Provider Onboarding Digital Packet

Priority Health™

Last revised June 19, 2024

Introduction

Thank you for being part of the Priority Health network. Whether you've been in our network for years or just joined, this digital packet is a resource for you to use both digitally and physically. Feel free to print the packet, in sections or in its entirety, for you to keep next to your desk for reference.

Provider manual

To be clear, **this is not the Priority Health provider manual**. The provider manual, which is your source of truth for everything you'll need to know about working with us and our members, is found at priorityhealth.com/provider/manual. This provider onboarding packet includes certain essential sections pulled from the provider manual and other supplemental resources, but it should not be viewed as a substitute for the provider manual.

Navigating this packet

Please use the table of contents on the next page to navigate this packet by topic. Note that the topics generally mirror the topics on our provider onboarding page[1] where you found this packet.

You can also use the PDF search function when using the packet digitally to find specific words, which you can access by pressing CTRL+F on your keyboard.

Updating the packet

We'll do our best to keep this packet up to date, but please note the date on the cover page to indicate when your version was last updated and check back on our provider onboarding page for the latest version.

Links

Hyperlinks are included throughout this packet wherever the text is green and underlined. However, to accommodate those using this in printed form, we've included footnotes with the URL spelled out, so you can manually type the URL into your browser.

Getting your questions answered

We know this packet won't answer all your questions, especially about specific situations, so please find our "Getting your questions answered" document in the appendices. This helpful document walks you through the steps you should follow when seeking help from our team.

[1] priorityhealth.com/provider/new-provider-onboarding

Table of Contents

Joining the Priority Health network

Join our networks[1]

If you're a Michigan provider interested in joining our network, see our service area maps[2] and follow the steps outlined below. It can take up to **90 calendar days** for us to process your enrollment request.

Step 1: Confirm your process

Your process for becoming an in-network provider with us depends on your specialty and whether you're affiliated with an organization with an active Priority Health contract.

Before applying online, we recommend you review:

- PO / PHO organizations with active contracts with us.[3]
    - If you're working with one of these organizations, contact its internal administrator first. They may handle your application for you.
- Our requirements for behavioral health providers,[4] organizational providers[5] and other provider types.[6]

Step 2: Register with CAQH® (if you haven't already)

Before you can apply to become an in-network provider, you must first be registered with Council for Affordable Healthcare (CAQH) Proview™ and make sure your information is up to date there.

You can:

- Register with CAQH online[7] or
- Call them at **888.599.1771**.

Step 3: Apply online

Once you are registered with CAQH Proview and determined you require an application to join our network:

[1] priorityhealth.com/provider/manual/join-our-networks
[2] priorityhealth.com/about-us/service-area
[3] priorityhealth.com/provider/manual/standards/credentialing/contracted-pos-and-phos
[4] priorityhealth.com/provider/manual/standards/credentialing/bh-credentialing
[5] priorityhealth.com/provider/manual/standards/credentialing/organizations
[6] priorityhealth.com/provider/manual/standards/credentialing/criteria-by-provider-type
[7] proview.caqh.org/Login

1. Register for **prism**,[1] our online provider tool, or log into your existing account.[2]

2. Click on **Enrollments & Changes** and select the appropriate enrollment type.

    - Learn more about how to complete the application.[3]

    - If you're a behavioral health provider, see our behavioral health provider participation instructions.[4]

3. Complete all fields and click **Submit**.

After you submit your application, you'll receive an inquiry number and can check the status of your application and submit questions through your prism account.

When you complete our online application, you consent to release your CAQH information to us.

Step 4: Wait until you receive your network effective date

Once you submit your application, we're working hard behind the scenes to get you set up and ready to see our members. Once we've completed everything on our end (see below for an overview of our process), we'll send you a message in prism with your network effective date. **Until then, you shouldn't see Priority Health members seeking in-network care from Priority Health providers.**

Our process, once we receive your application:

1. **Contracting**: Every provider must be under contract with us before they can be in our network. Learn more about provider contracts and agreements.[5]

2. **Credentialing**: We ensure providers meet our criteria to be approved as in-network by verifying licensure, malpractice coverage or claims, education and specialty training. Learn more about provider credentialing.[6]

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[1] priorityhealth.com/provider/manual/prism-resources
[2] provider.priorityhealth.com
[3] priorityhealth.com/provider/manual/standards/credentialing/application
[4] priorityhealth.com/provider/manual/standards/credentialing/bh-credentialing
[5] priorityhealth.com/provider/manual/standards/contracting
[6] priorityhealth.com/provider/manual/standards/credentialing

3. **Enrollment**: Once credentialed, we enroll providers in our systems.

4. **Reimbursement**: We configure each provider's reimbursement structure based on their contract.

Step 5: Visit and bookmark our provider onboarding page

Congratulations on officially becoming part of the Priority Health network. We know there can be a lot to learn, so we've created a provider onboarding page[1] to put the most useful resources in one central location. On the provider onboarding page, you can learn everything you need to know about submitting claims, filing authorizations, using Priority Health's most important digital tools, staying in the loop on the latest Priority Health updates, getting your questions answered and much more.

Be sure to bookmark the onboarding page so you can quickly return to it as needed. Share the link with everyone else in your organization, too.

[1] priorityhealth.com/provider/new-provider-onboarding

Contracting information[1]

By contracting with Priority Health, providers agree to abide by, comply with and participate in any and all policies and procedures of Priority Health and its plans. When we receive your complete credentialing information, it'll take us **up to 90 calendar days** to process your request.

- To be eligible for Medicaid participation, you must be actively enrolled in CHAMPS.
- Once you're credentialed and your contracts have been executed, you'll receive a comment on your inquiry in prism with your network effective date. You can begin billing for dates of service on the effective date. Claims submitted before the effective date may result in incorrect payment or denial.

Priority Health doesn't apply effective dates retroactively. You shouldn't see our members seeking in-network care from Priority Health providers until you receive notice from us that your request for network participation is complete, along with a network effective date. If you see a Priority Health member before you receive a network effective date, you must inform the member that your services are out of network. Claims submitted to us before you receive a network effective date will be denied as “care available in plan.”

Requesting medical records

Priority Health or authorized third party vendors, representing Priority Health, may periodically request access to or copies of medical records for a variety of business reasons.

Records may be requested for the purpose of medical record or billing record reviews, HEDIS, care management or risk adjustment, as examples.

Medical record requests will be in accordance with the terms of the participation agreement between Priority Health and provider. Requests will be subject to all applicable laws and confidentiality provisions in the agreement.

Priority Health prefers to work with providers to obtain needed medical records through secure, remote EMR access or alternate electronic methods. Remote access options, to obtain needed medical records can prevent on-site retrieval that can be both inefficient and disruptive.

Providers who utilize a vendor to produce copies of medical records are responsible for assuring that their vendor supplies requested medical records

[1] priorityhealth.com/provider/manual/standards/contracting

in accordance with the participation agreement between Priority Health and participating provider.

Cancellation or termination of physician contracts

All terms of cancellation, including how much notice is required, are in your contract.

Go to the process for notifying us[1] when you retire, leave the area or otherwise terminate your participation with us.

[1] priorityhealth.com/provider/manual/standards/physician-status/terminating-your-contract

Credentialing information[1]

You shouldn't see Priority Health members who are seeking in-network care from Priority Health providers until you receive notice from us that your request for network participation is complete, along with a network effective date. When we receive your complete credentialing information, it'll take us **up to 90 calendar days** to process your request.

For detailed information about credentialing and resources, visit prioritynhealth.com/provider/manual/standards/credentialing.

Want to participate with us?

Join our networks.[2]

[1] prioritynhealth.com/provider/manual/standards/credentialing
[2] prioritynhealth.com/provider/manual/join-our-networks

Finding your network effective date

Our team will post a provider's effective date in the Comments section of the enrollment request in question, triggering an email to let them know a new comment has been posted. To find that date, providers follow the steps for statusing a request.

Clearing up possible confusion

Our team shares two dates with providers in the Comments section of each enrollment request:

1. **Credentialing date:** this is the date when their application is through credentialing. It's an NCQA requirement to share this date with providers and can be confusing if providers believe this is the date they can start billing as in-network

2. **Effective date:** this is the actual date providers can start billing. Their effective date comes after their application moves through enrollment and reimbursement.

Requirements and responsibilities[1]

To learn more about the requirements and responsibilities of being in our network, visit priorityhealth.com/provider/manual/standards.

