialist **$0***

*Copay amount depends on level of extra help from Medicaid.

RxBIN 003858 **RxPCN** MD **RxGrp** CHWA **CMS** H5826 014

This card also covers dental and vision services.

Refer to back of card for member and provider information

CUSTOMER SERVICE 1-800-942-0247 (TTY: 711).

Member | medicare.chpw.org

LIFE-THREATENING EMERGENCY Call 911 or go to the nearest emergency care facility.
NURSE ADVICE LINE (NAL) 1-866-418-2920 (TTY: 711).
VISION SERVICE PLAN (VSP) 1-855-492-9028
DELTA DENTAL OF WASHINGTON 1-833-527-8090
PHARMACY COVERAGE DETERMINATIONS 1-844-605-8168

Provider | mychpw.chpw.org/en/provider

HOSPITAL ADMISSIONS Hospitals must notify customer service upon patient admission. Failure to do so may affect benefit payment.
SUBMIT MEDICAL CLAIMS CHPW Claims, PO Box 269002 Plano, TX 75026-9002.
SUBMIT DENTAL CLAIMS Delta Dental of Washington, PO Box 75983 Seattle, WA 98175-0983.
SUBMIT RX CLAIMS Express Scripts ATTN: Medicare Part D, P.O. Box 14718, Lexington, KY 40512-4718.

COMMUNITY HEALTH PLAN of Washington™
MEDICARE ADVANTAGE

MedicareRx Prescription Drug Coverage

Name John Sample **ID** 1234567801
Group CHPW Dual Select (HMO D-SNP) **Issuer** (80840)

PCP My CHC (123) 456-7890

Copay PCP **0-20%***/ ER **$0-$115***/ Specialist **0-20%***

*Copay amount depends on level of extra help from Medicaid.

RxBIN 003858 **RxPCN** MD **RxGrp** CHWA **CMS** H5826 017

This card also covers dental and vision services.

Refer to back of card for member and provider information

CUSTOMER SERVICE 1-800-942-0247 (TTY: 711).

Member | medicare.chpw.org

LIFE-THREATENING EMERGENCY Call 911 or go to the nearest emergency care facility.
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SUBMIT DENTAL CLAIMS Delta Dental of Washington, PO Box 75983 Seattle, WA 98175-0983.
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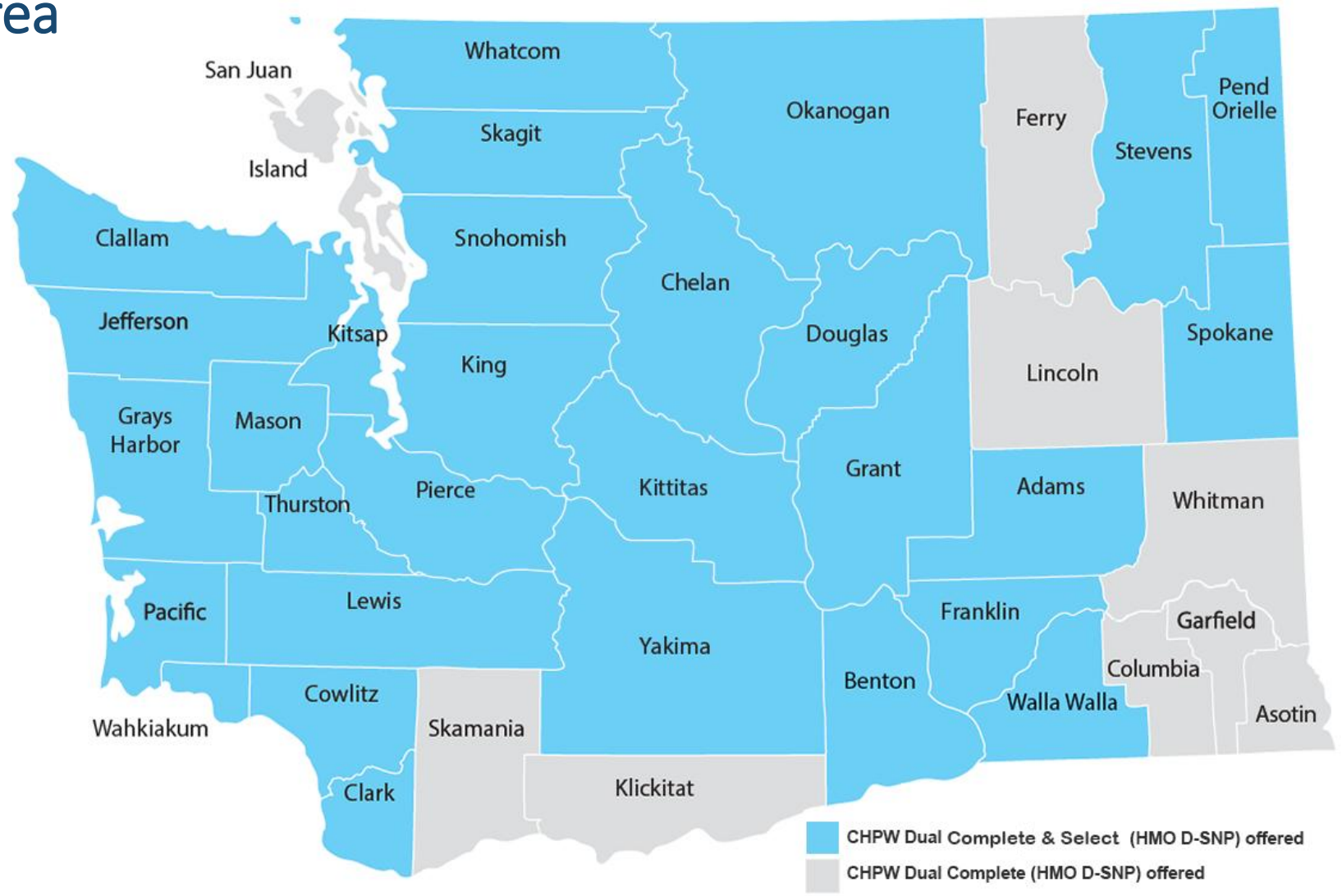
2026 Medicare Service Area

MEDICARE ADVANTAGE SPECIAL NEEDS PLAN



2026 Dual Complete and Dual Select Benefit Highlights

A comprehensive list of benefits available to CHPW members enrolled in Dual Complete or Dual Select can be found in the Summary of Benefits.

	Dual Complete	Dual Select
Health and Wellbeing	$0 copay for up to 25 visits per year for acupuncture, naturopathy, routine chiropractic and massage therapy.	$0 copay for up to 25 visits per year for acupuncture, naturopathy, routine chiropractic and massage therapy.
Dental	$2,250 annual limit for preventive and comprehensive dental services through Delta Dental	$1,250 annual limit for preventive and comprehensive dental services through Delta Dental
Hearing Services	$1,500 annual limit for hearing aids and related supplies. Limit of one per ear, per year.	$1,500 annual limit for hearing aids and related supplies. Limit of one per ear, per year.
Vision	$500 limit every year	$500 limit every year
Transportation	40 one-way trips to plan approved healthcare locations.	40 one-way trips to plan approved healthcare locations.
Post Discharge Meals	Up to 28 home delivered meals post discharge from a hospital or skilled nursing facility	Up to 28 home delivered meals post discharge from a hospital or skilled nursing facility
Fitness	$0 Fitness kit and gym membership through Silver & Fit	$0 Fitness kit and gym membership through Silver & Fit
Help with Certain Chronic Conditions	Members receive a $0 Personal Emergency Device, BP Cuff or Weight Scale if they have one of the approved chronic conditions.	Members receive a $0 Personal Emergency Device, BP Cuff or Weight Scale if they have one of the approved chronic conditions.

Dual Complete Grocery Benefit

Members who meet the eligibility criteria and are enrolled in the CHPW Dual Complete D-SNP plan will have access to the special supplemental benefit for the chronically ill **(SSBCI) starting 1/1/2026.**

Eligible members will receive a monthly stipend of $85 per month to spend on groceries.

As eligibility is partly based on diagnosis of specific chronic conditions, from time to time we may request your help to verify the conditions a member is managing.

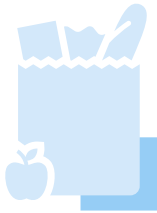
SSBCI/Grocery Benefit Eligibility

Dual Complete	1. Member must be enrolled in CHPW Dual Complete plan
Chronic Conditions	1. Member must have one of the CMS approved chronic conditions.
Chronically Ill	1. Member must have one or more of the following: • Have a pattern of multiple hospital stays or emergency room visits over the past year • Frequent use of emergency services, especially when combined with behavioral health needs • Regular visits to multiple specialists, indicating complex care needs

CMS Approved Chronic Conditions

Autoimmune diseases	Cancer	Cardiovascular disorders	Chronic alcohol and substance use disorders	Heart failure
Chronic lung disease	Chronic and disabling mental health disorders	Dementia	Diabetes mellitus	HIV/AIDS
End state liver disease	End stage renal disease	Neurologic disorders	Severe hematologic disorders	Stroke

Provider support for benefit eligibility verification



Some members will be automatically identified as eligible for the SSBCI/grocery benefit. Members not identified through the automatic enrollment process can contact CHPW Care Management (CM) to initiate the process.

If CM staff is unable to verify that a member has been diagnosed with one of the CMS approved chronic conditions, we will contact the member's provider office to attempt verification of the condition over the phone.

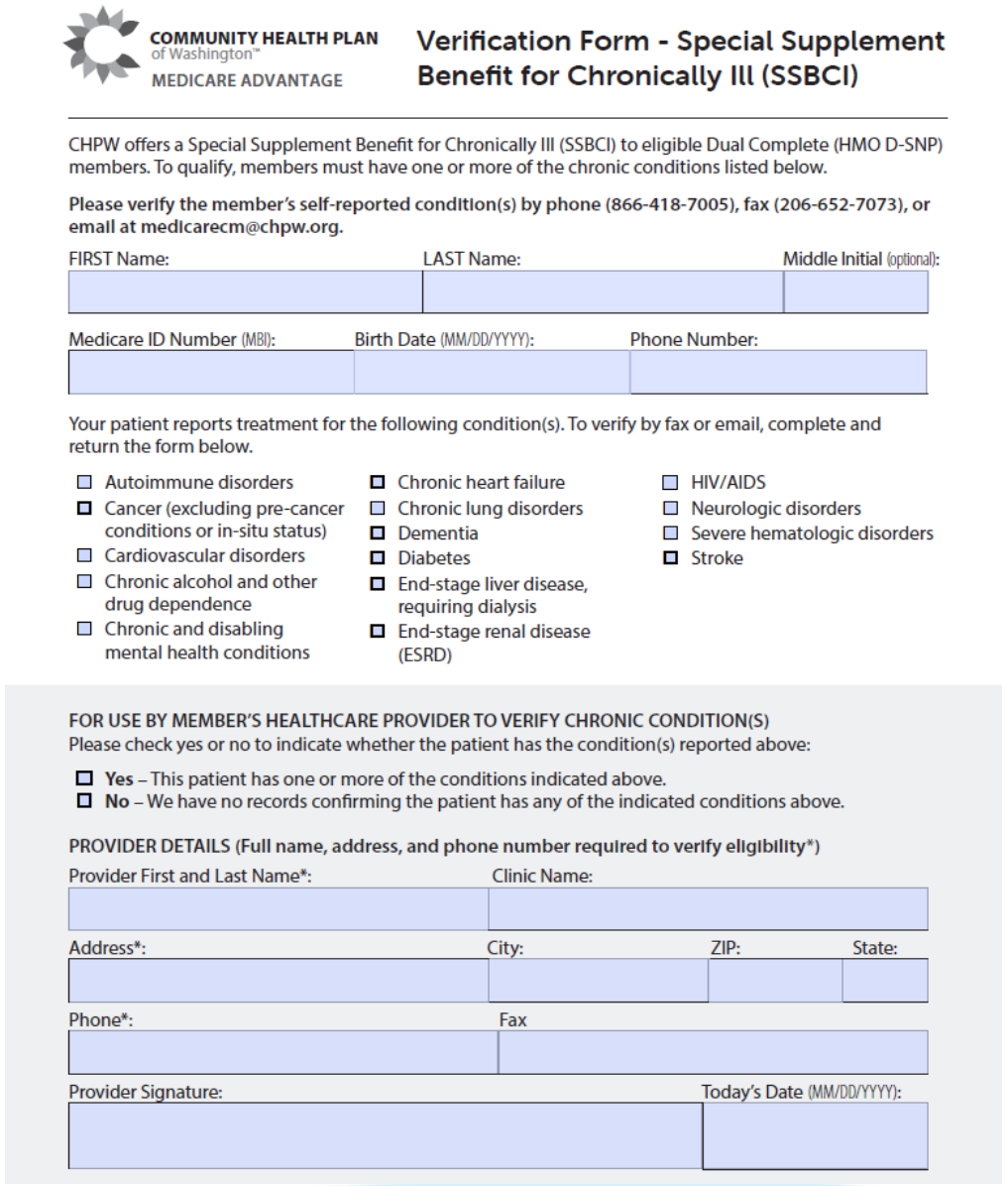
If we cannot contact you or you are unable to verify over the phone, we will fax the SSBCI Verification form to your office.

Verification Form - SSBCI

The SSBCI Verification form will include the member's name, Medicare ID number, date of birth and phone number. We ask that you check **yes** or **no** on the form indicating member's chronic condition status.

If you check **yes**, mark which chronic condition the member has been diagnosed with. Complete the **Provider Details** section and return the completed form via fax to **206-652-7073** or email at **medicarecm@chpw.org.**

Please complete and return the form within 5 business days.



COMMUNITY HEALTH PLAN of Washington™ MEDICARE ADVANTAGE

Verification Form - Special Supplement Benefit for Chronically Ill (SSBCI)

CHPW offers a Special Supplement Benefit for Chronically Ill (SSBCI) to eligible Dual Complete (HMO D-SNP) members. To qualify, members must have one or more of the chronic conditions listed below.

Please verify the member's self-reported condition(s) by phone (866-418-7005), fax (206-652-7073), or email at medicarecm@chpw.org.

FIRST Name: | LAST Name: | Middle Initial (optional):

Medicare ID Number (MBI): | Birth Date (MM/DD/YYYY): | Phone Number:

Your patient reports treatment for the following condition(s). To verify by fax or email, complete and return the form below.

- ☐ Autoimmune disorders
- ☐ Cancer (excluding pre-cancer conditions or in-situ status)
- ☐ Cardiovascular disorders
- ☐ Chronic alcohol and other drug dependence
- ☐ Chronic and disabling mental health conditions
- ☐ Chronic heart failure
- ☐ Chronic lung disorders
- ☐ Dementia
- ☐ Diabetes
- ☐ End-stage liver disease, requiring dialysis
- ☐ End-stage renal disease (ESRD)
- ☐ HIV/AIDS
- ☐ Neurologic disorders
- ☐ Severe hematologic disorders
- ☐ Stroke

FOR USE BY MEMBER'S HEALTHCARE PROVIDER TO VERIFY CHRONIC CONDITION(S)
Please check yes or no to indicate whether the patient has the condition(s) reported above:

- ☐ **Yes** – This patient has one or more of the conditions indicated above.
- ☐ **No** – We have no records confirming the patient has any of the indicated conditions above.

PROVIDER DETAILS (Full name, address, and phone number required to verify eligibility*)

Provider First and Last Name*: | Clinic Name:

Address*: | City: | ZIP: | State:

Phone*: | Fax

Provider Signature: | Today's Date (MM/DD/YYYY):

Part D Coverage

	Tier 1 Pref. Generic	Tier 2 Non-pref. generic	Tier 3 Pref. brand	Tier 4 Non-pref. brand	Tier 5 Specialty	Tier 6 Adherence
Coinsurance	25%	25%	25%	45% of Dual Complete 50% for Dual Select	25%	$0
Max members will pay per Rx at pharmacy	$5.10	$5.10	$12.65	$12.65	$12.65	$0.00
Insulin Costs	N/A	N/A	The lesser of $35 or 25%	The lesser of $35 or 25%	N/A	N/A

*45% cost share in Tier 4 is for Dual Complete members, and 50% cost share is for Dual Select members.

CHPW Contact Guide – Medicare Advantage/D-SNP

Community Health Plan of Washington (CHPW) Medicare Advantage/D-SNP Customer Services

Plan Served

COMMUNITY HEALTH PLAN of Washington™ MEDICARE ADVANTAGE

CHPW Medicare Advantage Plans includes two HMO Dual Special Needs Plans (D-SNP) –

- Dual Complete
- Dual Select

We draw on state and local social services to help members stay healthy in between check-ups.

Receive answers on the following

- Appeals & Grievances
- Claims Status
- Eligibility Verification
- General Information
- Hospital Notifications
- Member Benefits
- PCP Changes
- Prior Authorization Status

Contact Numbers

Customer Service

Phone (800) 942-0247TTY/TDD

Dial relay 711

Fax: (206) 652-7050

Email Customercare@chpw.org

Contact Numbers

Community Support Services

Phone: (866) 418-7006 (TTY/TDD Dial relay 711)

Email: CCSRequests@chpw.org

Care Management Services

Phone: (866) 418-7005 (TTY/TDD Dial relay 711)

Email: caremgmtreferrals@chpw.org
Fax: (206) 642-7073

Medicare Advantage D-SNP Medical Management:

Fax: (206) 652-7065 Hospital Notifications/Discharge; Clinical Records for Review

Fax: (206) 652-7065 Prior Authorization & Referrals; Mom & Baby Admits

Fax: (206) 652-7067 Behavioral Health Authorizations

Individual & Family Plan

Cascade Select

- About Cascade Select
- Service Area
- Plan Levels
- New Hearing Benefit
- Eligibility Requirements & Enrollment
- Hospital Systems
- CHPW Contact Guide – Cascade Select

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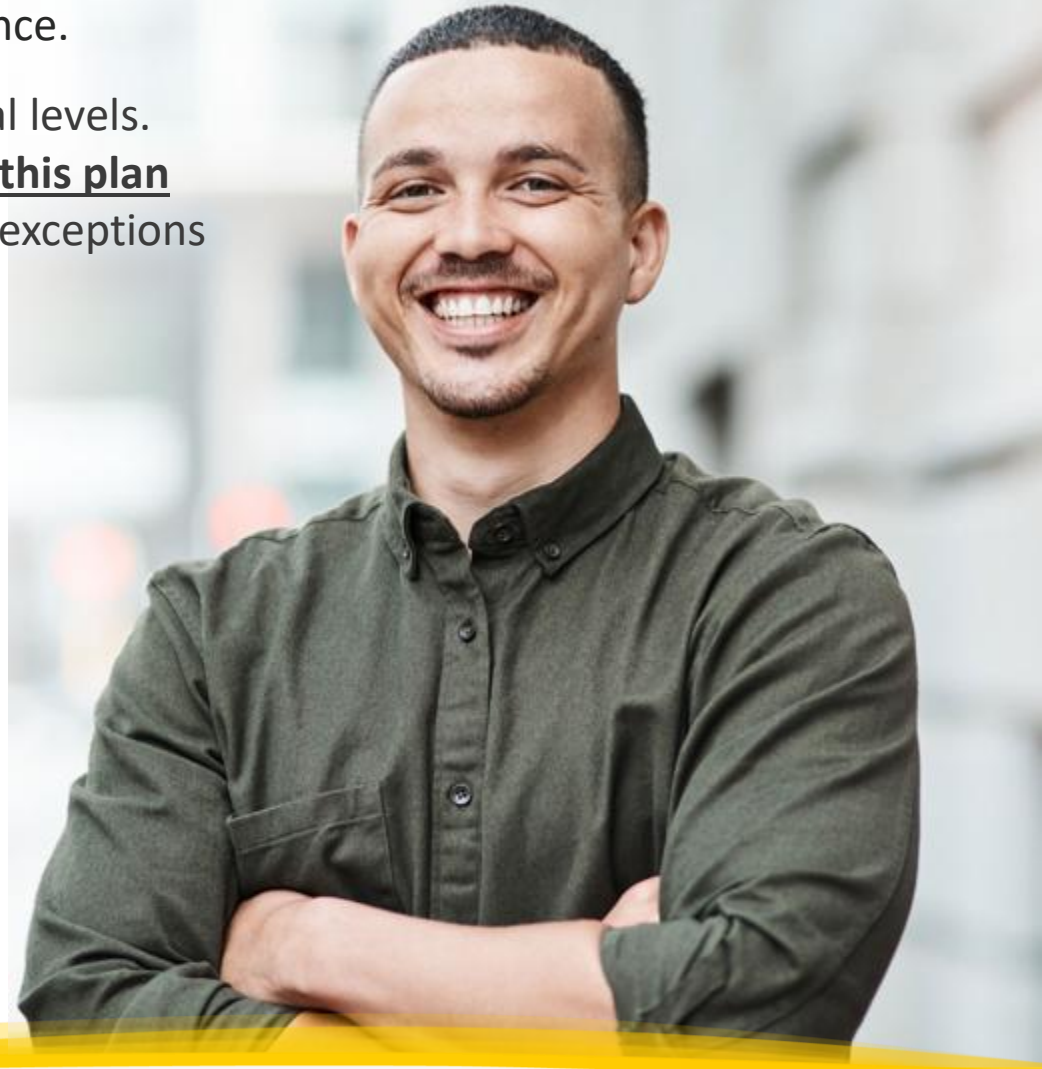
individualandfamily.chpw.org

About Cascade Select

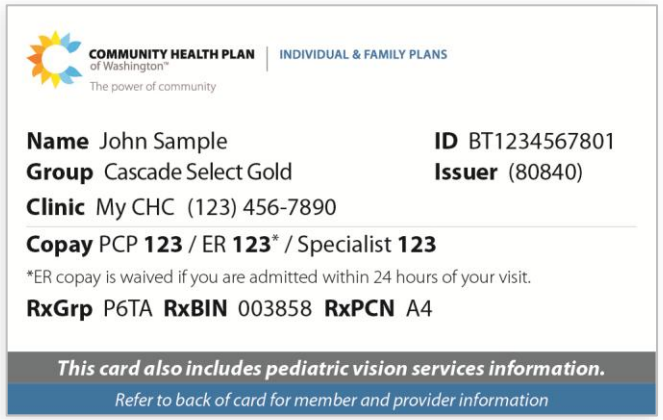
Cascade Care are health insurance plan offerings available on the Washington state health exchange for anyone looking for affordable, quality health insurance.

CHPW Individual & Family Plans offer Cascade Select plans in three metal levels. They are Exclusive Provider Organization (EPO) plans, which means that **this plan covers services only when received by Network Providers**, with limited exceptions such as emergency care.

Available for enrollment on wahealthplanfinder.org



CHPW Cascade Select Member ID: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Name John Sample
ID BT1234567801
Group Cascade Select Gold
Issuer (80840)
Clinic My CHC (123) 456-7890
Copay PCP **123** / ER **123*** / Specialist **123**
*ER copay is waived if you are admitted within 24 hours of your visit.
RxGrp P6TA **RxBIN** 003858 **RxPCN** A4

This card also includes pediatric vision services information.
Refer to back of card for member and provider information


CUSTOMER SERVICE 1-866-907-1906 (TTY: 711).
Member | individualandfamily.chpw.org
LIFE-THREATENING EMERGENCY Call 911 or go to the nearest emergency care facility. Contact your PCP or call CHPW customer service at 1-866-907-1906 within 24 hours.
NURSE ADVICE LINE (NAL) 1-866-418-2920 (TTY: 711).
PHARMACY COVERAGE DETERMINATIONS 1-800-753-2851.
VISION SERVICE PLAN (VSP) 1-800-877-7195.
Provider | individualandfamily.chpw.org/onehealthport
HOSPITAL ADMISSIONS Hospitals must notify customer service within one business day of hospital admissions.
SUBMIT HEALTH CLAIMS CHPW Claims, PO Box 269002 Plano, TX 75026-9002.
SUBMIT RX CLAIMS Express Scripts ATTN: Commercial Claims, P.O. Box 14711, Lexington, KY 40512-4711.
PHARMACY HELP DESK (Pharmacist Use Only): 1-800-922-1557.

Note: *Member ID images are examples; the actual ID cards can list specific regions, or specific plan names.*

Cascade Select Service Plan Area

CHPW Individual & Family Cascade Select will be offered in 26 counties in 2026

Cascade Select members can take advantage of CHPW's statewide network, including:

- **21** Community Health Centers – *includes **200** Primary Care Clinics*
- More than **1,400** primary care providers
- Over **9,700** medical specialists
- Over **4,400** behavioral health specialists
- Over **70** hospitals
- **27** Affiliate Primary Care Centers – includes ***59** Primary Care Clinics*

Cascade Select Information

Important Information for Providers when a Cascade Select member contacts or presents to your office:

Cascade Select members must:

- Receive care from in-network providers

In-network Providers who do not have an agreement with Cascade Select:

- To avoid serving a Cascade Select member as an out-of-network provider, provider staff should always check member/patient eligibility. This way, you will identify what line of business the member is enrolled with CHPW.
- In the event you identify the member is enrolled with Cascade Select, you should ensure that your agreement with CHPW includes this health plan before you render services.

Note: If you do not have an agreement with CHPW that includes Cascade Select, please send a request to add Cascade Select to your agreement by emailing Provider.Contracting@chpw.org

Cascade Select: Plan Levels

All CHPW Individual & Family Plans
(Cascade Select **Gold**, **Silver**, and **Bronze**) cover the same list of medical services.

The cost of deductibles, copays, and coinsurance for each service varies depending on the plan.

Visit our 2026 Cascade Select Plans or contact Customer Service for details, including:

- Services and procedures covered
- Limitations or exclusions
- Out-of-pocket costs
- Summary of Benefits and Coverage (SBC)
- Evidence of Coverage (EOC)

Cascade Select

Individual & Family Plan Hearing Coverage

NEW in 2026!

CHPW's Individual & Family Plans helps to cover hearing instruments, exams and other with services

With this benefit, members get one hearing exam per year, and one hearing aid per ear with hearing loss every three years. Cost-shares may apply.

Hearing exams

One exam per calendar year.

Hearing instruments

Hearing aids or bone conduction devices.

Device setup and support

Fitting, custom molds, and training.

For more information, go to:

Individual and Family Plan Benefits-Resources and Plan Documents/

Different types of hearing instruments are covered, in addition to device setup and support. Cost-shares may apply

Types of hearing instruments:

- Hearing aids (One per ear, per three years)
- Bone conduction hearing devices
- Cochlear implants*

*Cochlear Implants are covered under Rehabilitation Services for adults and children.

Individual & Family Plan – Cascade Select

Eligibility Criteria:

- Must be under the age of 65 (or not otherwise eligible for Medicare or Apple Health, Medicaid)
- Lives in a Cascade Select service area and do not already have employer-provided health care

Open Enrollment: November 1 - January 15

- Folks can sign up for a new health plan or switch plans for the new year, until January 15.
- Folks may qualify for a Special Enrollment Period at any time of year if they experience certain life changes.

Note: Folks that live in the state of Washington can buy health insurance through Washington Healthplanfinder, even if they are an immigrant who is undocumented. Folks do not need U.S. citizenship, a green card, or other immigration papers.

How to Enroll

Over the Phone:

- Call 1-833-993-0181 (TTY Relay: Dial 711)
- Monday through Friday – 8am to 5pm
- State-Licensed experts will help folks enroll through Washington Healthplanfinder, the state's online health insurance marketplace.

Online:

- Enrollment can be done through Washington Healthplanfinder.

Major Hospital Partners Include

(Hospital & Specialty Services Only)

- Cascade Medical Center
- Central Washington Hospital
- St. Michael's Hospital
- Columbia Basin Hospital
- Kittitas Valley Hospital
- Lake Chelan Community Hospital
- Mid Valley Hospital
- MultiCare (All Locations)
- Quincy Valley Medical Center
- Shriners Hospital For Children
- Sunnyside Community Hospital
- Three Rivers Hospital
- Toppenish Medical Center
- Wenatchee Valley Hospital
- Yakima Valley Memorial
- Columbia County Health Systems
- Providence Health & Services
- Morton General Hospital
- Jefferson County Public Hospital District (Facility)
- Mason General Hospital
- Kadlec Regional Medical Center-Facility (All Locations)
- PacMed Clinics (All Locations)
- Swedish Health Services (All Locations)
- St. Luke's Rehabilitation Medical Center (All Locations)
- UW Medicine
- Harborview Medical Center
- Valley Medical Center
- Ferry County Health
- Whitman Hospital
- Pullman Regional Hospital
- Dayton General Hospital
- Othello Community Hospital
- East Adams Rural Healthcare
- Tri-State Memorial Hospital
- Olympic Medical Center
- Forks Community Hospital

CHPW Contact Guide – Cascade Select

Cascade Select Powered by CHPW

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- **Bronze**
- **Silver**
- **Gold**

Cascade Select is an Exclusive Provider Organization (EPO) plans, which means that this plan covers services only when received by Network Providers, with limited exceptions such as emergency care.

Receive answers on the following

- Claims Status
- Eligibility Verification
- General Information
- Hospital Notifications
- Member Benefits
- Prior Authorization Status

Contact Numbers

Customer Service

Phone: (866) 906-1906

TTY/TDD Dial relay 711

Fax: (206) 652-7040

Email: CustomerCare@Chpw.org

Contact Numbers

Community Support Services

Phone: (866) 418-7006 (TTY/TDD Dial relay 711)

Email: CCSRequests@chpw.org

Care Management Services

Phone: (866) 418-7004 (TTY/TDD Dial relay 711)

Email: caremgmtreferrals@chpw.org

Fax: (206) 652-7092

Cascade Select Medical Management

Fax: (206) 652-7078 Prior Authorization & Referrals

Fax: (206) 652-7078 Prior Authorization for Behavioral Health Authorizations

Fax: (206) 652-7078 IP Notification, Admission, Discharge

Claims & Billing

- HCA - NPI Registration
- Timely Filing
- Corrected Claims
- New - Itemized Statement Requirement
- Claims Inquiries/Issues
- Other Health Insurance
- CHPW Billing Guidelines
- Prohibition of Member/Patient Billing
- Fee Schedule/ Rate Updates
- Encounter Data
- Post Payment Review

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HCA Core Provider Agreement - Provider One

NPI Registration

To avoid claims processing and reimbursement delays, **All** individuals and organizations are required to register their NPI number with the HCA as a billing or non-billing provider.

When you enroll a provider, please use the providers start date as the effective date.

How do I enroll:

hca.wa.gov/billers-providers-partners/apple-health-medicaid-providers/enroll-provider#how-do-i

WA Health Care Authority
Contact Information:
Phone: 1-800-562-3022, ext. 16137
Phones are open: Tuesdays and Thursdays from 7:30 a.m. to 4:30 p.m. (Closed from noon to 1 p.m.)
Phones are closed: Mondays, Wednesdays, and Fridays.
Email: providerenrollment@hca.wa.gov

IMPORTANT: CHPW is required to reject/deny claims when providers/organizations NPI numbers are not registered.