Being a part of the Priority Health network

- Contracting[2]
- Credentialing[3]
- Physician status[4]
- Confidentiality[5]
- Fraud, waste and abuse[6]
- Utilization management program[7]
- NPI numbers[8]

Treating patients

- Medicaid patient treatment[9]
- Medicare patient treatment[10]
- MyPriority patient treatment[11]
- Provider-patient relationship[12]

Office and staff

- Availability standards[13]
- Keeping your data up to date[14]
- Medical and office records[15]
- Audits[16]
- Site visits[17]

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[1] priorityhealth.com/provider/manual/standards
[2] priorityhealth.com/provider/manual/standards/contracting
[3] priorityhealth.com/provider/manual/standards/credentialing
[4] priorityhealth.com/provider/manual/standards/physician-status
[5] priorityhealth.com/provider/manual/standards/confidentiality
[6] priorityhealth.com/provider/manual/standards/fraud-waste-and-abuse
[7] priorityhealth.com/provider/manual/standards/utilization-management-program
[8] priorityhealth.com/provider/manual/standards/npi-numbers
[9] priorityhealth.com/provider/manual/standards/provider-standards-medicaid-patient-treatment
[10] priorityhealth.com/provider/manual/standards/medicare-patient-treatment
[11] priorityhealth.com/provider/manual/standards/mypriority-patient-treatment
[12] priorityhealth.com/provider/manual/standards/provider-patient-relationship
[13] priorityhealth.com/provider/manual/standards/availability
[14] priorityhealth.com/provider/manual/standards/keeping-your-data-up-to-date
[15] priorityhealth.com/provider/manual/standards/records
[16] priorityhealth.com/provider/manual/standards/audits
[17] priorityhealth.com/provider/manual/standards/site-visits

Go-to tools

Priority Health provider manual[1]

The provider manual is our source of truth for everything you need to know about working with us and our members. Visit priorityhealth.com/provider/manual to find information on:

- Authorizations[2]
- Billing & payment[3]
- Procedures & services[4]
- Review & appeals[5]
- Drugs[6]
- Find medical policies[7]
- Data exchange[8]
- Find provider forms[9]
- Seeing Cigna members in Michigan[10]
- News & education[11]
- Member programs[12]
- Requirements & responsibilities[13]
- Plans[14]
- prism resources[15]

[1] priorityhealth.com/provider/manual
[2] priorityhealth.com/provider/manual/auths
[3] priorityhealth.com/provider/manual/billing
[4] priorityhealth.com/provider/manual/services
[5] priorityhealth.com/provider/manual/appeals
[6] priorityhealth.com/provider/manual/drugs
[7] priorityhealth.com/provider/manual/medical-policies
[8] priorityhealth.com/provider/manual/data-exchange
[9] priorityhealth.com/provider/manual/forms
[10] priorityhealth.com/provider/manual/cigna-strategic-alliance
[11] priorityhealth.com/provider/manual/news
[12] priorityhealth.com/provider/manual/member-programs
[13] priorityhealth.com/provider/manual/standards
[14] priorityhealth.com/provider/manual/provider-plans
[15] priorityhealth.com/provider/manual/prism-resources

prism[1]

Prism is our provider portal. It is the most important digital tool when it comes to working with us. Please use the following links to help you use prism and **refer to the prism quick reference guide, the prism FAQ and the prism tech tips included in the appendices to this packet**.

All users must create a prism account, even if you previously used the Provider Center.

For technical support for prism, contact the Provider Helpline at **800.942.4765.**

Be sure to visit and bookmark our prism resources page,[2] where you can learn about:

- creating a prism account[3]
- prism tutorials and tips
    - Creating an account
    - Managing your group or facility
    - Reviewing claims and appeals in prism
    - Provider enrollments & changes
    - General requests
    - prism Notification Center
- prism Security[4]
    - Learn about prism Security Administrators (pSAs) and additional security measures we've implemented to keep your account safe.

[1] provider.priorityhealth.com
[2] priorityhealth.com/provider/manual/prism-resources
[3] provider.priorityhealth.com/providers/s/provider-selfservice
[4] priorityhealth.com/provider/manual/prism-resources/security

Electronic data interchange (EDI)[1]

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires that all health care providers and payers must use the **X12 5010** version to exchange EDI business data.

- **Electronic data interchange (EDI) setup**

  We accept ANSI X12 EDI files through a direct connection with Clearinghouses that use Secure File Transfer Protocol (SFTP).

  - **Companion guides**

    - Priority Health doesn't publish companion guides, as we strictly adhere to HIPAA standards. Refer to Products I X12.[2]

  - **Registration forms**

    - Electronic Remittance Advice (835). To receive the 835 payment/remittance advice electronically, complete this Electronic Remittance Advice (835) registration form.[3]

    - Service receipts. Service receipts summarize the number of claims submitted to Priority Health, including upfront rejections. They're sent directly to your office by email or fax as selected by your office. The report lists any claims rejected up front for invalid or missing data elements.

      To receive service receipts electronically, complete this Service receipt registration form.[4]

  - **Transaction types available for EDI**

    - 270, Eligibility requests, batch and real time
    - 271, Eligibility responses, batch and real time
    - 276, Claim status requests, batch and real time
    - 277, Claim status responses, batch and real time
    - 277CA, Claim acknowledgment

[1] priorityhealth.com/provider/manual/set-up-edi
[2] x12.org/products
[3] survey.alchemer.com/s3/6688306/ElectronicRemittanceAdviceRegistration
[4] survey.alchemer.com/s3/6688220/servicereceipt

- 278, Authorizations
- 834, Group enrollment
- 835, Payment/Remittance advice
- 837P, 837I and 837D, Claims
- 999, Functional acknowledgments

Real-time transaction exceptions

Eligibility and claim status transactions are both available 24/7, with these exceptions:

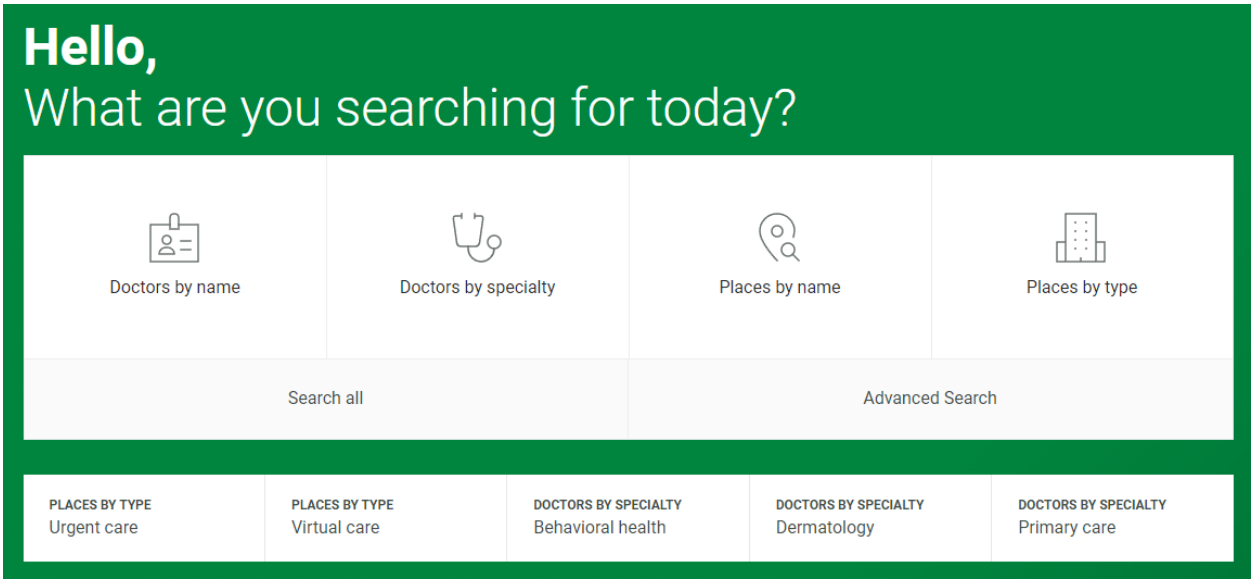
- Regularly scheduled maintenance periods, which occur on the second weekend of each month.
- Non-routine downtime periods, which are published a week in advance.
- Unscheduled downtime periods, which are communicated within an hour directly to clearinghouses and/or trading partners who utilize real time services.

Questions / Updating your EDI setup

Have questions? Need to change your EDI setup? Contact our EDI team via email at *edisetup@priorityhealth.com.*

Find a Doctor tool[1]

Our Find a Doctor (FAD) tool lets you look up any provider in our network, across all specialties, categories, locations and plan types. **Learn more about using Find a Doctor on our "Find a Doctor, for providers" one-pager in the appendices.**



[1] priorityhealth.com/member/getting-care/find-a-doctor

Training topics

Submitting a claim[1]

Claim requirements

- **All claims must be electronic or typed on paper**

  Priority Health will not accept hand-written claims.