Claims - Timely Filing

Timely Filing Requirements

LOB: Apple Health Medicaid, Medicare Advantage and Cascade Select

CHPW maintains the following timely filing requirements for claim submissions:

- CHPW is the **primary payer**: original claim must be received **within 12 months from date of service (DOS).**
- CHPW is the **secondary payer**: original claim must be received **within 12 months from the process date** noted on the primary payer's remittance advice (RA) or explanation of benefits (EOB).
- **Corrected Claims**: must be received **within 24 months of DOS.**

Note: When CHPW is the secondary payer, CHPW follows the primary payors denial/processing policies.

For more information, go to: CHPW Provider Billing & Claims Webpage

Send claims to:
Electronic Claim -
EDI 837 Transaction
Availity Payor ID: CHPWA

Paper Claim – Send to:
CHPW Claims,
PO Box 269002
Plano, TX 75026-9002

Corrected Claims

What is a Corrected Claim:

- A claim that was accepted and finalized (paid or denied).
- The claim is updated with additional information that may potentially impact the payment of the claim.
- **Example:**
  - ❑ The initial claim submission is accepted and contains a single service line. The provider realizes lab charges were omitted from the original claim and submits a corrected claim that contains the original billed services plus the new service lines with the lab charges.

Note: If a claim was previously processed and is not submitted as a corrected claim, it will be denied as a duplicate claim.

Corrected Claims – How to file a Corrected Claim

Electronic:

837P (Professional) Claims: In Loop 2300 (Claim Information), segment CLM05-3, use Claim Frequency Type Code "7" for "Replacement." The corrected claim will process as a replacement claim and reverse the original claim on file.

837I (Institutional) Claims: In Loop 2300 (Claim Information), segment CLM05-3, use Claim Frequency Type Code "7" for "Replacement." The corrected claim will process as a replacement claim and reverse the original claim on file.

Paper:

CMS 1500 (Professional Claim Form): Submit code 7 in box 22.
UB-04 (Facility Claim Form): Submit Type of Bill ending in 7 in field 4 (Type of Bill).

What to include in your mailing:

- CHPW Corrected Claim Cover Sheet
- Attach the corrected claim and supporting documents to the cover sheet and mail to:

CHP Claims
PO Box 269002
Plano, TX 75026-9002

Note: Corrected Claims can also be submitted online through CHPW's HealthMAPS Portal

Itemized Statement Requirement for Claims

Effective **November 1, 2025**, Community Health Plan of Washington (CHPW) requires providers to submit detailed itemizations for all claims with billed charges exceeding $100,000.00.

Why This Matters

This requirement applies to all lines of business and is essential to ensure accurate calculation of outlier payments and to verify that CHPW is reimbursing only those services that are separately reimbursable under applicable Apple Health and Medicare guidelines and program limitations.

REQUIREMENT

This policy supports CHPW's commitment to:

- Ensuring compliance with state and federal reimbursement guidelines
- Promoting transparency in billing practices
- Preventing overpayments
- Ensuring program integrity

Itemized Statement Requirement for Claims

Itemization Format Requirements

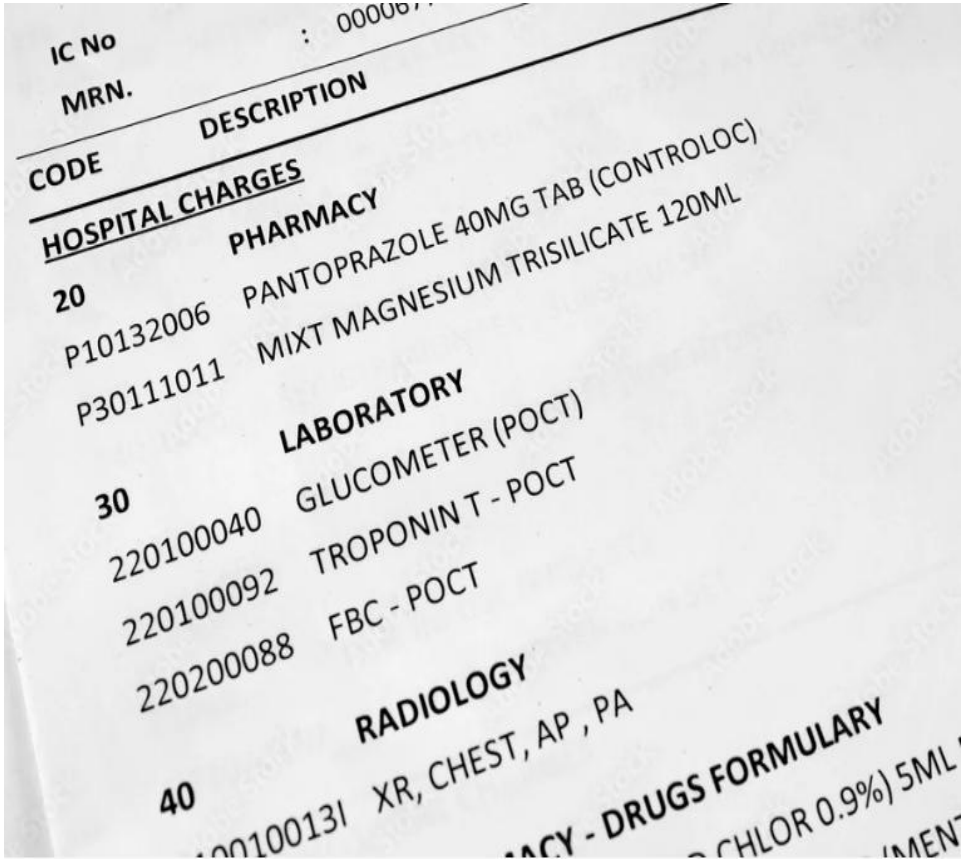
To facilitate efficient review and processing, CHPW strongly prefers itemizations to be submitted in one of the following formats:

- **.**xml
- .csv
- .xls
- .xlsx

Itemizations must:

- Include the claim number(s)
- Clearly outline all billed charges associated with the claim(s)
- Include CPT and HCPC codes where appropriate

Please email itemizations to cs.claimsdistribution@chpw.org. Claims submitted without the required itemization may be delayed or denied pending receipt of the necessary documentation.



Claims Inquiries/Issues

Steps to address Claims Inquiries/Issues

Step 1: Contact Customer Service (CS):

- Phone: (800) 440-1561, or
- HealthMAPS (CHPW's portal)

Step 2: After attempts through CS have been exhausted without resolution:

- Email the Claims Investigation Unit (CIU) at cs.claimsdistribution@chpw.org or fax: 206 652-7009

Following are examples of inquiries that are addressed by Customer Service and the CIU:

- Re-admission issues
- Health Home claims questions
- Applied behavioral analysis (ABA) claims
- Post Payment Review
- ICD-10 billing issues
- Fee schedule issues
- Anesthesia pricing issues
- Recoup/Negative balance issues
- Re-occurring benefit config issues
- Interim billing issues

Claims Inquiries/Issues

How to avoid delays in addressing your claims inquiries/issues:

- ❑ Clearly describe and summarize your inquiries/issues.
- ❑ Clearly outline your disputes – i.e., for FS disputes, include calculations to show how you derived to the expected rate.
- ❑ Include examples (CHPW claim numbers, citations, references, guidelines, etc.)
- ❑ Include your Tax ID
- ❑ Include your contact information (name, email and phone number)
- ❑ Include any other pertinent information that might help address the inquiry/issue

IMPORTANT: Email Subject Line – Please include your clinic/facility name on the subject line before other text is added.

Claims Inquiries/Issues

Expected Turnaround Times:

CHPW does their best to address and respond to your claims inquiries/issues as quickly as possible. Please note the following targeted timelines after you submit a claims inquiry/issue to the following departments (CHPW's Customer Service and CIU):

Customer Service & Claims Investigation Unit (CIU):

- Allow **15-30 days** for a response.
- If you do not receive a response from Customer Service or the CIU within 30-business days, please contact:
  - ❑ Provider Relations Representative
    or
  - ❑ Email Provider.Relations@chpw.org

Note: If you made a phone call to Customer Service and do not have an email correspondence, email your PR Rep the reference number you received for the call, and include the details concerning your inquiry/issue as outlined on the previous slide.

Other health insurance (OHI)

Consider HealthMAPS as the system of truth concerning CHPW members' other health insurance information.

Other health insurance (OHI) information in the state's ProviderOne system may be inaccurate or out of date. CHPW collects, verifies, and then reports other health insurance for our members back to the Health Care Authority via a monthly update file.

View capitation and member roster reports. Providers are in violation of State Code when they refuse to provide services to CHPW members based on TPL information in ProviderOne, HealthMaps and/or etc.

Delaying or stopping a member from receiving healthcare due to private insurance is addressed in WAC 182-501-0200 as follows: A Provider cannot refuse to furnish covered services to a client because of a third-party's potential liability for the services.

Billing Guidelines

CHPW billing guidelines may change over time. To access the most recent guidance concerning the topics below, we encourage providers to Use the resources on our webpage here:

CHPW_Billing Guidelines

- Alternative Treatments Billing Guideline
- Apple Health Dental Services
- Billing and Rendering Taxonomy Requirements
- Circumcision — Apple Health (Medicaid)
- Core Provider Agreement and NPI Status
- Pricing Methodologies
- Primary Care Behavioral Health Billing Updates
- Z Codes as Primary Diagnosis - Denials for RHCs

CHPW's Provider Manual is another resource: CHPW Provider Manual

Billing Guidelines - Behavioral Health Agencies

Service Encounter Reporting Instructions (SERI) are a set of guidelines that help providers report behavioral health service encounters to the Washington State Health Care Authority (HCA). SERI provides information on: When and how to report services, What encounters to report, Program information, Standardized nomenclature for data, and Record documentation guidelines

SERI is used by:

- Apple Health Managed Care Organizations (MCOs)
- Behavioral Health Administrative Services Organizations (BH-ASOs)
- Behavioral health providers in licensed community mental health clinics and licensed behavioral health agencies

Behavioral Health Agencies are reminded to follow the SERI guide for all billing guidance and requirements.

It is important to check SERI frequently as there may be updates that could impact your claims. The link below is v2026 and the effective date is January 1, 2026, unless otherwise specified.

Service Encounter Reporting Instructions v2026

To sign up for SERI updates, go to: Sign-Up for SERI Updates.

CHPW's Provider Manual is another resource: CHPW Provider Manual

Billing Guidelines - Telehealth

CHPW follows regulatory telehealth billing requirements for allowed services.

Billing guidelines currently in place can be found using the links below. Please check for updates routinely.

Telehealth Guidelines:

HCA Telehealth Billing Policies
HCA Apple Health FAQ for BH Provider Billing Telemedicine Services
Medicare Telehealth Billing Policies
Medicare Telehealth Services

Note: While Original Medicare reverted to pre-pandemic limitations for many services as of October 1, 2025, CHPW's Medicare Advantage D-SNP plans will continue to cover telehealth services.

CHPW's Provider Manual is another resource: CHPW Provider Manual

Member/Patient Billing

Apple Health (Medicaid)

Providers are prohibited from billing a patient for the difference between Apple Health reimbursement and the providers billed charges – also known as Balance Billing.

Apple Health (Medicaid)

- Billing is not permitted for covered services.
- Billing is not permitted unless the Provider and Member/Patient fully complete and sign the "HCA 13-879 Form " Agreement to Pay for Healthcare Services."
  - **Examples:** Member/patient wants services rendered that are not covered by Apple Health or maximum services have been exhausted and the member/patient would like to continue services.
- Services must be rendered within 90 days of signing the HCA 13-879 Form, otherwise a new form must be completed and signed
  - For members with limited English proficiency, the agreement must be the version translated in the client's primary language and interpreted if necessary. If the agreement is translated, the interpreter must also sign it.

All other requirements for HCA 13-879 apply, as outlined in "Billing a Client" WAC 182-502-0160

Member/Patient Billing

Medicare Dual-Eligibles

Providers cannot seek payments for cost sharing from D-SNP members for health care services; cost sharing is handled by Medicaid.

- Providers cannot bill D-SNP members for services not reimbursed by Medicaid.
- Medicare cost sharing is paid according to WA state's Medicaid reimbursement logic.
- Medicaid does not reimburse for Medicare cost sharing if the payment has already met or exceeded Medicaid reimbursement methodology.

To help avoid billing CHPW members when prohibited, the member/patient should be registered in your billing system as follows:

- Community Health Plan of WA (Medicare): **Primary**
- Medicaid: **Secondary –**

Note: Medicaid secondary coverage could be through CHPW, another MCO or the State's FFS program. Check Provider One to identify the secondary Medicaid payor.

Fee Schedule/Rate Updates

Throughout any given year, numerous government payer rate changes occur, sometimes with retroactive effective dates.

To improve CHPW claim payment turnaround times in cases where federal and state rate changes do not provide sixty (60) days advance notice, CHPW will implement rate changes on the later of:

- The date that CHPW completed the reconfiguration of its claim system; or
- The published effective date of the new rates provided by the governmental entity.

CHPW uses Medicare and appropriate Medicaid fee schedules for Cascade Select pricing/rates and follow the same protocol for fee schedule updates.

Encounter Data

CMS and HCA require encounter data reporting (EDR) from contracted managed care organizations (MCOs). Data reporting must include all health care, including behavioral health (mental health and substance abuse) services delivered to eligible clients.

Complete, accurate, and timely encounter reporting is the responsibility of each MCO and is critical to the success of the managed care health care delivery system.

For more information and resources, please reference:

- CHPW Provider Manual, under the “Encounter Data” section.

HCA Encounter Data Reporting Guide:

- Managed Care Organizations (MCO)
- Managed Care Third-Party Administrators (TPA)
- Retail Pharmacy (NCPDP)
- Health Home Lead Entities (HH)
- Behavioral Health – Administrative Services Organizations (BH-ASO/ASO)

Post Payment Review (PPR) – Program Integrity Audits

CHPW strives to be stewards of state and federal funding as well as taxpayer dollars. As part of our due diligence to ensure that claims are paid appropriately, we conduct post payment reviews:

Our PPR includes, but is not limited to:

- Medical necessity of the admission and/or procedure(s) performed
- Appropriateness of the treatment setting or length of treatment
- Patient's status upon discharge
- All patient diagnosis-related group (AP-DRG) validation
- General quality of care delivered
- Validation of the procedure(s) and diagnosis codes submitted records

Our goal in conducting PPR is to:

- Educate our provider community on appropriate billing and guidelines
- Ensure we are paying according to our contracts
- Monitor for potential fraud, waste, and abuse (FWA)

Post Payment Review (PPR) – Program Integrity Audits

- CHPW requires providers/facilities provide complete/accurate records timely.
- Retrieval and duplication of records will be at the provider's expense.
- CHPW does not check third party portals or websites for records that were requested for post payment review.
- Providers must notify CHPW when records are ready for retrieval from the third-party vendor.

Should you have any questions concerning PPR requests email:
Operations.Intake@chpw.org

If you disagree with PPR results, please contact the CIU at
cs.claimsdistribution@chpw.org

Provider & Member Appeals

- Member Appeals
- Member Grievances
- Provider Appeals
- Provider Appeals – *Non-Par
- CHPW Contact Guide - Appeals

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Member Appeals

CHPW members have the right to file an appeal.

An **appeal** is when the member wants CHPW to reconsider a decision made about what benefits the plan covers or what will be paid. An appeal can be filed when a service or referral has been denied.