- **Do not fax or email claims, original or corrected**

  Send claims only electronically or, for paper claims, through the U.S. Mail.

- **Use the member ID number to identify the patient**

  Don't use a Social Security number. We reject electronic and paper claims submitted without a valid subscriber ID (with two-digit suffix) or Medicaid recipient ID number.

- **Total charges should appear only on the last page**

  Omit the total charges until the final page of multi-page paper claims.

- **Secondary claims must be billed with primary EOB**

  Billed charges must match the amount shown as billed on the EOB. If they don't, your claim will be rejected as "Inappropriate EOB - does not match claim." You will then have to rebill the claim.

  If a claim denies for needing the primary EOB, you must resubmit the claim with the EOB attached via electronic or paper claim submission. We do not accept EOBs via fax or email.

- **National Uniform Billing Committee (NUBC) standard code sets**

  Valid ICD-10, CPT, and HCPCS codes only

  Claims containing invalid codes will be denied upfront, and we will notify you within 48 hours of the denial. See the Diagnosis coding guidelines in this section.

- **Multiple services on the same day must bill on one claim**

[1] priorityhealth.com/provider/manual/billing

Multiple services reported by the same provider for the same day of service will be denied or adjusted to deny if services are split between multiple claims.

- **Use Place of Service codes**

  See the Medicare Claims Processing Manual, Chapter 26,[1] sections 10.5 and 10.6.

- **Use the modifier FB**

  When you received a drug or item at no cost and are billing that charge for informational purposes, not for reimbursement, use the modifier FB.

How to submit electronic claims

Learn how to set up HIPAA-compliant electronic (EDI) claim files.[2]

Where to mail paper claims

Priority Health Claims
P.O. Box 232
Grand Rapids, MI 49501

More billing information

For more information, including on service-specific billing, specific billing scenarios and payment, visit priorityhealth.com/provider/manual/billing.

[1] cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c26.pdf
[2] priorityhealth.com/provider/manual/set-up-edi

Checking the status of a claim[1]

Claims inquiry

Logged in? Use this tool[2] (behind prism login) to check the status of your claims and print a pending claims report.

Visit Reviews & Appeals[3] if you would like us to reconsider coverage and payment.

If you submit claims to us frequently, create a prism account.[4] Then you'll be able to use our **Claims Inquiry** tool to status all your claims.

[1] priorityhealth.com/provider/manual/billing/status-claims
[2] provider.priorityhealth.com/s/claims
[3] priorityhealth.com/provider/manual/appeals
[4] priorityhealth.com/provider/manual/prism-resources

Checking patient eligibility[1]

Save time—use our Member Inquiry tool. Once you have an online account with us, you can log in to use our online tools.

The online Member Inquiry tool[2] lets you:

- Check eligibility and contract history
- Check address and phone
- Update COB information
- See out-of-pocket limits
- See deductible balance(s)
- See copays and coinsurance
- See many benefits/coverages, such as DME, home health care, maternity, prosthetic/orthotic

If you do not have access to prism, you can confirm that a patient is a current Priority Health plan member by calling the Provider Helpline at **800.942.4765**, option 1.

[1] priorityhealth.com/provider/manual/patient-eligibility
[2] provider.priorityhealth.com/providers/s/members

Requesting authorizations[1]

We require prior authorization for certain drugs, services and procedures. In these cases, providers will submit clinical documentation and medical records demonstrating that the drug, service or procedure is medically necessary.

Authorizations for in-network providers[2]

We require prior authorization for certain services and procedures. In these cases, providers will submit clinical documentation and medical records demonstrating that the service or procedure is medically necessary.

How to request an authorization

Submit authorizations through our Authorizations Request tool[3] (behind prism login). Turnaround times vary by plan requirements, but in all cases are 14 days or less. You can use this tool to:

- Request an authorization
- Check authorization status

Exceptions

The following procedures are exceptions and require authorization forms to be submitted. Visit priorityhealth.com/provider/manual/auths/in-network to download each of these forms.

- Solid organ transplant
- Bone marrow/stem cell transplant
- NICU/sick newborn
- Inpatient PMU Medicaid medical consult

About our Authorization Request tool

Our Authorization Request tool has two portals—GuidingCare and eviCore. The tool will automatically select the correct portal based on your authorization type.

GuidingCare authorization types

[1] priorityhealth.com/provider/manual/auths
[2] priorityhealth.com/provider/manual/auths/in-network
[3] provider.priorityhealth.com/providers

- Post-acute facilities
- Behavioral health
- Durable medical equipment (DME)
- Inpatient
- Outpatient
- Spine surgery
- Joint surgery
- Home health care
- Planned surgeries and procedures

eviCore authorization types

- High-tech imaging
- Lab and genetic services

Services not included in our Authorization Request tool

- Drug authorizations[1] not related to an inpatient stay or home infusions. Use our drug authorization request forms.
- Medicare non-coverage notices[2]
- Services not covered by our plans[3]

Authorizations for out-of-network providers[4]

We require prior authorization for certain services and procedures. In these cases, providers will submit clinical documentation and medical records demonstrating that the service or procedure is medically necessary.

How to request an authorization

Use the forms available for download at priorityhealth.com/provider/manual/auths/out-of-network to request prior authorization for medical services, including:

- Outpatient, elective/planned inpatient admissions

[1] priorityhealth.com/provider/manual/drugs
[2] priorityhealth.com/provider/manual/auths/medicare-non-coverage
[3] priorityhealth.com/provider/manual/services
[4] priorityhealth.com/provider/manual/auths/out-of-network

- Hospital and other facility
- Behavioral health
- Home health services

Always use a specific service form when available. Turnaround times vary by plan requirements, but all cases are 14 days or less.

How to check your authorization status

1. Log into[1] your **prism** account
2. Open the **Authorizations** menu
3. Click **Check Auth Status**

Don't have a prism account? Contact Provider Services[2] for help checking the status of your authorization request.

Drug authorization & billing[3]

Search our online formulary tools to understand drug and plan specific coverage information, including prior authorization, step therapy requirements, age limits and quantity limits.

Drugs covered under the medical benefit

Reference the Medical Benefit Drug List (MBDL)[4] (formerly the Injectable Drug List) to view coverage details for medications that are covered under the medical benefit. Forms for drugs that require authorization are linked in the MBDL.

Drugs covered under the pharmacy benefit

Coverage for medication and any applicable utilization management criteria can be found on the Approved Drug Lists.[5] Since coverage and criteria differ by plan, choose the plan type to view the correct plan-approved drug list.

General drug request forms

[1] provider.priorityhealth.com
[2] priorityhealth.com/provider/contact-us
[3] priorityhealth.com/provider/manual/drugs
[4] priorityhealth.com/-/media/priorityhealth/documents/pharmacy/medical-benefit-drug-list.xlsx
[5] priorityhealth.com/formulary

Visit priorityhealth.com/provider/manual/drugs for general drug request forms for Medicare, MyPriority (individual), commercial and Medicaid members. Fax completed forms to Priority Health at **877.974.4411**.

Use these general forms when there is no drug-specific form listed.

Resources

Visit the following pages for more authorization resources:

- Authorization quick reference list[1]
- Make authorization changes[2]
- Medical necessity criteria[3]
- Urgent and emergency authorizations[4]
- Retrospective authorizations[5]
- Behavioral health authorizations[6]
- Medicare non-coverage[7]
- Authorization news[8]

[1] priorityhealth.com/provider/manual/auths/quick-reference-list
[2] priorityhealth.com/provider/manual/auths/auth-changes
[3] priorityhealth.com/provider/manual/auths/medical-necessity-criteria
[4] priorityhealth.com/provider/manual/auths/urgent-and-emergency
[5] priorityhealth.com/provider/manual/auths/retrospective-auths
[6] priorityhealth.com/provider/manual/auths/mental-health-substance-use
[7] priorityhealth.com/provider/manual/auths/medicare-non-coverage
[8] priorityhealth.com/provider/manual/news/authorizations

Reviews & appeals[1]

In the pages linked below, you'll find detailed instructions on how to ask us to reconsider a decision we've made, whether coverage and payment or authorizations denials.

Claim reviews & appeals

Use the instructions on the pages below to submit reviews and appeals requests for medical and behavioral health claims.

- Medicare claim reviews & appeals[2]
- Non-Medicare claim reviews & appeals[3]

Authorization reviews & appeals

Use the instructions on the pages below to submit reviews and appeals requests for medical and behavioral health claims.

- Medicare authorization reviews & appeals[4]
- Non-Medicare authorization reviews & appeals[5]

[1] priorityhealth.com/provider/manual/appeals
[2] priorityhealth.com/provider/manual/appeals/medicare-claim
[3] priorityhealth.com/provider/manual/appeals/non-medicare-claim
[4] priorityhealth.com/provider/manual/appeals/medicare-authorization
[5] priorityhealth.com/provider/manual/appeals/non-medicare-authorization

Changes to staff, practice name, address or phone[1]

To notify us of changes in your name, address, staff, tax ID number, or if you're opening or closing to new patients, you must notify us 60 days ahead of the change.

The name and information you provide us must be up-to-date. For example, the name you provide us for your practice must match the name you use when you answer patient phone calls.

When you submit your practice name and other details—like your location—during the enrollment process, we use this information in our Find a Doctor[2] tool. This tool helps our members—and prospective patients for you—find the care they need. The Centers for Medicare and Medicaid Services (CMS) requires that this information is up-to-date.

For example, if you answer the phone as "ABC Family Medicine" your name in Find a Doctor should be "ABC Family Medicine."

Need to update the name of your practice?

To notify us of a name change, follow these steps 60 days or more before the change takes effect:

1. Log in to your prism account[3]
2. Click on **Enrollments & Changes**
3. Select either Change Individual Provider or **Change Provider Organization**
4. Follow the directions as indicated. For individual requests, submit a Provider Change Form. For multiple requests, submit a Provider Change Template.

The form must contain:

- What's changing
- The effective date of the change
- Entity or tax ID number (EIN or TIN) W-9, as applicable

[1] priorityhealth.com/provider/manual/standards/keeping-your-data-up-to-date
[2] priorityhealth.com/member/getting-care/find-a-doctor
[3] provider.priorityhealth.com

- NPI number and taxonomy designation (specialty type) that you'll be using for billing
- If your request is to change the group information for a provider group, include the Type 1 NPIs of the impacted practitioners

Check the status of your request

Once you submit your request, our team will receive an inquiry. You can check the status of your request and view comments from our team any time in prism by clicking on Enrollments & Changes and selecting the Inquiry ID. When your request is completed, you'll receive a comment from our team. Any time our team posts a comment, you'll receive an email notification.

Reporting retirement/termination

At least 90 days prior to your retirement or termination of contract with Priority Health, notify us of the change. Learn how.[1]

You may be removed from our directory if your data isn't up to date

To keep our Find a Doctor tool accurate and to meet our requirements as a health plan, we may remove providers who do not maintain their information with us. This means you may be removed from Find a Doctor if your practice name doesn't match the name you answer your phone with or if your other data, like locations or hours of operation, are not accurate.

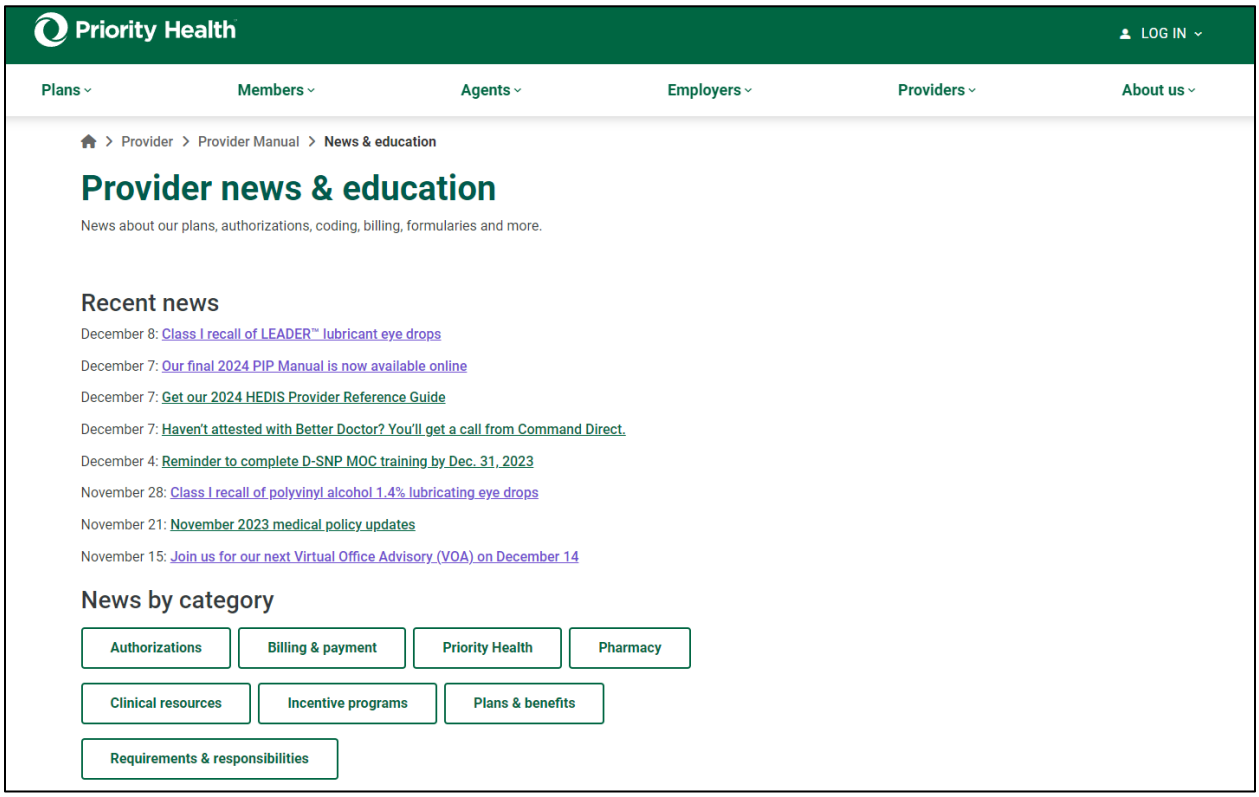
[1] priorityhealth.com/provider/manual/standards/physician-status/terminating-your-contract

Staying in the loop

Provider news site[1]

Our provider news site is the go-to source for everything you need to know about our plans, authorizations, coding, billing, formularies and more. Be sure to bookmark it and check it regularly—we suggest at least once a week.

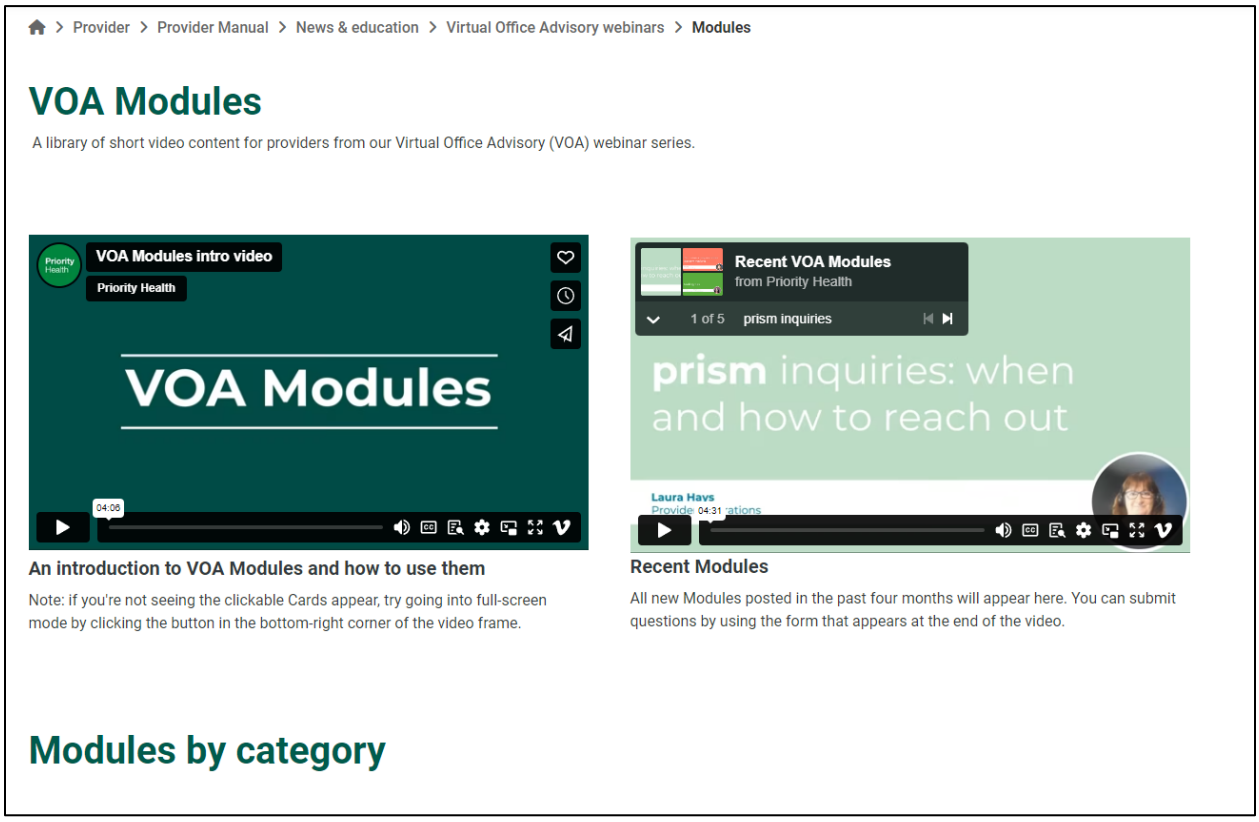
The main page has a roundup of all recent news across categories. You can then click the buttons below to navigate to news items by category.