All standard member appeals require the written consent of the member -

- A member can request an appeal verbally.
- A provider may need to submit an appeal on the member's behalf, but we will need to receive written consent before proceeding.
- If an appeal submitted as urgent is determined not to meet medically urgent criteria, written consent will need to be obtained to continue processing the appeal.

Note: The Health Care Authority requires CHPW to obtain written consent for any member appeal that is not determined to be medically urgent.

Appeal Consent Form: Consent Form

Member Grievances

Member Grievance Process

A **grievance** is a complaint that members can file with CHPW if they are not happy with the quality of care or services, problems with getting care, billing issues etc.

The following is what CHPW members can expect after they file a grievance:

- Grievances are kept private.
- Acknowledgement of receipt within two business days.
- Efforts are made to take care of grievances right away.
- Grievance are resolved within 45 days and members are advised how it was resolved.

CHPW members have the right to file a grievance, and they should contact Customer Service for filing:

Phone: 1-800-440-1561 (TTY Relay: Dial 711)
Fax: 206-521-8834
Email: customercare@chpw.org

Member Appeals/Grievances – Apple Health

For more information on member appeals and grievances, you can click on the hyperlinks below:

- Apple Health (Medicaid): Apple Health Member Appeals -Grievances
- Medicare Advantage: Medicare Member Appeals - Grievances
- Cascade Select (individual & family): Cascade Select Member Appeals - Grievances

Provider Appeals – Participating Providers

Participating Providers:

First-level appeals **must be in writing and submitted within twenty-four (24) months** from the date of the notice of denial or initial payment of a clean claim.

Second-level appeal requests must be submitted to CHPW **within sixty (60) days of the first-level decision** and will be reviewed **if new information is provided.**

Physicians and suppliers who have executed a waiver of liability statement are not required to complete the Appointment of Representation (AOR/CMS-1696) form. (*In this case, the physician or supplier is not representing the beneficiary, and thus does not need an AOR)*

Provider Appeals Non-Participating Providers

Non-Participating Providers:

Apple Health (Medicaid)

Non-participating provider appeals must be in writing and submitted within **60 days** from the date of the notice of the denial; or initial payment of clean claim.

Medicare Advantage – D-SNP

Non-participating provider appeals must be in writing and submitted within **60 days** from the date of the notice of the denial; or initial payment of clean claim.

Cascade Select

Non-participating provider appeals must be in writing and submitted within **180 days** from the date of the notice of the denial; or initial payment of clean claim.

New!

Cascade Select appeals/disputes should be filed with the CIU using the following email or fax number:

Email: cs.claimsdistribution@chpw.org
Fax: 206 652-7009

A non-par provider is permitted to file a standard appeal for a denied Medicare claim, but only if the non-par provider completes a "**Waiver of Liability Statement**". This Waiver of Liability statement will not allow the provider to bill the enrollee regardless of the outcome of the appeal.

Provider Appeals

Provider appeals must include:

- CHPW's Appeal Request Form or Letter
- Member name and member ID number
- CHPW Claim number(s) (if applicable)
- Date of service
- All supporting documentation pertinent to the reason for the appeal –
  - Provider/vendor should note which pages are pertinent to the appeal (*especially important when filing with a large number of pages*).
- Reason for requesting the appeal *(please explain/show why you disagree with the Plan's specific reason for denial)*
- A contact from the provider appealing office/vendor – phone/**fax**
- Signed consent (if filing on behalf of a member) – *pre-service*

Note: Incomplete appeals may be rejected and will require the provider to resubmit the appeal following the bullets above to ensure the ability for CHPW to adjudicate the appeal. When an appeal is rejected, it will not be counted as an appeal and the required timelines to file an appeal will be enforced – see required filing timelines on the previous slide

Appeal Request Cover Sheet: Appeal Request Form

Member Consent Form: Consent Form

Provider Appeals

Please do not file an appeal for the following:

- DRG Disputes
- Fee Schedule Disputes
- Refund Requests
- COB
- Post Payment Review (PPR)
- Claims Disputes (*a processed claim with no denied line items*)

Please send the disputes as described and bulleted above to CHPW's Claims Investigative Unit:

Email: cs.claimsdistribution@chpw.org
Fax: 206 652-7009

Email Subject Line: <Provider Group Name> – Tax ID

Provider Appeal Submission Options

Providers may submit appeals using the following methods -

Fax / Email

Methods for filing appeals – fax & email

Apple Health

- Fax: (206) 613-8984 (routine)
- Fax: (206) 613-8983 (clinically urgent)
- Email: Appealsgrievances@chpw.org

Cascade Select - Individual & Family Plans

- Fax: (206) 613-8984 (routine)
- Fax: (206) 613-8983 (clinically urgent)
- Email: Appealsgrievances@chpw.org

Medicare Advantage & D-SNP

- Fax: (206) 652-7010 (routine)
- Fax: (206) 652-7011 (clinically urgent)
- Email: Appealsgrievances@chpw.org

No more…

Provider Responsibilities

- Provider Rights
- Provider Responsibilities
- Credentialing
- Provider Data
- Appointment Availability & Wait Times
  - ❑ Appointment Access Standards
  - ❑ Emergency Care
  - ❑ After-Hours Access Standards
  - ❑ Annual Appointment and After-Hours Access Reviews
  - ❑ Best Practices
  - ❑ Interpreter Services
  - ❑ Transportation Services
- Clinical Data Repository (CDR)

Provider Rights

- To be treated with dignity and respect by our members.
- To receive accurate and complete information/medical history for the members' care.
- To expect members to follow treatment plans and protocols.
- To file a complaint or appeal against CHPW and/or a member.
- To file a grievance on behalf of a member (with member consent).
- To have access to CHPW's Quality Improvement Program, including goals, activities, and outcomes that relate to the members care/services.
- To collaborate with other health care professionals who are involved in the care of the member.
- To have access to Provider Relations and/or Customer Service staff for issues, concerns, or questions.

Provider Responsibilities

The following includes a partial list of provider responsibilities as outlined in CHPW's provider manual:

- Inform members of their right to self-refer for certain services.
- Provide or arrange interpretive services for members who are hearing impaired or who's primary language is not English.
- Obtain informed consent from the member or from a person authorized to consent on behalf of the member, prior to treatment.
- Inform members of their right to file a grievance and how to do so. In the case of a member grievance regarding behavioral health services, offer the assistance of the Behavioral Health Ombuds in the region where the member resides.
- Utilize research-based practices for individuals, including those with a co-occurring mental health and chemical dependency diagnosis.
- Provide adult members with written information about advance directives and the right to make anatomical gifts.
- Assist members in receiving health care services not covered by CHPW.
- Must not be excluded or sanctioned by the Office of Inspector General (OIG) and the General Services Agency (GSA).

For additional details concerning Provider responsibilities: CHPW Provider Manual

Provider Credentialing

Provider credentialing is a regulatory requirement. CHPW follows policies and procedures in accordance with CHPW, NCQA, CMS State credentialing requirements.

- CHPW accepts the Washington Practitioner Application (WPA) and participates in CAQH.
- CHPW notifies providers via email when credentialing is completed.
- CHPW will not backdate credentialing effective dates.
- CHPW follows HB1552.
- Claims will be paid back to the date the *completed* application is received, or the date the provider started at the clinic, whichever is later.
- Re-credentialing is required every 3-years, notice will be sent **5-months** in advance.

Send your new credentialing staff contact information to:

Email:
Provider.Credentialing@chpw.org

Email:
Provider.Relations@chpw.org

Provider Credentialing

Please follow the steps below to initiate provider credentialing:

Standard Credentialing:

For new provider credentialing:

- CHPW uses CAQH for a credentialing vendor – please email CHPW's credentialing department and advise that your providers WPA is available on CAQH.

or

- Email a completed provider WPA to CHPW's credentialing department

Standard Credentialing Email:
Provider.Credentialing@chpw.org

Delegated Credentialing Email:
DelegatedCredentialing@chpw.org

Delegated Credentialing:

- Follow the requirements per your delegated credentialing agreement.
- To avoid claims issues, submit Rosters timely and include required information – *complete all fields on the roster*.

Note: *Credentialing can take up to 60-90 days to complete. If the providers credentialing file is not clean, it may take longer.*

Provider Credentialing

To request a credentialing status:

- Email CHPW's credentialing department and include the following:

  Subject Line: <Provider Group Name> – Status Check

  Body of email:

  - ❑ Group Name
  - ❑ Group Tax ID
  - ❑ Provider Name
  - ❑ Provider NPI

Standard Credentialing Email:
Provider.Credentialing@chpw.org

Delegated Credentialing Email:
DelegatedCredentialing@chpw.org

If you do not receive a response within 5 business days from the credentialing team, you can email Shawna Backman, Credentialing Supervisor: Shawna.Backman@chpw.org.

In the event you need to follow up with Shawna Backman, please use the email you sent to Provider.Credentialing and **forward** it to Shawna or attach it to your email.

Provider Data Services – Quality Assurance

Network providers should provide accurate and timely provider and group information including, but not limited to:

- Tax ID – changes/updates
- NPI Number – individual and/or group
- Billing address – changes/updates
- Office phone and fax numbers
- Provider terminations (include provider date of termination)
- Clinic/facility locations – adding a location, changing a location (include start and/or end dates)
- Provider Open/Close panel status for new members/patients
- Clinic Contacts & Information (names/emails/phone #'s) – i.e., Office Managers, Billing Managers/Staff, Credentialing Coordinators – other key contacts

CHPW's goal is to ensure that provider changes/updates are completed accurately and timely to avoid claims delays/issues. It is also important that CHPW's provider directory is up to date.

Provider Data Services – Quality Assurance

A 60-day notice is required when changes/updates are requested.

CHPW needs this time to complete updates that include, but are not limited to:

- Provider profile system updates
- Claims processing system updates
- Notify members of provider availability changes
- Update CHPW's provider directory

Provider changes/updates should be reported to CHPW by completing a:

1. Provider Add/Change/Term Form
2. Clinic and Group Add/Change/Term Form

or

3. Submit an email to Provider.Changes@CHPW.org by following the steps below:
   - **Email Subject Line**: Name of Group/Organization – Tax ID
   - **Body of Email** (at minimum):

- ❑ Include a clear summary of the updates/changes/adds etc. that you are requesting
- ❑ Include applicable provider names, credentials, NPI #'s (Individual and/or Group)
- ❑ Include service locations (addresses & phone numbers)
- ❑ Billing/Pay To address and phone number
- ❑ Include desired effective dates
- ❑ Include your contact information – Name, Phone and Email.

Provider Data Services – Quality Assurance

You can find the forms here https://www.chpw.org/provider-center/forms-and-tools/, and under Provider Updates there are three (3) options to submit the form:

- PDF form can be emailed to: Provider.Changes@chpw.org
- Excel form can be emailed to: Provider.Changes@chpw.org
- On-line form is available here: Provider Updates- Changes Online Form

Our customer service team can help you with questions regarding any of CHPW's forms – Customer Service 800-440-1561

CHPW makes every effort to process your provider or clinic changes or updates within 30-60 days from the date you submit your requests. To status your requests, you can:

- Email Provider.Changes@chpw.org - Please wait for at least 30-days to request a status.

Appointment Access Standards

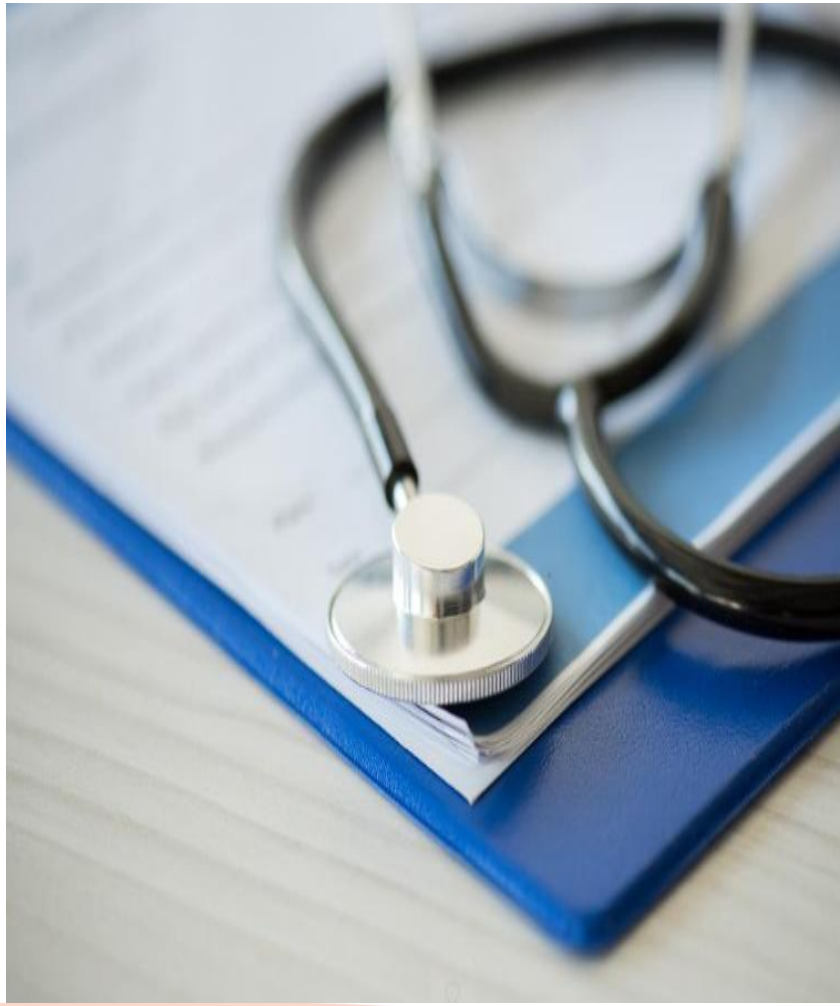
Access to care means **a patient has the ability to see a qualified health provider within a reasonable period of time**.

Access standards have been developed to ensure that all health care services are provided in a timely manner.

Access to transportation, and language services are important to ensure adequate access to care.

Note:

- Phone pick up time should be no longer than 10-seconds
- Office waiting time for scheduled appointments:
    - If a provider is delayed, the patient should be notified
    - Not to exceed sixty (60) minutes
    - If wait time exceeds ninety (90) minutes, the patient should be offered a new appointment.



Appointment Access Standards – ALL Providers

Type of Appointment	Scheduling Time Frame
All Providers	
Emergency Care	Immediately, and available 24/7
Transitional visit (clinical assessment or care planning)	Within seven (7) calendar days of member's discharge from an inpatient or behavioral health facility or substance use disorder treatment program.
Second Opinion	Within thirty (30) calendar days of the request unless the Enrollee requests a postponement of the second opinion to a date later than thirty (30) calendar days.

Appointment Access Standards – PCP, OB/GYN, Midwife

Type of Appointment	Scheduling Time Frame
PCP, OB/GYN, Midwife	
Preventative office visit - non-symptomatic	Within thirty (30) business days
Non-urgent routine office visit - symptomatic	Within seven (7) business days
Urgent office visit - symptomatic	Within twenty-four (24) hours

Appointment Access Standards – Behavioral Health

Type of Appointment	Scheduling Time Frame
Behavioral Health Providers	
Care for a non-life-threatening emergency	Within six (6) hours
Urgent office visit - symptomatic	Within twenty-four (24) hours
Non-urgent routine office visit - symptomatic	Within seven (7) business days
Follow-up, routine care	Within thirty (30) business days

Appointment Access Standards - Specialists

Type of Appointment	Appointment Wait Time Standards
Specialty Care Providers	
Specialty Care	Within thirty (30) business days

Specialists should provide the member's PCP with a written report within 14 days of the date of service regarding the proposed plan of treatment, including any proposed hospitalization or surgery and information regarding self-referred services such as women’s health care services.