[1] priorityhealth.com/provider/manual/news

VOA Modules

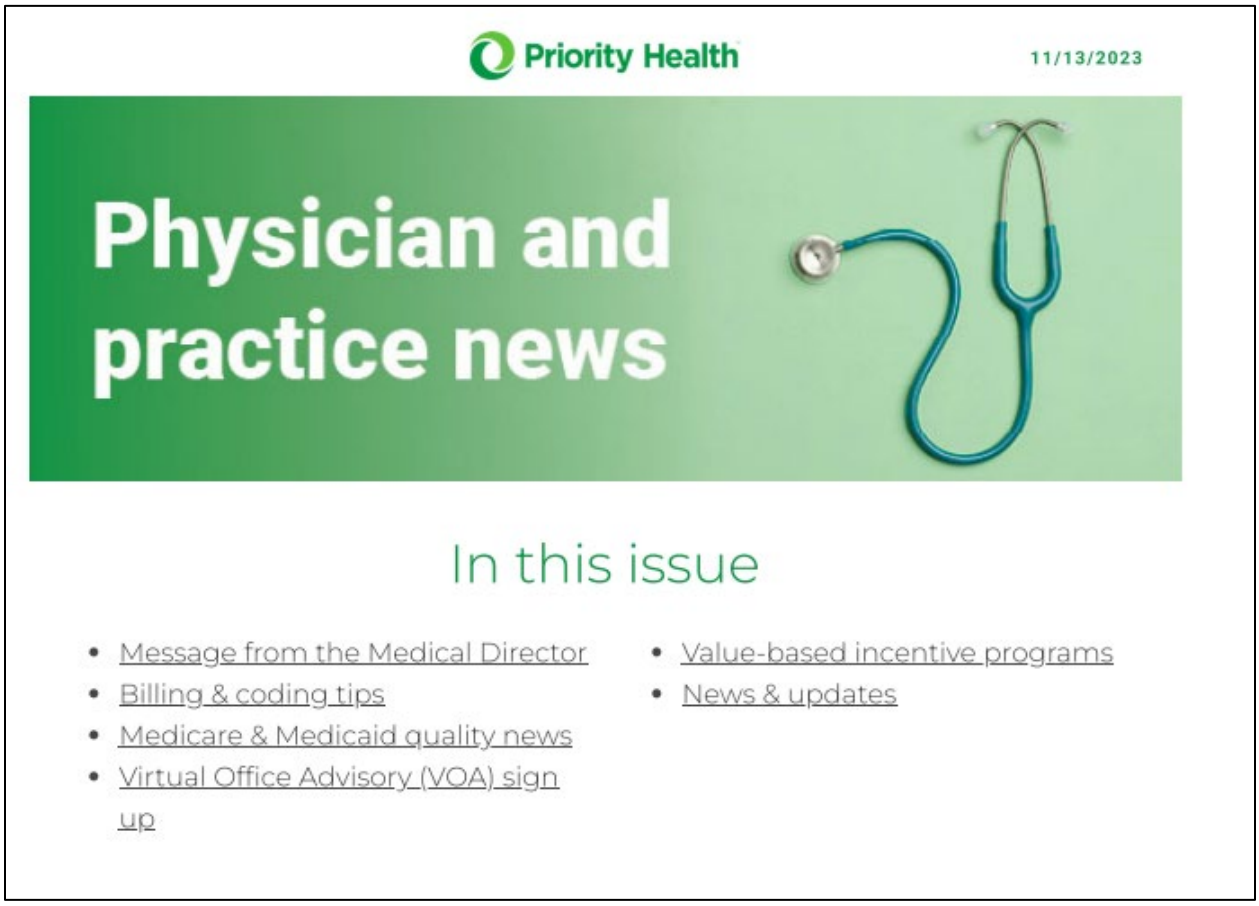
Be sure to check our VOA Modules page[1] regularly for short, on-demand videos on a variety of topics, including billing & coding, appeals, prism, etc.



[1] priorityhealth.com/provider/manual/news/voa/modules

Quarterly news digest[1]

Our quarterly news digest is a newsletter sent to provider inboxes that includes all physician and practice news items from the last quarter. It is sent to all providers who have a prism account. Click each season's link to see what was sent that quarter.



Medicare/Medicaid quality newsletter

Also on this page are links to past issues of the quarterly Medicare/Medicaid quality newsletter, which is a newsletter that helps providers close gaps in care with tools, resources and member engagement campaigns.

[1] priorityhealth.com/provider/manual/news/archive

Priority Health

Medicare and Medicaid quality news

Helping you close gaps in care with tools, resources and member engagement campaigns

Fall 2023

★ Medicare quality

The National Committee for Quality Assurance (NCQA) is moving to Electronic Clinical Data Sets (ECDS) measure reporting.

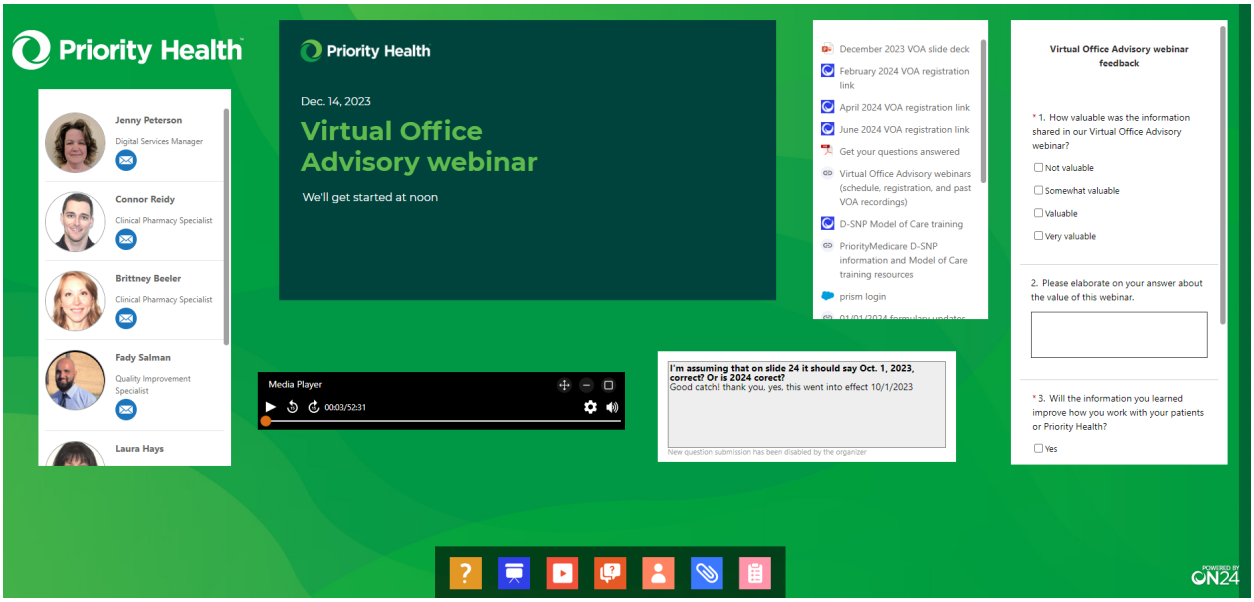
What's ECDS?
A new reporting methodology created to help HEDIS implementers understand how health IT can optimize quality reporting using electronic data feeds such as EHR feeds, case management platforms, and immunizations registries.

How will this impact you?
As part of our Digital First initiative, you'll see an increased push to transition to direct data feeds for electronic exchange of clinical data. With increased electronic data exchange, providers can expect fewer requests for medical records.

Virtual Office Advisory (VOA) webinars

Our Virtual Office Advisory (VOA) webinars are bimonthly webinars, each under an hour long, that allow you to hear from Priority Health experts on a variety of topics, including billing and coding tips and updates on products, risk adjustment, formulary changes, Medicare and Medicaid quality, behavioral health and more.

Visit the VOA page[1] to find registration links to future VOAs and archived recordings of past VOAs.



[1] priorityhealth.com/provider/manual/news/voa

Priority Health products

Product updates and information

We release an annual provider product guide to walk you through the most important changes for the year ahead. Find this and more updates, organized chronologically from most recent on back, about our products and member benefits at plans, benefits and coverage news page.[1]

Visit our provider-facing plans page[2] to learn more about our member plans that have specific provider requirements. These include:

- Government programs
  - Medicare Advantage (MAPD) plans[3]
  - Medicaid programs[4]
- Specialty commercial plans
  - Narrow networks[5]
  - Tiered networks[6]
  - Corewell Health East employee plan[7]

[1] priorityhealth.com/provider/manual/news/plans
[2] priorityhealth.com/provider/manual/provider-plans
[3] priorityhealth.com/provider/manual/mapd
[4] priorityhealth.com/provider/manual/medicaid-programs
[5] priorityhealth.com/provider/manual/provider-plans/narrow-networks
[6] priorityhealth.com/provider/manual/provider-plans/tiered-networks
[7] priorityhealth.com/provider/manual/provider-plans/corewell-health-east-employee

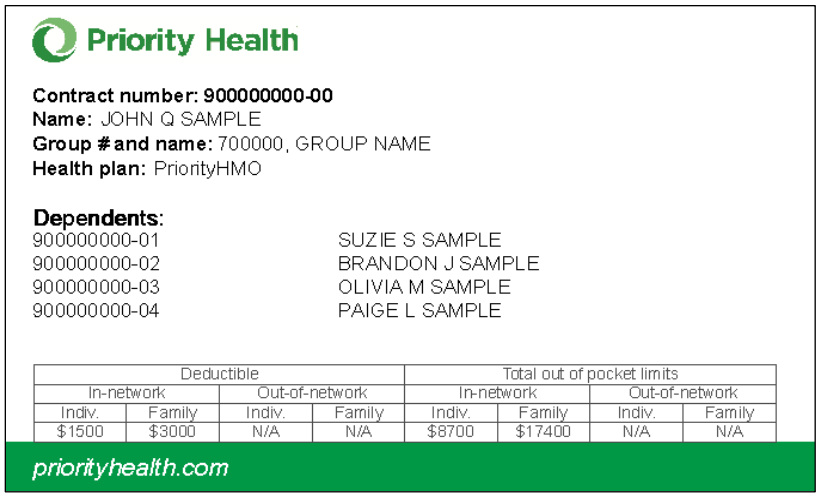
Member ID cards

Please use Member Inquiry in prism whenever possible for information about a member's plan. However, in certain situations, member ID cards are a helpful identifying resource. See below for sample member ID cards organized by line of business.

Note: these are just samples. Details will be different on every member's card, depending on the specifics of their plan. For more information, please refer to the "How to read your member ID card" document included in the appendices of this packet for a visual guide to using our members' ID cards.

Employer group plans

Standard group



Priority Health

Contract number: 900000000-00
Name: JOHN Q SAMPLE
Group # and name: 700000, GROUP NAME
Health plan: PriorityHMO

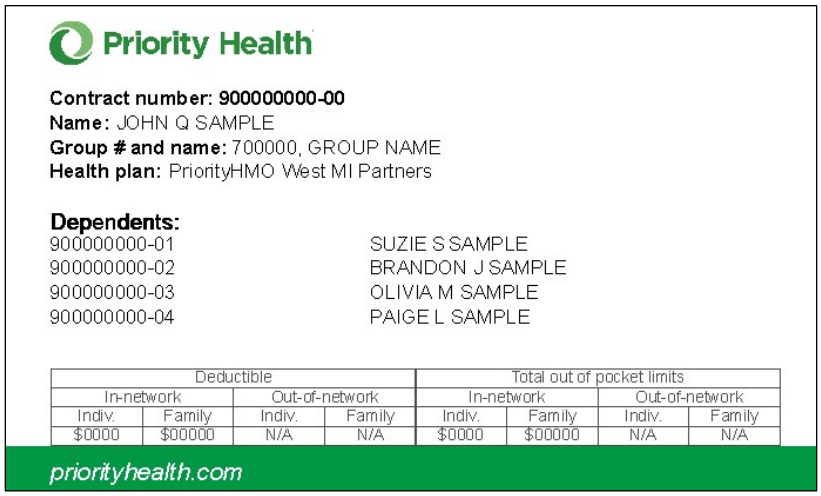
Dependents:

900000000-01	SUZIE S SAMPLE
900000000-02	BRANDON J SAMPLE
900000000-03	OLIVIA M SAMPLE
900000000-04	PAIGE L SAMPLE

Deductible				Total out of pocket limits			
In-network		Out-of-network		In-network		Out-of-network	
Indiv.	Family	Indiv.	Family	Indiv.	Family	Indiv.	Family
$1500	$3000	N/A	N/A	$8700	$17400	N/A	N/A

priorityhealth.com

Tiered network[1]



Priority Health

Contract number: 900000000-00
Name: JOHN Q SAMPLE
Group # and name: 700000, GROUP NAME
Health plan: PriorityHMO West MI Partners

Dependents:

900000000-01	SUZIE S SAMPLE
900000000-02	BRANDON J SAMPLE
900000000-03	OLIVIA M SAMPLE
900000000-04	PAIGE L SAMPLE

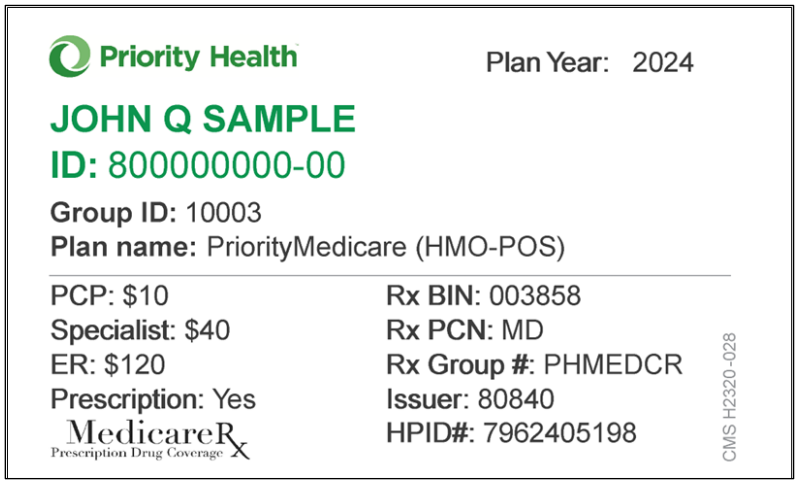
Deductible				Total out of pocket limits			
In-network		Out-of-network		In-network		Out-of-network	
Indiv.	Family	Indiv.	Family	Indiv.	Family	Indiv.	Family
$0000	$00000	N/A	N/A	$0000	$00000	N/A	N/A

priorityhealth.com

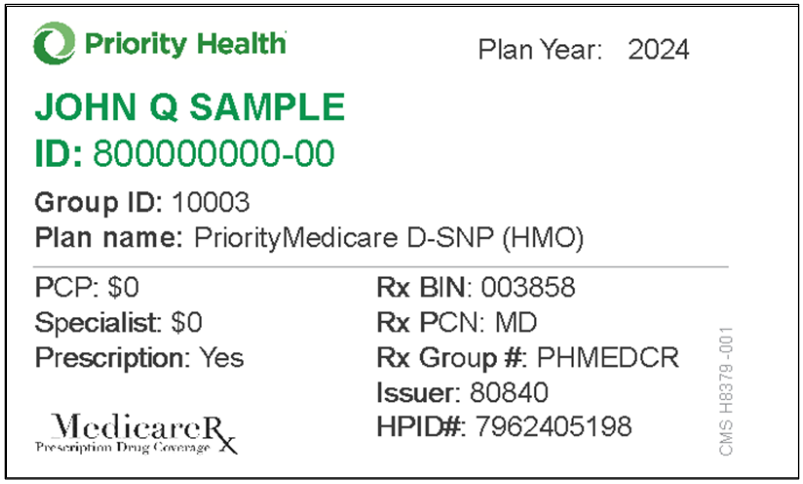
[1] prioritynhealth.com/provider/manual/provider-plans/tiered-networks