Emergency Care

Emergency Care shall be available 24 Hours a Day, Seven Days a Week

CHPW providers are required to maintain access to health care services on an ongoing basis and shall ensure that services are available to members 24 hours per day, seven days per week.

Provider offices must answer the phone during normal business hours. After normal business hours and on weekends, a provider must have:

- A covering provider.
- An answering service.
- A triage service or voicemail message that provides a second phone number that is answered. For example, behavioral and mental health providers should include a crisis center phone number on their answering machine.
- Any recorded message must be provided in English. If the provider's practice includes a high population of Spanish speaking members, the message should also be recorded in Spanish.

After-Hours Access Standards

Provider Types: PCP, OBGYN, Midwife, Specialist, Behavioral Health

After-hours requirements:

1. Must have an answering machine or on-call service – *call pick up within 10 seconds.*
2. Must have an on-call provider available

After-hours messaging requirements (live answering service or answering machine):

1. "If this is an emergency, hang up and dial 911"

2. How to contact an on-call provider messaging examples -
   - "This is how to contact our on-call provider, dial ……."
   - "I will connect you to our on-call provider now"
   - "I will have our on-call provider contact you within 30-minutes"
   - "Please contact the nurse line at……"

3. Behavioral Health Providers – after-hours messaging should also include 988 and a crisis center phone number

After-Hours Access Standards

- Physicians (PCPs, Behavioral Health Providers, OB/GYN, Midwife, Specialists, or covering physicians) are required by contract to provide 24 hours a day, 7 days per week coverage to CHPW members.
- Physicians, or his/her on-call coverage or triage/screening clinician must return urgent calls to member, upon request within 30 minutes.
- Clinical advice can only be provided by appropriately qualified staff, e.g., physician, physician assistant, nurse practitioner or RN.

Annual Appointment and After-Hours Access Reviews

- It is a regulatory requirement for health plans to have monitoring procedures in place to accurately measure the accessibility and availability of contracted providers.
- CHPW conducts annual appointment access and after-hours reviews as required by regulatory and accreditation agencies.
- The purpose for conducting these annual reviews is **to ensure compliance with the Health Care Authority (HCA), CHPW and accreditation agency standards for timely access to care**.

Best Practices | Meeting Access Requirements

- Review and educate staff on Access standards and policies on a quarterly basis and/or as needed.
- Open more appointment time slots to accommodate patients.
- Allot time for walk-ins and same day appointments.
- Offer telephone or video appointments as applicable to the patient's condition.
- Take the time to ensure that the person(s) in charge of appointment scheduling understand Access standard requirements.
- Periodically check your after-hours answering machine and/or answering service to ensure it meets 911 messaging and on-call provider requirements.

Interpreter Services

Apple Health (Medicaid)

Language services are covered by the HCA through Universal Language Service. For additional information about this interpreter services program, please visit HCA's Interpreter Services Webpage

To access **Lionbridge** on demand over-the-phone interpretation:

- Dial: 1 855-461-1323 (Toll Free)
- Department Code: 60

CHPW Medicare Advantage D-SNP

To access **Lionbridge** for on demand over-the-phone interpretation:

- Dial: 1 855-461-1323 (Toll Free)
- Department Code: 60

Cascade Select

To access **Lionbridge** for on demand over-the-phone interpretation:

- Dial: 1 855-461-1323 (Toll Free)
- Department Code: 60

Interpreter Services

Apple Health Expansion (AHE)

CHPW provides in-person, virtual, and over-the-phone Interpreter services. Providers/Clinic staff are responsible to ensure your patient is an AHE member to utilize the following services. This is free of charge.

To access **Language Line** Interpreter Services:

- Dial: 1 888-225-6056 (Toll Free)
- Select Option 1
- Enter Client ID: 705722
- Enter Fund Code: Member's CHPW ID Number

To access **Lionbridge** on demand over-the-phone interpretation:

- Dial: 1 855-461-1323 (Toll Free)
- Department Code: 11

Please note that all in-person and virtual appointments must be made at least two hours in advance. Cancelation of in-person and virtual appointments must be done with at least one full business days' notice.

Note: If you have questions regarding language assistance for CHPW members, please contact Customer Service at (800)-440-1561.

Transportation Services

The Washington State Health Care Authority (HCA) covers transportation for individuals who otherwise have no means to access medical care. This includes:

- Public transit bus
- Gas vouchers
- Client and volunteer mileage reimbursement
- Taxi rides
- Wheelchair van or accessible vehicles
- Commercial bus and airfare
- Ferry tickets

HCA Transportation Directory

If your patients are having trouble connecting with a transportation provider for any reason, please advise your patients to contact CHPW at **1-800-440-1561** (TTY Relay: Dial 711).

Clinical Data Repository (CDR)

What is the Clinical Data Repository?

A Clinical Data Repository or CDR is a database designed to collect and index clinical content for specific uses.

The Health Care Authority (HCA) has advanced Washington's capabilities to collect, share, and use integrated **physical and behavioral health** information from provider's Electronic Health Record systems (EHRs) by implementing the Washington Link4Health Clinical Data Repository (CDR).

Note: This requirement does not apply to SUD treatment providers.

WASHINGTON Link4Health

The Strategy: Advance Health IT Beyond Organizational EHR's with a CDR:

- The WA Link4Health initiative is part of the State's long-term efforts to improve health care quality, better manage costs and improve health outcomes for all Washingtonians.
- HCA initiated Washington Link4Health, a multi-year initiative to advance the statewide electronic exchange of near real time, consolidated clinical records.

CDR Features and Benefits

Features

- Leverages standards for sharing clinical summaries
- Supports clinical data exchange with organizations without similar platforms
- Offers common place to share information for those participating in different arrangements
- Aggregates clinical and administrative data into longitudinal patient record
- Available beyond Medicaid

Benefits

- May help providers meet ongoing Meaningful Use Objectives and qualify for additional incentive payments
- Provides the care team a more comprehensive understanding of the patient's medical history.
- Provides mainstream quality reporting capabilities
- Enables large data extracts for advanced analytics and population health

OneHealthPort | CDR

HCA has partnered with OneHealthPort to develop and manage the CDR. Please see the HCAs CDR FAQ's here: HCA CDR FAQs

- The OneHealthPort Clinical Data Repository (CDR) is a patient-centric database that collects clinical data from many sources across the community.
- The CDR is designed to simplify access to clinical history and provide a longitudinal view of an individual's patient record.
- The healthcare community contributes clinical data and can view data through a Clinical Portal to see what is available from other providers to better coordinate and enhance care delivery.
- This service is being offered in response to the growing need to aggregate and access clinical information from diverse electronic health record (EHR) systems.

OneHealthPort | CDR

To use the OneHealthPort CDR, your organization must be registered with the OneHealthPort SSO and have a OneHealthPort Health Information Exchange (HIE) Participation Agreement.

- **If your organization does not have an SSO account,** learn how your organization can register at https://www.onehealthport.com/sso/register-your-organization.
- **Don't know if your organization is already a participant** with the OneHealthPort HIE? Check the Participant List at https://www.onehealthport.com/hie/participants.
- **To become a participant** with the OneHealthPort HIE, go to https://www.onehealthport.com/hie/contracting.
- **For more information and to learn more** about the steps that need to be taken to participate in CDR please visit the Washington State Health Care Authority's CDR website, hosted by OneHealthPort, at http://www.onehealthport.com/hca-cdr.

OneHealthPort | CDR

- **For assistance** contact the OneHealthPort help desk at 1.800.973.4797 (toll free) 24 hours a day, seven days a week. You can also contact them with your questions by submitting a form at: https://onehealthport.formstack.com/forms/contact_us

- **Users can complete training** in one hour or less and reference materials are available on the OneHealthPort website at: https://www.onehealthport.com/.

- **Providers with certified EHRs seeing Apple Health Managed Care members** must send a Consolidated Clinical Document Architecture (CCDA) summary from the provider's EHR to the CDR.

**C-CDA stands for Consolidated Clinical Document Architecture.

CDR Participation Criteria

If you/your organization meet(s) the following criteria, you are required to participate in the CDR:

- Your organization is part of a Managed Care Organization that serves Apple Health consumers;
- Your organization has a 2014 certified EHR system; and,
- You have received monies from either the Medicare or Medicaid EHR Incentive Program

Note: Substance use disorder providers are not required to submit CCDA to the CDR.

**C-CDA stands for Consolidated Clinical Document Architecture.

Important: Providers who meet participation criteria but are not submitting CDR data as required by the HCA, should contact **Provider.Relations@chpw.org** and request a meeting to discuss participation status.

Health Services Utilization Management

- Referral Management
- Prior Authorization
- Clinical Criteria - Prior Auth for Services
- Clinical Criteria – Behavioral Health Services
- Prior Authorization Timelines
- Prior Authorization – Emergency Services
- Inpatient Notification and ETR
- Concurrent Review & Discharge Planning
- CHPW Benefit Grids

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Referral Management

A referral is a primary care provider's written statement of intent to refer a member to a specialist or other provider types.

Apple Health (Medicaid), Medicare Advantage D-SNP:

- CHPW changed its policy on non-participating referral requirements in 2019 to decrease administrative work for our providers and facilitate faster appointment times for our members.
- An approval from CHPW to refer a member to a participating and/or non-participating specialist provider is not required.

  Note: Even though CHPW does not require a referral or an approval for its members to receive care from specialist providers, many specialist groups require a referral from the members PCP before an appointment can be scheduled. PCPs should help CHPW members get the care they need by providing timely referrals and helping to coordinate care.

Cascade Select:

- Members must seek care from a participating provider.

All providers must adhere to prior authorization requirements and obtain approval for applicable services.

Referral Management

Referrals that require pre-approval from CHPW:

PCP to PCP Referrals:

- A Plan referral is a pre-approval required for members to schedule visits for care with a PCP outside of their assigned PCP or group.
- CHPW must be notified and approve PCP to PCP referrals to avoid claim denials.

PRC Members:

- PRC is an HCA controlled program designed to control overutilization and inappropriate use of medical services by members.
- Members who are in the Patient Review and Coordination (PRC) program are restricted to one PCP, pharmacy and hospital. *Members in PRC must go to these providers only*.
- CHPW must be notified and approve referrals for members to seek care outside of the PRC program.
- For more information go to: Patient Review and Coordination Program

Prior Authorizations

To access CHPW's Prior Authorization List and Utilization Guidelines, go to:
CHPW Provider Center - Prior Authorizations

For questions or assistance with an authorization, contact CHPW at:
Customer Service: (800) 440-1561

To access CHPW's Procedure Code Lookup Tool, go to:
Procedure Code Lookup Tool

The Procedure Code Lookup Tool is not intended to replace the use of the Prior Authorization list, nor is the tool necessarily complete. Providers should only use this tool as a supplement to and after first consulting the Prior Authorization list.

Clinical Criteria – Prior Authorization for Service

Apple Health (Medicaid) - CHPW looks first to clinical criteria established by the Health Technology Assessment (HTA) Program of the Health Care Authority (WAC 182 55 055).

- ❑ If no HTA exists for a service, CHPW then reviews against our internal Clinical Coverage Criteria (CCC) or national MCG guidelines if no CCC exists.

For more information, go to:
Apple Health - Physical Health - PA and Clinical Criteria

Medicare Advantage D-SNP - CHPW utilizes the Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs).

- ❑ If no NCD or LCD exists for a service, CHPW then reviews against our internal Clinical Coverage Criteria (CCC) or national MCG guidelines if no CCC exists.

For more information, go to:
Medicare - Physical Health - PA and Clinical Criteria

Clinical Criteria – Prior Authorization for Service

Cascade Select – CHPW utilizes MCG, LOCUS, CALOCUS and ASM

For more information, go to:
Cascade Select - Physical Health - PA and Clinical Criteria

Behavioral Health

Clinical appropriateness and the medical necessity of behavioral health services requested are based on criteria guidelines used.

CHPW uses **ASAM** (American Society of Addiction) criteria for substance use disorder services or **LOCUS** (Level of Care Utilization System) *or* **CALOCUS** (Child and Adolescent Level of Care Utilization System) for mental health services.

For more information, go to:
Apple Health - Behavioral Health - PA and Clinical Criteria
Medicare - Behavioral Health - PA and Clinical Criteria
Cascade Select - Behavioral Health - PA and Clinical Criteria

Prior Authorization Determination Timelines

Apple Health (Medicaid):

- Standard portal requests 3-14 calendar days and standard fax requests 5-14 calendar days. Clinically urgent requests 1-5 days. Timeline dependent on clinical documentation being submitted with the request.

Medicare Advantage D-SNP:

- Standard prior authorization requests are processed within 14 calendar days. Clinically urgent requests are processed within 72 hours.

Cascade Select:

- Standard portal requests 3-14 calendar days and standard fax requests 5-14 calendar days. Clinically urgent requests 1-5 days. Timeline dependent on clinical documentation being submitted with the request.

Note: Documentation to support medical necessity must be submitted with Prior Authorization requests.

Prior Authorization – Emergency Services

Emergency services do not require prior authorization and are defined as:

Psychiatric:

- When the patient is a danger to them self, others, or is gravely disabled.

Medical:

- A medical condition with acute symptoms of sufficient severity that the absence of immediate medical attention may result in placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, or serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

Inpatient Notification and ETR

Inpatient Admission Notification

- Must be provided by Facilities within 24 hours or the next business day after an admission.
- To access CHPW's Inpatient Admissions Form: CHPW Inpatient Admission Form

Exception to Rule (ETR)

- An Apple Health (Medicaid) member and/or the member's provider may request CHPW pay for a non-covered health care service.
- Can be requested within 90 days of the denial notification but **must be requested prior to the service being rendered.**
- To access CHPW's Exception to Rule Form: CHPW ETR Form

Retro Authorizations

- CHPW will not process retro authorizations or referrals.

Concurrent Review – Discharge Planning

Concurrent Review

- During the inpatient hospitalization, the member's clinical progress is reviewed by the CHPW clinical team using clinical criteria approved by CHPW.

Discharge Planning

- Discharge planning needs are identified through the concurrent review process or by referral from someone on the member's care team.

Note: No referrals or authorizations are required for treatment in an Emergency Room.

CHPW Benefit Grids

Access the links below to learn more about program benefits, copays, and more:

2025 Apple Health Integrated Managed Care

- Apple Health Benefit Grid

2026 Medicare Advantage and Dual Eligible Special Needs Plan (SNP)

- Medicare Benefit Grid

2025 Behavioral Health *Only* Benefit Grid

- Behavioral Health Benefits

2026 Cascade Select

- Cascade Select Benefit Grid

Note: CHPW's *2026* Benefit Grid will be available after January 1, 2026.

You can access CHPW's Provider Manual to pull the benefit grids listed above at:
CHPW Provider Manual

Health Services Care Management

- What is CHPW Care Management
- Care Management Services
- Coordinate Services, Solutions, and Resources
- Apple Health – Health Homes
- Contact Care Management

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Care Management

CHPW Care Management:

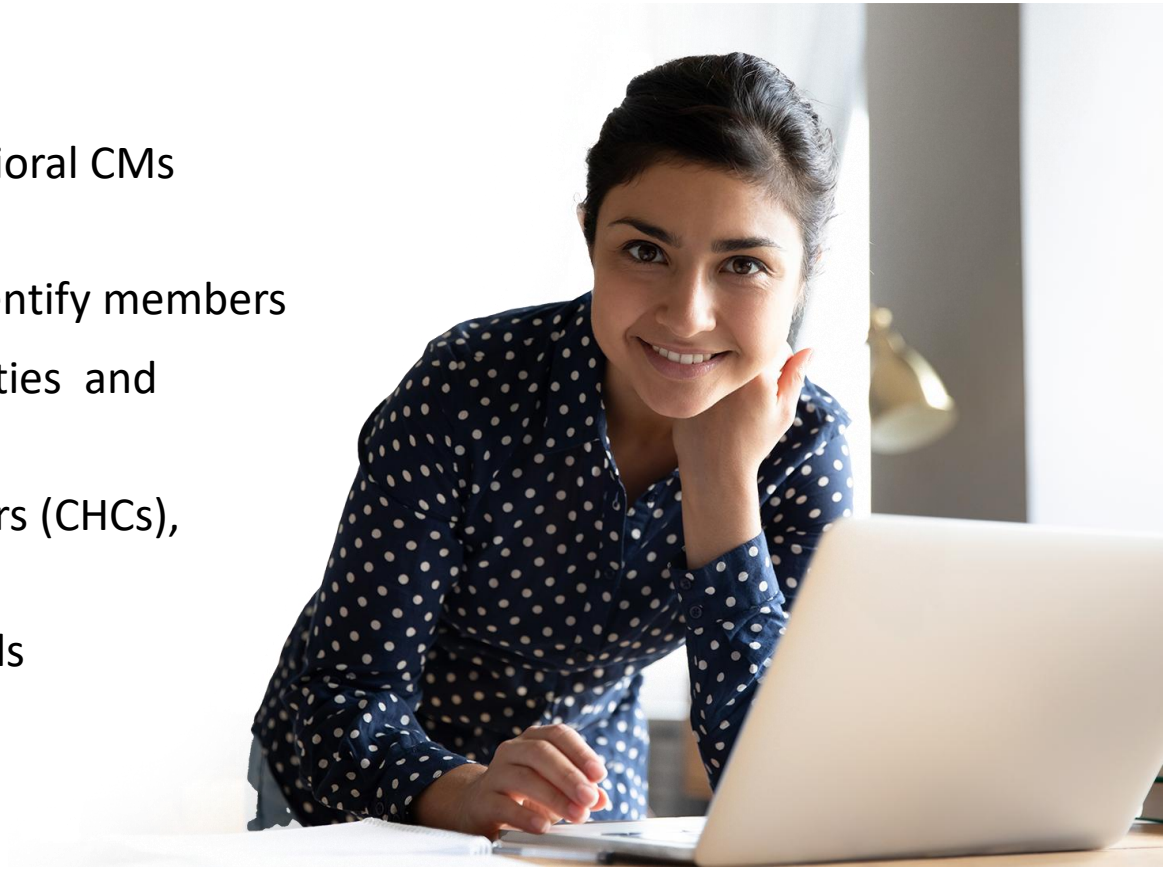
Focused on the whole person: teams include medical and behavioral CMs working side-by-side

Data-driven: uses real-time, predictive and pattern analysis to identify members

Consumer-centric: care plans designed to address member priorities and concerns

Community-based: fully integrated with community health centers (CHCs), behavioral health providers and resources

Regionally focused: regional teams to best support member needs



Care Management Services Available to All

Although CHPW Care Management team is available to support all members, there are specialty care management programs as follows:

- **Autism/Applied Behavioral Analysis (ABA)**
  - Assist with needs associated with Autism and therapies associated with Autism Spectrum Disorder.
  - To request ABA therapy, call the ABA line at 1-844-225-8624.
- **Bariatric**
  - Support members through the bariatric surgery process including coordinating care with providers for the prior authorization process.
- **Children's Mental Health**
  - Case Manager assist in navigating behavioral health needs for children and their families. Including navigation and admission into WISe or CLIP.
- **LGBTQ+ Health**
  - Support members through medically necessary gender affirming treatments and connect members with community resources for support.
- **Healthy You, Healthy Baby**
  - Provide support to members before, during and after pregnancy.

Care Management Services Available to All

Specialty care management programs, **Cont'd**

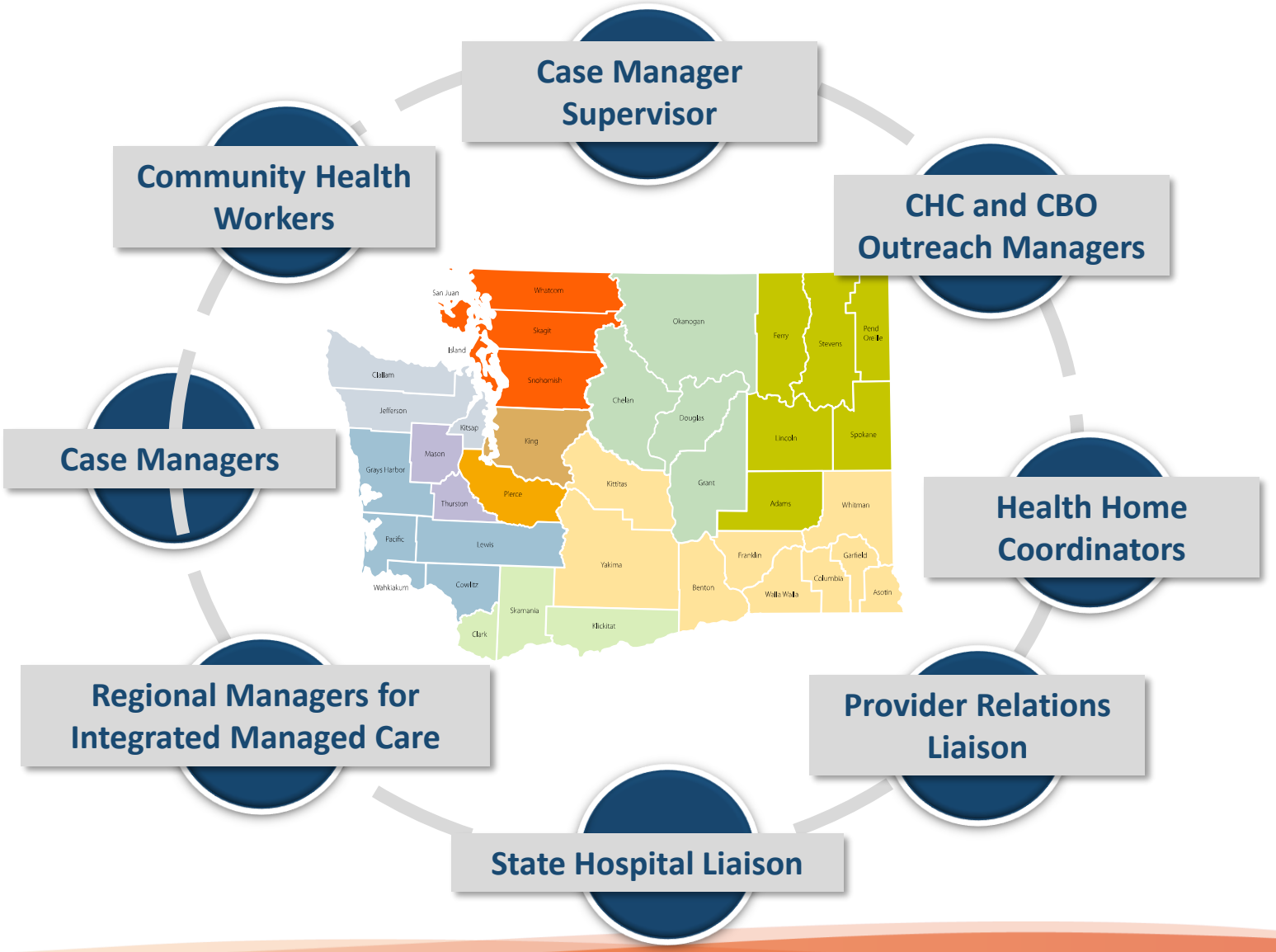
- **Patient Review and Coordination (PRC)**
  - Coordinate care for members with high utilization of opioids and services.
- **Transitional Aged Youth**
  - Care Management for 15-26 year old members navigating adolescent to adult and in need of physical, behavioral health needs or community connections for housing, education, or employment services during these transitional years.
- **Jail Transitions**
  - Coordinate with the jail and justice involved individuals as a release date approaches to ensure continuity of care for the member.
- **Complex Discharge**
  - Coordinates care for medically stable for a lower level of care but there are barriers to discharge.
- **Diabetes Care Program**
  - Health Coaches and Case Managers support members with pre-diabetes, type 1 and type 2 diabetes.
- **Dual Special Needs Plan**
  - Support members that are dual eligible for Medicaid and Medicare

CHPW Regional Teams

- Clinical and non-clinical staff serving members, providers, community partners across all lines of business
- Meet weekly and know regional cultures and resources, and can connect across the state
- Can make decisions quickly

These teams work with all our partners to advance health equity

Coordinate Services, Solutions, and Resources



Health Homes

CHPW is a Qualified Health Home Lead Entity

- Health Homes establishes services for Apple Health, Fee-For-Service and DSNP members with complex and high service needs

Health Home services provided by CHPW's Care Coordination Organization network include:

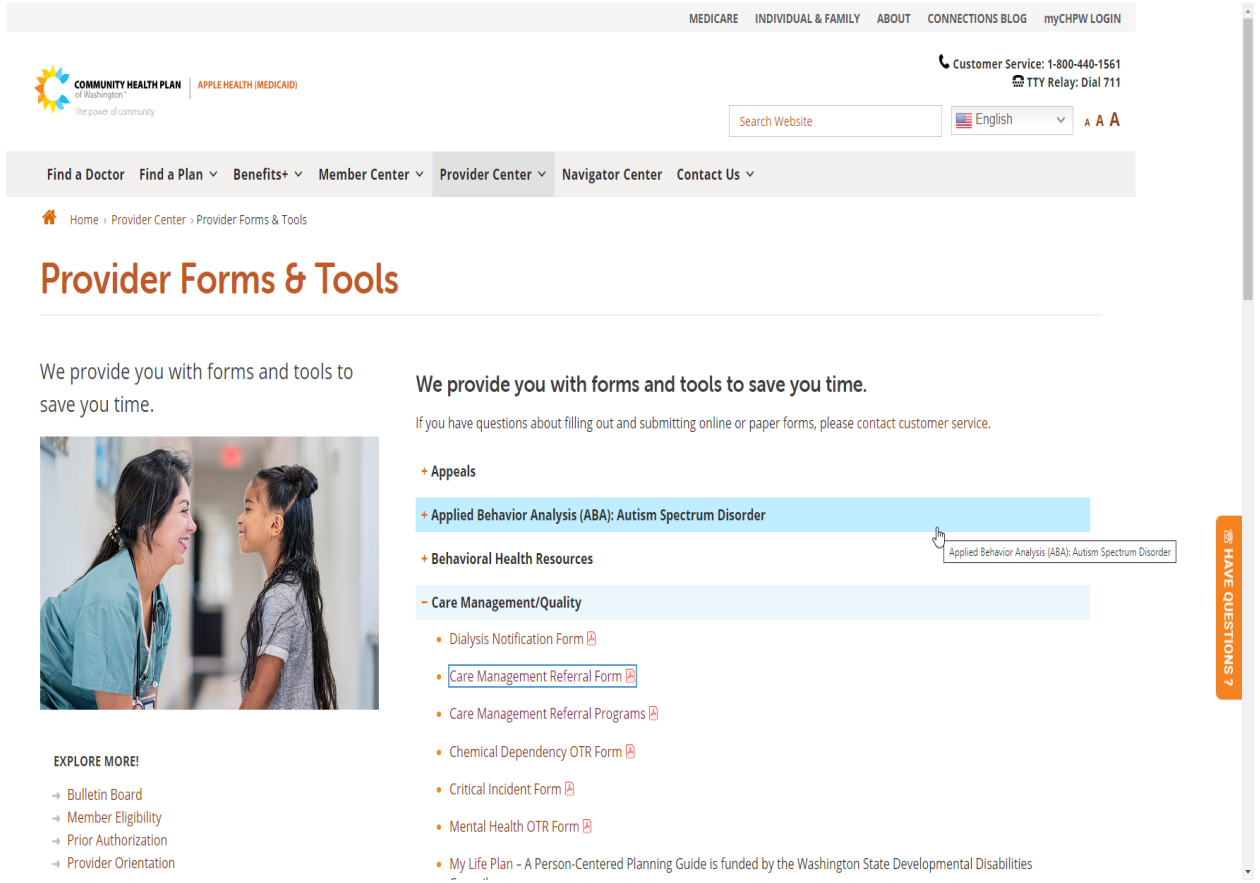
- Comprehensive care management
- Care coordination
- Transitional care and follow-up
- Patient and family support
- Referral to community support services
- Health promotion

Health Home services can be provided in primary care settings and through community-based organizations, depending on the particular care needs of an enrollee.

Contact Us!

Please contact us to refer a member for care management services, collaborate on a member, or to connect with a member of our team!

- **Referrals**
  - Care Management Referral Form
- **Care Management Department**
  - CareMgmtReferrals@chpw.org
  - 866-418-7004



Provider Trainings and Tools

- Portals
  - ❑ HealthMAPS
  - ❑ JIVA
- CHPW Website:
  - ❑ Provider Center
- Provider Trainings:
  - ❑ Mandatory
  - ❑ Optional
- Clinical Practice Training/Resources
- On-Line Provider Directory

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HealthMAPS Portal

Registered users have access to the following information:

- The ability to send claims and corrected claims directly to CHPW
- Eligibility and Benefit Details
- Member Rosters
- Capitation Rosters
- Other Health Information (COB)
- View Claim Status & Run Claims Reports
- Send and receive secure messages with CHPW.
- Register for HealthMAPS

In October 2025, CHPW announced the following portal enhancements where you can access:

- Remittance Advices (RA)/Explanations of Payment (EOP);
- Claim rejection letters; and
- Other letters and correspondence generated from within the claims system. Correspondence generated from within the Jiva Care Management portal will not be available in HealthMAPS.

HealthMAPS Portal Training & Guides:

HealthMAPS Provider User Guide
Instructions for Professional Claims Entry
Instructions for Corrected or Replacement Claims Entry
Instructions for Institutional Claims Entry

Access HealthMAPS through OneHealthPort: https://www.onehealthport.com/

JIVA Care Management Portal

Registered users have access to the following:

- Submit prior authorization requests, referral requests
- Submit Inpatient Notification
- Review Status of Requests
- View Letters (approval, denial, correspondence)
- Register for JIVA: Register here

Note: JIVA is the preferred method for submitting requests.

To access JIVA Portal Guides and Training Programs, go to:

CHPW JIVA Portal Guides and Training Programs

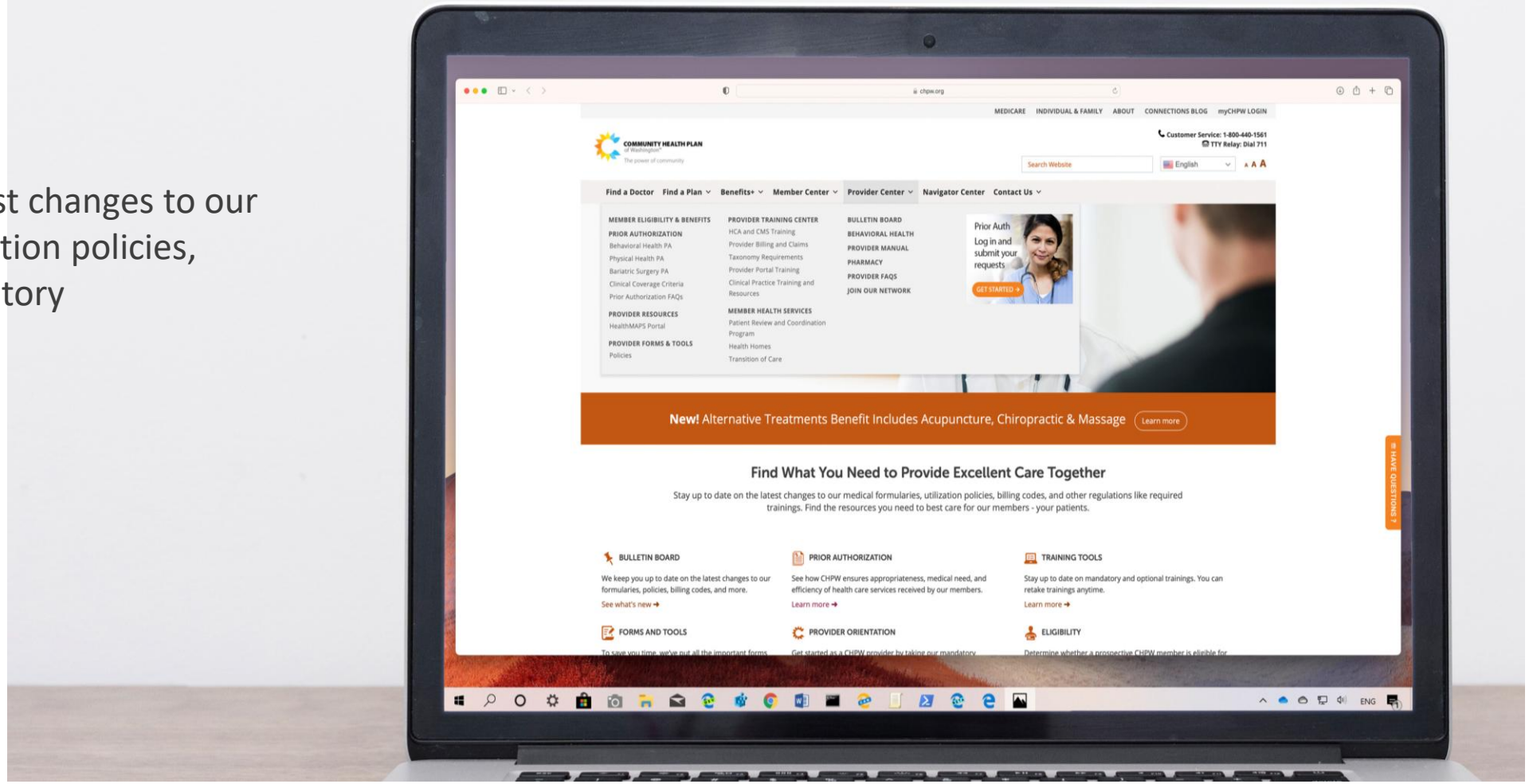
Registration issues or technical assistance:
Contact Portal Support at portal.support@chpw.org

Provider Center Web Site Resources

Stay up to date on the latest changes to our medical formularies, utilization policies, billing, trainings and regulatory requirements.

Provider Center Web Site

Provider Bulletin Board



Provider Trainings - Mandatory

Provider Orientation

- Newly contracted providers must complete orientation within 90-days of their contract effective date and complete an attestation of completion.

Dual Eligible Special Needs (D-SNP) Plan and Model of Care (MOC)

- The Centers for Medicare and Medicaid Services (CMS) requires all care provider who treat patients enrolled in a Special Needs Plan (SNP) to complete this training.

Patient Rights & Responsibilities & Advance Directive Training

- Must be completed by Providers & staff (i.e. MD, DO, ARNP, RN LPN, Administrators, Office Managers, Medical Assistants, Receptionists, Medical Record Coordinators, Referral coordinators, etc.)

General Compliance & Fraud, Waste and Abuse Training

- All staff must complete the CMS General Compliance and/or Fraud, Waste and Abuse Training annually under 42 CFR §438.608 (a) and (b), §422.503(vi)(C) and §423.504(b)(vi)(C). Provider is required to maintain evidence and must make evidence of training available for up to 10 years upon request.

Provider Training - Optional

Established Provider Orientation

- Established providers may access our orientation for a refresher and updates.

Culturally and Linguistically Appropriate Services (CLAS) Training

- Recommended for all healthcare workers (MD, DO, ARNP, RN, LPN, Administrators, Office Managers, Medical Assistants, Receptionists, Medical Record Coordinators, Referral Coordinators, etc.).

Health Management Overview

- Get to know CHPW's different Health Management Programs. These programs can help patients who have complex or multiple conditions better manage their health.

Appointment and After-Hours Access Standards

- Access standards have been developed to ensure that all health care services are provided in a timely manner. It means a patient has the ability to see a qualified health provider within a reasonable period of time.

Note: Mandatory and Optional Provider trainings can be found HERE

Clinical Practice Training/Resources

CHPW's Regional Systems Integration team wanted us to share the following links to ensure you were made aware of other available Training programs:

- Clinical Practice Training and Resources - Washington State Local Health Insurance - CHPW
- MCO Resources (wahealthcareplans.org)

Training Areas of Focus:

- Evidence Based Practices/Promising Practices (Bree Collaborative)
- Recovery and Resiliency
- Screening Recommendations
- Collaborative Care and Shared Care Planning
- Discharge
- Cultural Competency
- Required safety training

Please access CHPW's Provider Manual to identify all training requirements at https://www.chpw.org/provider-center/provider-manual/

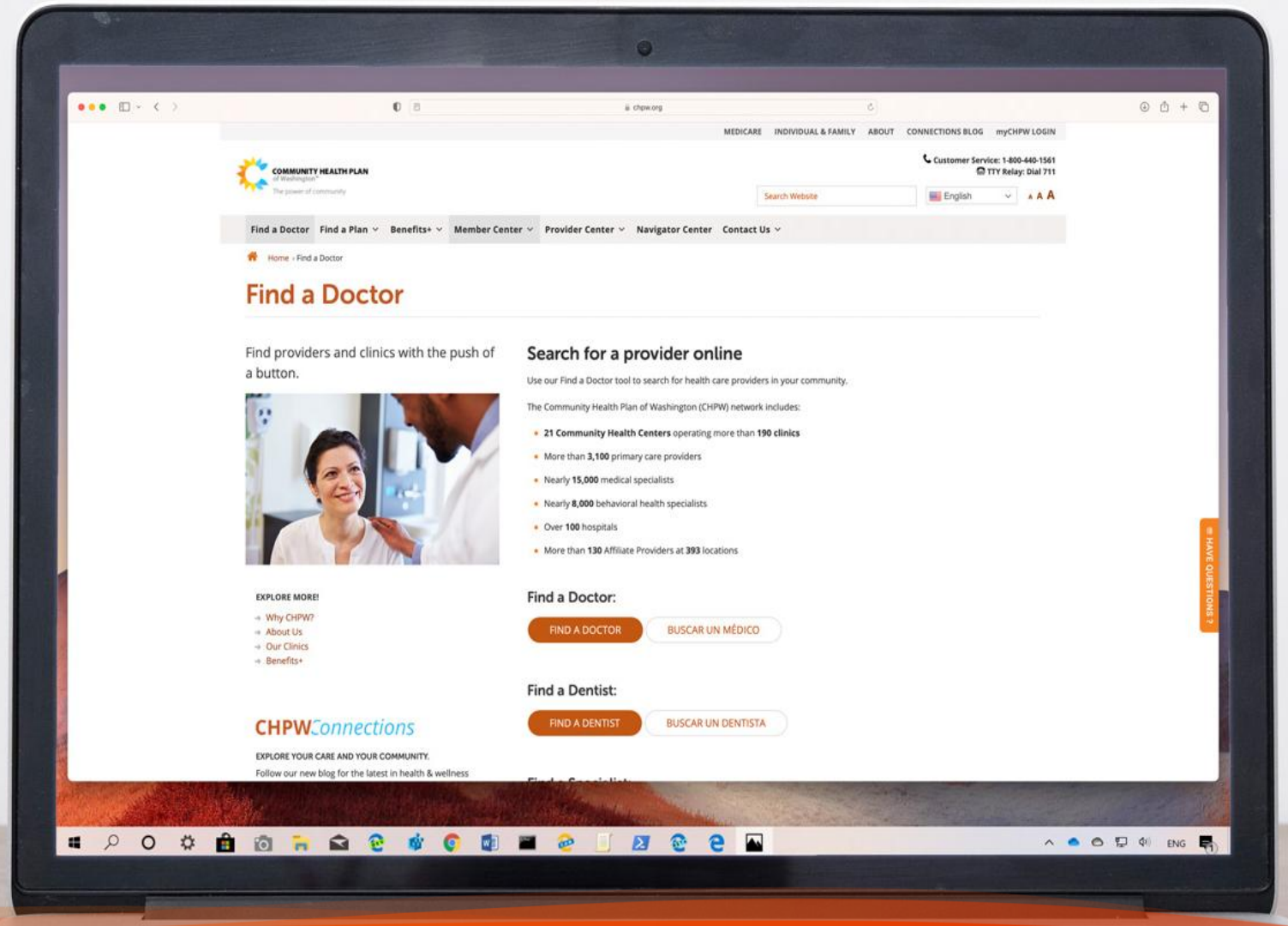
To contact our Regional Systems Integration Team, please email: kate.ingman@chpw.org

**New Resource for BH Providers Relias: available on quarterly basis upon request

Online Provider Directory

Looking for a Community Health Plan of Washington (CHPW) provider? You're in the right place!

https://www.chpw.org/find-a-doctor/



Pharmacy

- Prescription Drug Coverage
- Pharmacy Searchable Formulary
- Medication Assisted Treatment (MAT)

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Prescription Drug Coverage

- **Apple Health Single Preferred Drug List (PDL)**
  is used by all managed care plans & Apple Health fee-for-service.
- **Prior Authorization-** to request prior authorization, step therapy, nonformulary, or quantity limit override, contact Express Scripts (ESI) at 1-844-605-8168, 24 hours a day, 7 days a week or use https://www.CoverMyMeds.com to start PA process.
- **Pharmacy Reimbursement Issues** – Submit inquiry to ESI through the Pharmacist Resource Center.
- **Pharmacy Emergency Fills** – Emergency fills may be covered to prevent interruptions in therapy. View our policy on emergency fills.
- **Medications available for 90-day fills** – CHPW covers 90-day supplies for most chronic medications.
- **For more information**, please visit our pharmacy web site – Provider Center for Pharmacy

Apple Health (Medicaid) & Medicare

Express Scripts

Phone: 844-605-8168

Fax: 877-251-5896

Pharmacy Searchable Formulary

CHPW uses a list of approved drugs. This is called a **“formulary”** or a **“preferred drug list.”**

To access formularies and/or preferred drug lists, go to:

CHPW Apple Health Formulary,

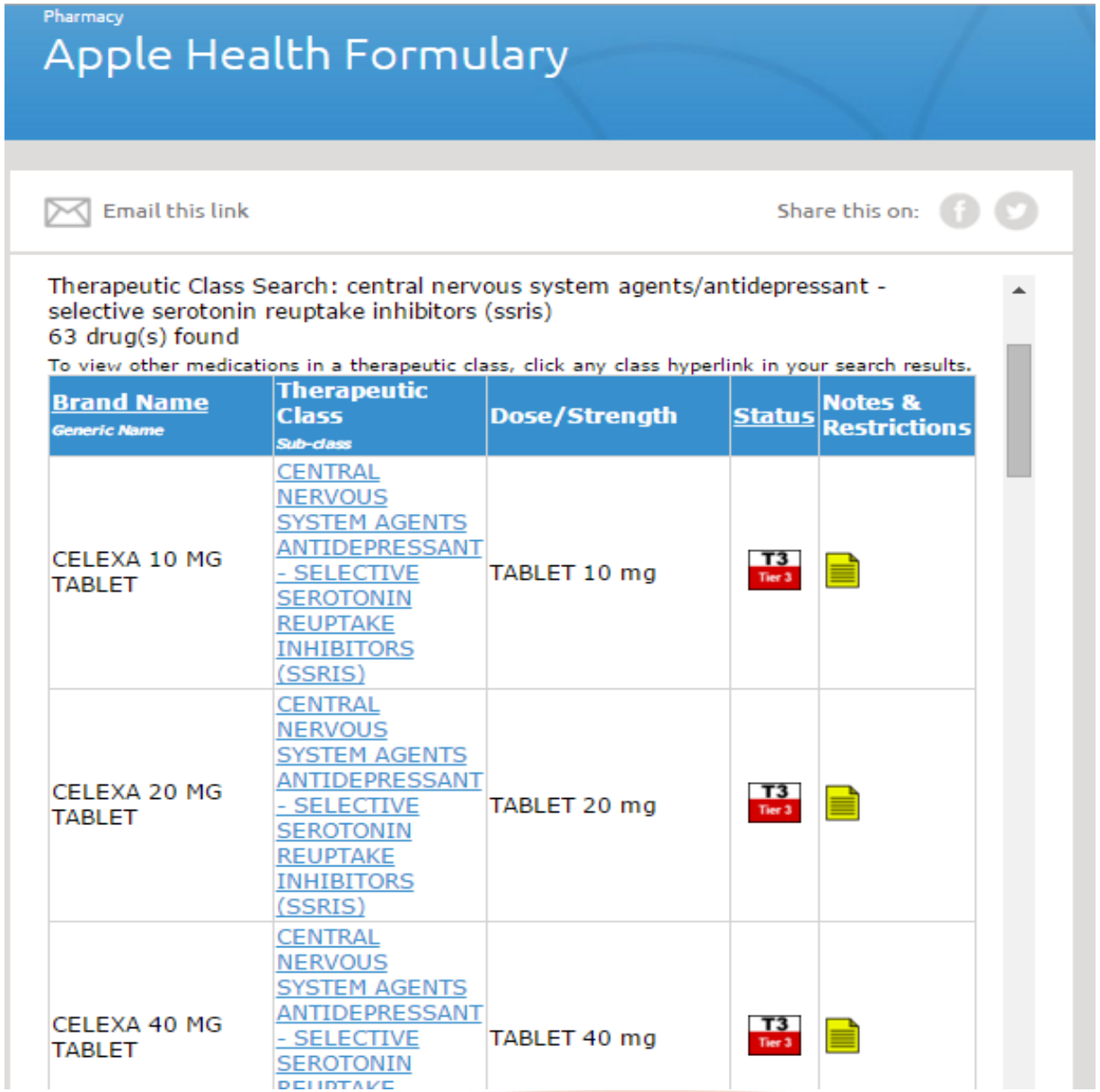
CHPW Medicare Formulary

CHPW Cascade Formulary

Providers can search or browse by generic or brand name, or therapeutic class.

From this section, Providers can identify:

- formulary status,
- prior authorization requirements
- step therapy
- additional notes



Medication Assisted Treatment (MAT)

- **MAT**
  - Certain chemical dependency medications require providers to follow the HCA MAT guidelines and provide documentation
  - Buprenorphine monotherapy does not require a prior authorization
  - Substance Use Disorder Information

- **Opioid Prescriptions**
  - Information on the HCA Opioid Policy
  - Opioid Attestation Form: Fax the completed attestation form to Express Scripts at **1-877-251-5896**
  - Opioid Agonists Medical Policy
  - Pharmacy Expedited Authorization Codes

MEDICATION ASSISTED TREATMENT

Provider Information Resources & Tools

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- Receive CHPW Updates & Notices
- Apple Health Information & Resources
  - ❑ Vaccine for Children (VFC) Billing Guide
  - ❑ Hepatitis C General Information
  - ❑ CHPW Provider Bulletin
  - ❑ HCA Pregnancy /First Steps Program
  - ❑ Partnership Access Line (PAL)
  - ❑ Partnership Access Line (PAL) for Moms
  - ❑ Psychiatry Consultation Line (PCL)
  - ❑ UW PACC - Psychiatry & Addictions Case Conference
  - ❑ Washington Recovery Help Line
- Patient Rights & Responsibilities
- Advanced Directives
- POLST
- CHPW Website: Member Center

Receive CHPW Updates & Notices

To receive the provider newsletter, updates and notices from CHPW, please email Provider.Relations@chpw.org and provide contact information (Group/Facility Name, Tax ID - name, title, phone, fax and email addresses) for the following staff/departments:

- CEO/CFO
- Office Clinic Managers/Administrators
- Billing Managers/Staff
- Contracting Managers/Staff
- Credentialing Managers/Staff
- Referral Managers/Coordinators/Staff
- Appeals Managers/Staff
- Medical Records Managers/Staff
- Team Members (billers, receptionists, medical record clerks, etc.)

Provider Office Contacts Grid (example):

Clinic/Facility Name	Tax ID	Title	Name	Phone	Email
Favorite Clinic	55-5555555	Billing Manager	Jane Doe	(555) 555-5555	Jane.Doe@favoriteclinic.org

Vaccines for Children (VFC)

The process for billing childhood vaccines changed effective, July 1, 2024. **This change is only relevant to the Vaccines for Children (VFC) Program.**

The VFC vaccine reimbursement rate is at $2.62 and an additional payment for procedure codes 90471-90474 was also implemented.

Please submit your claims with the appropriate billing codes (90471-90474) and modifier for VFC.

The link to access the HCA Provider Alert outlined above is as follows:
Vaccines For Children (VFC) – VFC Administration billing update, effective July 1, 2024:

For questions, please contact CHPW's Customer Service Department:

Email: CustomerCare@chpw.org

Phone: (800) 440-1561

Hepatitis C General Information

There are about ~2.3 million people in the U.S. living with Hep C.

The Hep C virus spreads when infected blood comes in contact with the blood of an uninfected person. Nowadays, it is common for people to get infected with the Hep C virus by sharing needles, syringes, or other items used for preparing or injecting drugs.

All adults, pregnant women, and people with risk factors should get tested for Hepatitis C.

Talking Points:

- Hepatitis C is sometimes called Hep C.
- It is an infection caused by a virus that attacks the liver.
- Many people with Hepatitis C don't have symptoms, but it can lead to serious health problems, including liver damage and liver cancer.
- Good news, today Hepatitis C is treatable.
- All adults need to get screened for Hepatitis C at least once in their life.
- There is a new treatment available, and it is covered for *CHPW Apple Health members*.
- Doctors can help decide if Hep C treatment is right for their patients.

For more information: Hep C Resources

CHPW Provider Bulletin Board

CHPW uses various avenues to communicate key information. The following links include some of the recent bulletins posted here: CHPW Provider Bulletin Board

HCA First Steps Program

First Steps helps Medicaid-eligible, pregnant, or up to 60-days postpartum women and their infants get needed health-related services.

Medical Services: Full medical coverage, prenatal care, delivery, post-pregnancy follow-up, and family planning with Apple Health.

Maternity Support Services: Preventive individual and group health-related services as early in pregnancy as possible.

Infant Case Management: Help learning about and getting needed medical, social, educational, and other support services.

Childbirth Education: Group childbirth and newborn care education generally provided during the third trimester of pregnancy.

A Medicaid program for pregnant women and their infants, including:

- ✔ Medical Services
- ✔ Maternity Support Services
- ✔ Infant Case Management
- ✔ Childbirth Education

FIRST STEPS

HCA First Steps Web Site

Washington State Health Care Authority

Partnership Access Line (PAL)

What is the Washington Partnership Access Line?

The Partnership Access Line (PAL) supports primary care providers (doctors, nurse practitioners and physician assistants) with questions about mental health care such as diagnostic clarification, medication adjustment or treatment planning. Our child and adolescent psychiatrists are available to consult during business hours.

PAL has a master's-level social worker available to assist with finding mental health resources for your patients. PAL is also partnered with Washington's Mental Health Referral Service for Children and Teens, where families can speak directly with a referral specialist.

The PAL program is funded by Washington's Health Care Authority and is available to providers caring for any patient in Washington, regardless of insurance type. The phone consultation is covered by HIPAA, section 45 CFR 164.506; no additional release of patient information is required to consult by phone.

Washington providers - to be directly connected to a PAL child and adolescent psychiatrist:

Call 866-599-7257
Monday–Friday
8am – 5pm

paladmin@seattlechildrens.org

seattlechildrens.org/healthcare-professionals/access-services/partnership-access-line/

UW Partnership Access Line for Moms

PAL for Moms is a free state-funded program providing perinatal mental health consultation, recommendations and referrals for providers caring for pregnant or postpartum patients. For more information, go to: Perinatal Psychiatry Consultation Line for Providers

HOW DOES IT WORK?

- Complete a brief intake
- Consult with a UW perinatal psychiatrist (usually immediately, or within 1 business day)
- Receive written documentation of recommendations and resources

WHAT KIND OF QUESTIONS CAN I CALL ABOUT?

- We consult on any behavioral health-related questions for patients who are pregnant, in the first year postpartum, or who have pregnancy-related complications (e.g., pregnancy loss, infertility). Topics may include:
- Depression, anxiety, other psychiatric disorders (e.g., bipolar disorder, post-traumatic stress disorder), substance use disorders, or co-occurring disorders
- Pregnancy loss, complications, or difficult life events
- Weighing risks and benefits of psychiatric medication
- Non-medication treatments

WHO CAN CALL? Any provider in Washington State who cares for pregnant or postpartum patients.

UW Psychiatry Consultation Line (PCL)

The UW Psychiatry Consultation Line (PCL) helps eligible providers who are seeking clinical advice regarding adult patients (18+) with mental health and/or substance use disorders

How does PCL work?
Providers call and after a short intake with a UW health navigator, are connected to a UW psychiatrist. At the conclusion of the conversation, the UW psychiatrist will send a brief written documentation of the recommendations to the caller via email.

Who is eligible to call?
Prescribing health care providers in Washington State from:
*Primary care clinics
*Community hospitals
*County and municipal correctional facilities

What PCL psychiatrists CANNOT do:
*Speak directly to patients
*Review written records
*Manage psychiatric emergencies or satisfy Single Bed Certification requirements

Questions? Email PCLWA@uw.edu

UW PCC

The UW Psychiatry and Addictions Case Conference is a free weekly teleconference that connects community providers with UW Medicine psychiatrists and addictions experts.

Sessions include both an educational presentation and case presentations where providers who participate receive feedback and recommendations for their patients.

UW PACC sessions take place Thursday from 12:00 to 1:30 pm PT. Any community providers (physicians, nurse practitioners, physician assistants and mental health professionals) are welcome to join the weekly teleconference.

CME offered for nominal fee

For more information and training opportunities, go to:
UW PACC | Integrated Care Training Program

For providers interested in didactic presentations and case-based learning
uwpacc@uw.edu
Thursdays 12:00-1:30 pm

Washington Recovery Help Line

Washington Recovery Help Line
24-Hour Help for Substance Abuse, Problem Gambling & Mental Health
1.866.789.1511

Behavioral Health is essential to health. Prevention is effective, treatment works, and people recover. If you have a patient who may need Behavioral Health services, please note the resources below and share with your patients.

The WA Recovery Help Line, a service of Crisis Clinic, is a free
24-hour crisis intervention and referral line for those struggling with issues related to mental health, substance abuse, and problem gambling. Professionally trained volunteers and staff provide confidential support and referrals to detox, treatment, and recovery support groups.

For Immediate Help, your patients could call the Washington Recovery Help Line at:
1-866-789-1511 warecoveryhelpline.org

For more information about the Crisis Clinic, go to: https://www.crisisconnections.org/

Patient Rights

Patient have the right to:

- Make decisions about their health care, including refusal of care.
- Be informed about all available treatment options, regardless of cost.
- Change their Primary Care Provider.
- Request a second opinion from another contracted provider.
- Obtain services within specified appointment standards.
- Be treated with dignity and respect. Discrimination on the basis of race, color, national origin, sex, sexual preference, age, religion, creed or disability will not be tolerated.
- Speak freely about their health care and concerns about adverse results.
- Have their privacy protected and information about care remain confidential.
- Request and receive copies of their medical records.
- Request and have corrections made to medical records if an error has been made.

Request and receive information about:

- Their health care and covered services.
- Their provider and how referrals are made to specialists and other providers.
- How their Managed Care Plan pays providers for care provided.
- All options for care and why they are receiving certain types of care.
- Assistance with filing a grievance or complaint about their care.
- Their Apple Health Managed Care Plan's organizational structure, policies and procedures, practice guidelines and how to recommend changes.
- Enrollee Rights and Responsibilities at least annually.
- Receive a list of crisis telephone numbers.
- Receive help completing mental or medical health advance directive forms.
- Receive mental health and substance use disorder services.

Patient Responsibilities

- Help make decisions about their health care, including refusal of treatment.
- Keep and be on time to their appointments.
- Call their provider's office if they will be late or need to cancel an appointment.
- Present their ProviderOne and Apple Health Managed Care Plan ID cards to their provider for billing purposes.
- Be respectful to providers.
- Learn about their plan, including covered and excluded services.
- Access care when necessary.
- Learn about their health problems and take part in making agreed upon treatment goals whenever possible.
- Provide to their provider and health plan complete information about their health to ensure appropriate care.
- Follow their provider's instructions.
- Use health care services appropriately.
- Renew their Apple Health coverage annually.
- Inform the HCA of the following changes:
- Family size
- Address
- Income
- Other insurance
- Medicare eligibility

Advanced Directives

An advance directive is a document that indicates, in writing, your choices about the treatments **you want** or **do not want** and/or **who will make healthcare decisions for you** if you become incapacitated and cannot express your wishes.

There are three forms of Advance Directives:

1. Durable Power of Attorney (POA) for Health Care - This names another person to make medical decisions for the enrollee if they are unable to make the decision themselves.

2. Healthcare Directive (Living Will) **-** This is a written document that states whether or not an enrollee wants treatment to prolong their life. An enrollee may document their request to die naturally.

3. Organ Donation Request - This allows an enrollee to donate their organs after their death.

Physician Orders for Life Sustaining Treatment (POLST)

The **Physician Orders for Life Sustaining Treatment (POLST)** form is for anybody who has a serious health condition and needs to make decisions about life-sustaining treatment. Your provider can use the POLST form to represent your wishes as clear and specific medical orders.

A POLST form complements the advance directive — it does not replace it. The POLST form is a medical order that tells your emergency health care professional what to do during a medical crisis when the patient cannot speak for him or herself. An Advance Directive is a legal document that tells who the patient wants making medical treatment decisions for him/her when he/she cannot speak and gives general directions on treatments the patient does or does not want to help create a treatment plan.

For more information on POLST and POLST Form, please go to the Washington State Medical Association website: https://wsma.org/POLST

Providers should review their obligations concerning Advance Directive in WAC 182-501-0125.

CHPW Policy (CM118) - Advance Directives and Physician Orders for Life Sustaining Treatment (POLST) Policy

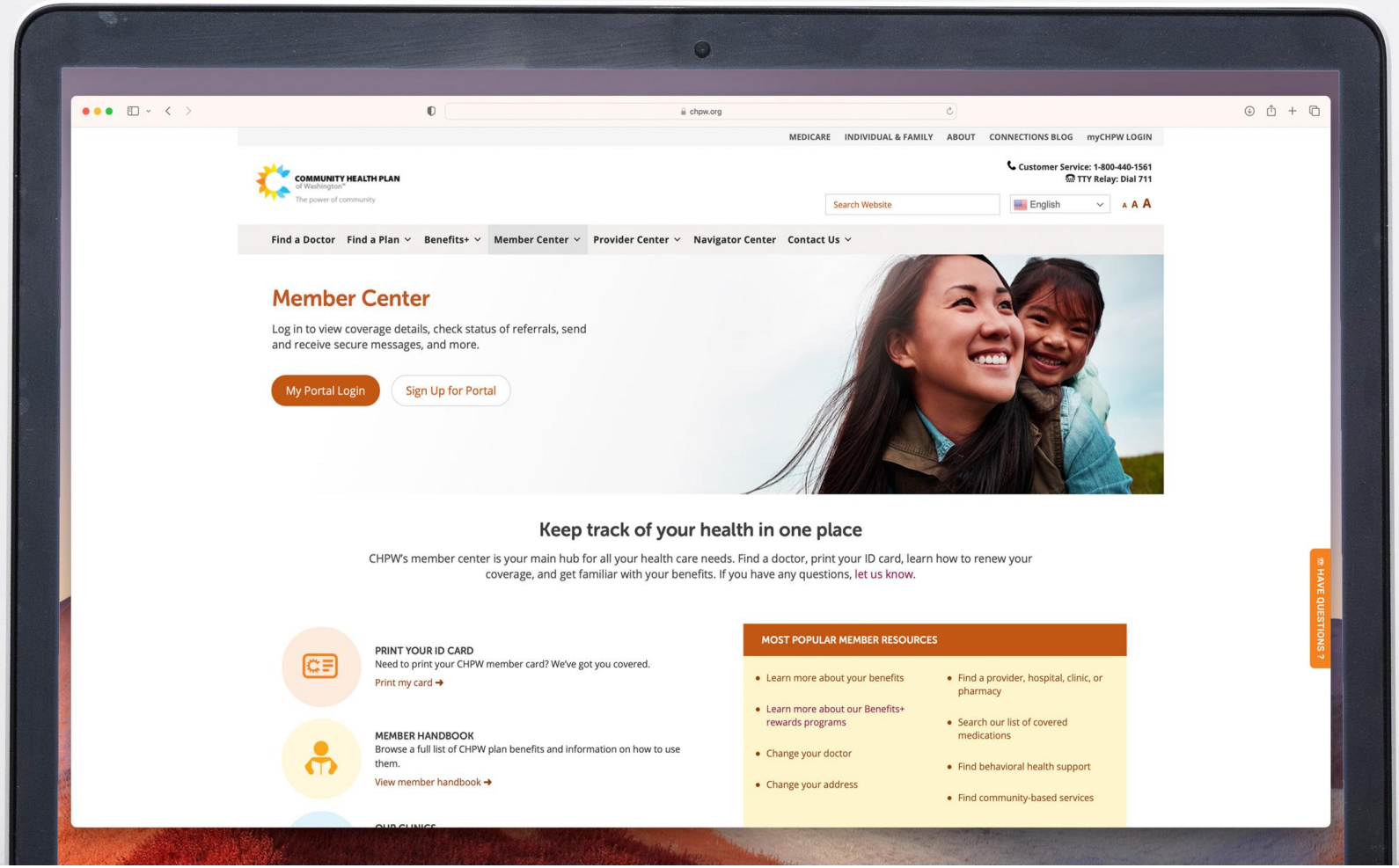
Member Center Website

CHPW's member center a main hub for all member health care needs.

Members can find a doctor, print ID cards, learn how to renew coverage, and get familiar with benefits.

Members can contact Customer Service with questions at let us know.

Member Center



Training Attestation

Thank you for completing CHPW's Provider Orientation Program!

To receive credit for completing this training program, please click on the hyperlink below to complete and submit your Training Attestation Form:

Training Attestation Form

For questions, please contact Provider.Relations@chpw.org

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