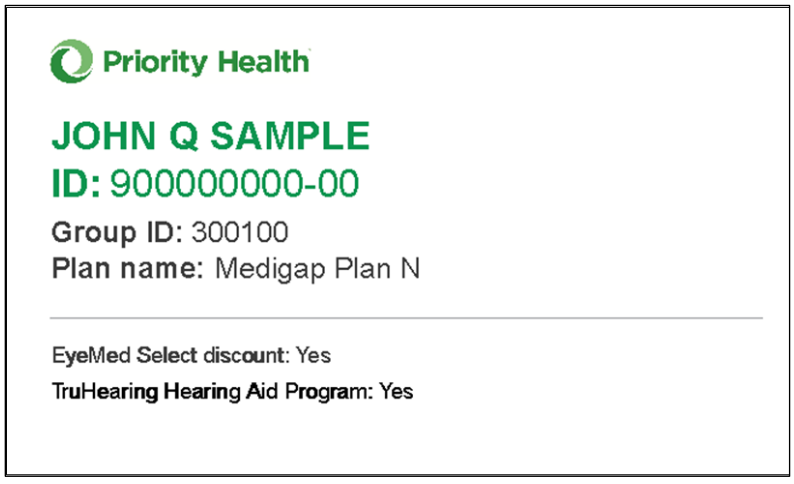
Medicare plans

Medicare Advantage

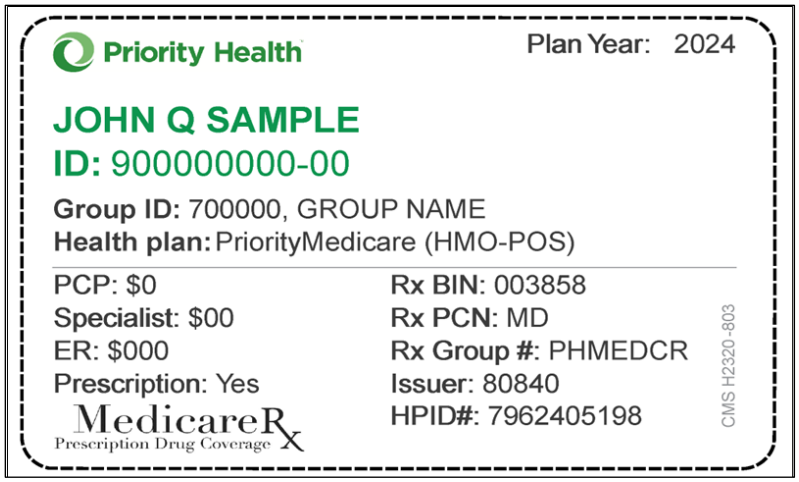


D-SNP (dual-eligibility special needs)



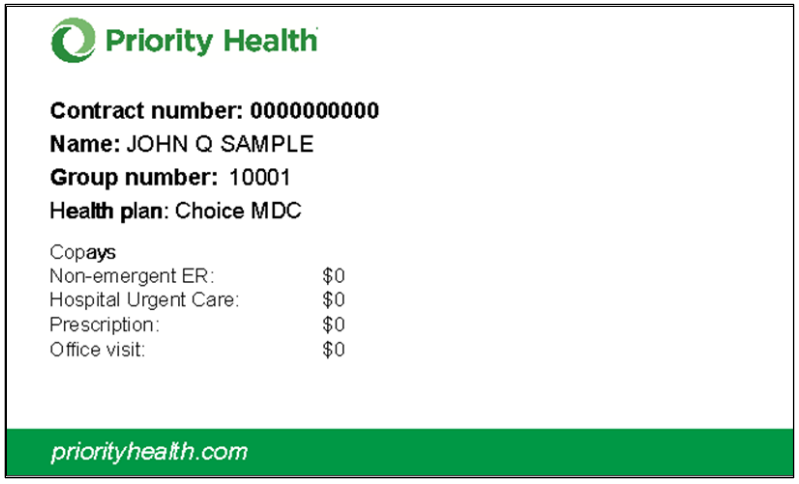


EGWP (employer group waiver plan)

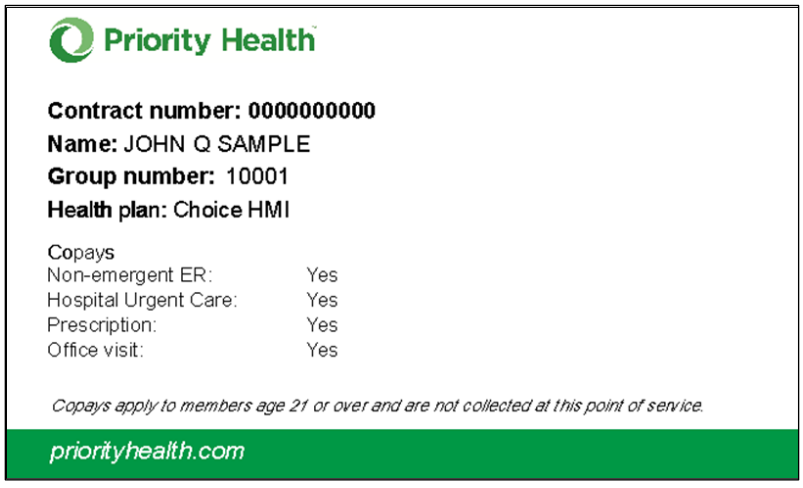


Medicaid plans

Priority Medicaid

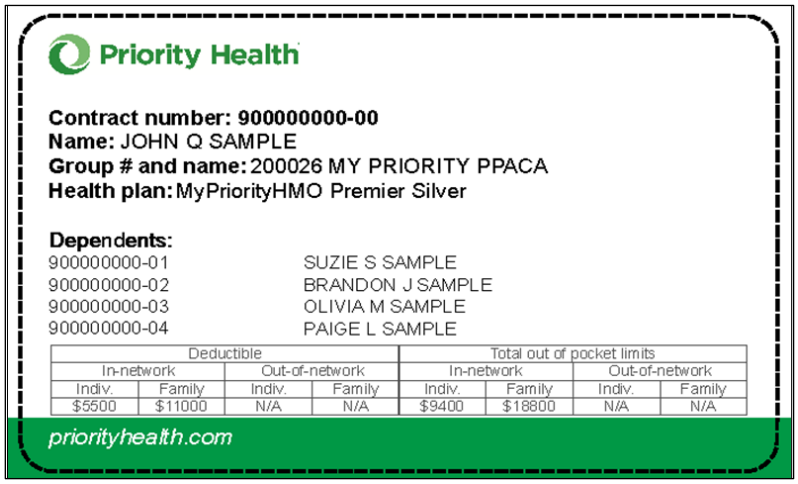


Healthy Michigan Plan



Individual MyPriority plans

Standard MyPriority



Priority Health

Contract number: 900000000-00
Name: JOHN Q SAMPLE
Group # and name: 200026 MY PRIORITY PPACA
Health plan: MyPriorityHMO Premier Silver

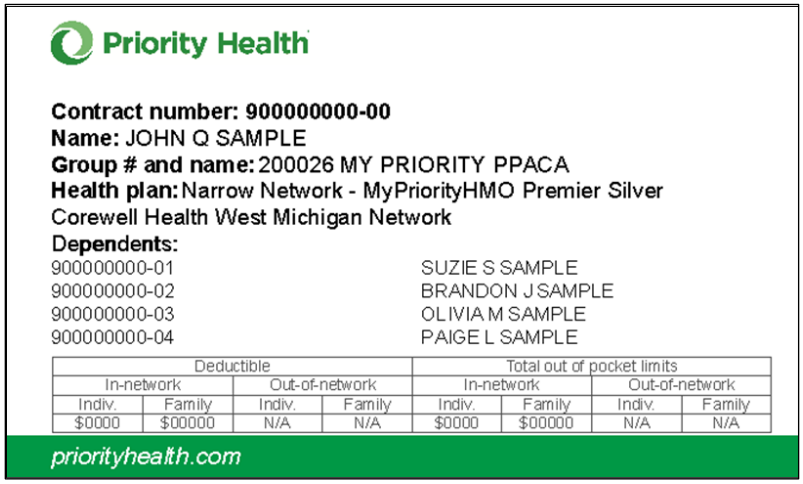
Dependents:

900000000-01	SUZIE S SAMPLE
900000000-02	BRANDON J SAMPLE
900000000-03	OLIVIA M SAMPLE
900000000-04	PAIGE L SAMPLE

Deductible				Total out of pocket limits			
In-network		Out-of-network		In-network		Out-of-network	
Indiv.	Family	Indiv.	Family	Indiv.	Family	Indiv.	Family
$5500	$11000	N/A	N/A	$9400	$18800	N/A	N/A

priorityhealth.com

Narrow network[1]



Priority Health

Contract number: 900000000-00
Name: JOHN Q SAMPLE
Group # and name: 200026 MY PRIORITY PPACA
Health plan: Narrow Network - MyPriorityHMO Premier Silver
Corewell Health West Michigan Network
Dependents:

900000000-01	SUZIE S SAMPLE
900000000-02	BRANDON J SAMPLE
900000000-03	OLIVIA M SAMPLE
900000000-04	PAIGE L SAMPLE

Deductible				Total out of pocket limits			
In-network		Out-of-network		In-network		Out-of-network	
Indiv.	Family	Indiv.	Family	Indiv.	Family	Indiv.	Family
$0000	$00000	N/A	N/A	$0000	$00000	N/A	N/A

priorityhealth.com

[1] priorityhealth.com/provider/manual/provider-plans/narrow-networks

Priority Health + Cigna strategic alliance[1]

What providers need to know about our new Strategic Alliance

Since 2018, Priority Health and Cigna have partnered to offer Priority Health commercial group members living or traveling outside Michigan access to Cigna's nationwide network of providers through a Strategic Alliance.

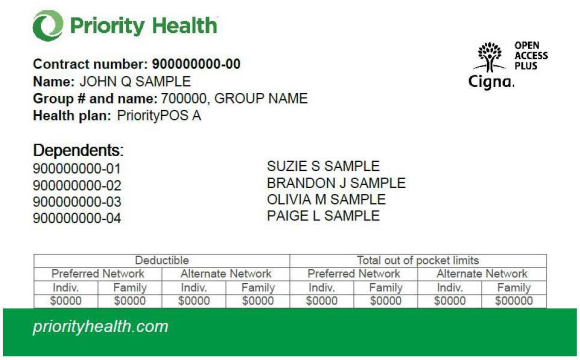
What this means for you

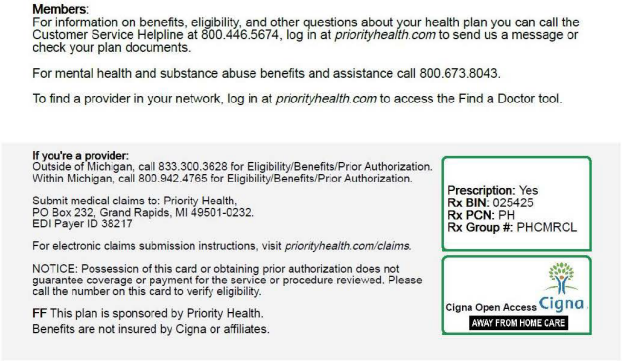
- Cigna commercial group members and Cigna affiliated members that get care in Michigan can access the Priority Health preferred provider organization (PPO) network. This means other Cigna Strategic Alliances with other health plans can access our network.
- If a patient presents a Cigna ID card, they are covered under the Priority Health network. Visit our FAQ[2] for exceptions within Ancillary care.
- Priority Health commercial group members that get care outside of Michigan have access to the Cigna Open Access Plus (OAP) network.
- **All Priority Health member claims should be submitted to Priority Health, *not Cigna*.** Likewise, all claims Cigna member claims should be submitted to Cigna. Follow any instructions on the member ID card for submitting claims, prior authorizations or calling for assistance.

Member ID cards[3]

Sample member ID cards are shown below. Note that actual ID cards may vary depending on plan type, funding type and other factors.

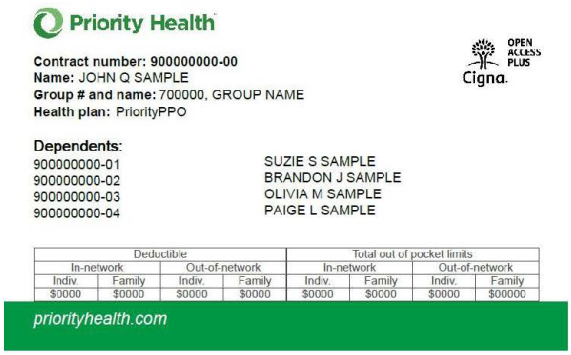
Priority Health members living in Michigan

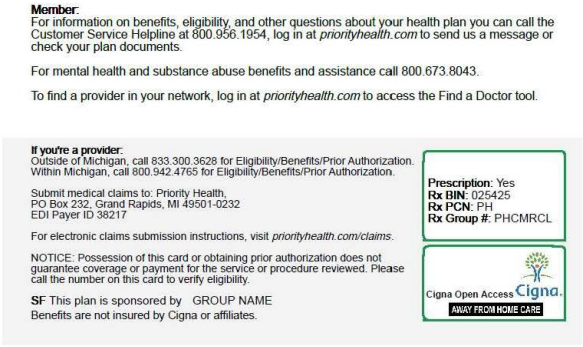




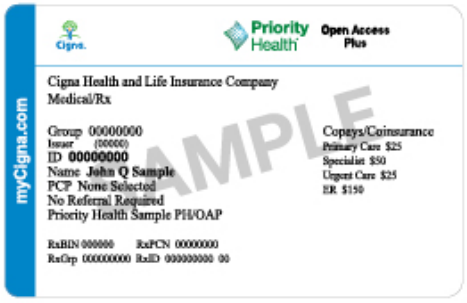
[1] priorityhealth.com/provider/manual/cigna-strategic-alliance
[2] priorityhealth.com/provider/manual/cigna-strategic-alliance/faqs-for-providers
[3] priorityhealth.com/provider/manual/cigna-strategic-alliance/member-id-cards

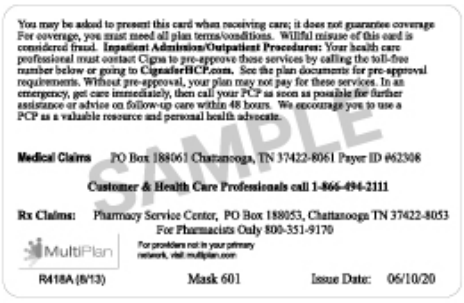
Priority Health members living outside of Michigan





Cigna members living in Michigan will have the Priority Health logo on their Cigna ID card





Reminder: Cigna members who are part of a Cigna Strategic Alliance are covered under the Priority Health network.

here.[1]

Seeing a Priority Health or Cigna member in Michigan[2]

Question	Priority Health member	Cigna member
How do I know if my patient has Priority Health or Cigna as the	Your patient will have a Priority Health ID card.	Your patient will have a Cigna ID card. Their card may display the Cigna logo and the name of the

[1] static.cigna.com/assets/chcp/resourceLibrary/referenceGuides/medicalReferenceGuides.html
[2] priorityhealth.com/provider/manual/cigna-strategic-alliance/members-in-michigan

Question	Priority Health member	Cigna member
primary plan administrator?		Strategic Alliance their plan is affiliated to.
What is the network and governing contract for reimbursement?	• Providers in Michigan: Priority Health contractual terms and reimbursement apply, with a few exceptions in ancillary care. For Cigna members getting ancillary services like durable medical equipment, behavioral health and home infusion, Cigna's national ancillary agreements will apply. See FAQs below for more information about ancillary care. • Providers outside Michigan: Cigna's contractual terms and reimbursement apply in all other states.	
How do I confirm eligibility or benefits for my patients?	• Online[1] • Within Michigan: **800.942.4765** • Outside of Michigan: **833.300.3628** • Electronic data interchange (EDI) clearinghouse	• Visit Cigna for Health Care Professionals[2] > Patients (To use this tool, you must be a registered user with access to view patient information.) • Cigna Customer Service: **800.882.4462** • EDI clearinghouse
How do I submit claims? ***(See FAQs for exceptions related to ancillary care.)***	• Electronic: Use Priority Health payer ID 38217 • Paper: Priority Health Claims P.O. Box 232 Grand Rapids, MI 49501	• Online[3] • Electronic: Use Cigna payer ID 62308 • Paper: Use the address on back of ID card
Who processes claims and issues the explanation	Priority Health	Cigna, or a Cigna Strategic Alliance partner

[1] priorityhealth.com/provider/manual/patient-eligibility
[2] cignaforhcp.cigna.com/app/login
[3] cigna.com/health-care-providers/coverage-and-claims/submit-claims/

Question	Priority Health member	Cigna member
of payment, explanation of benefits, or statement of account? ***(See FAQs for exceptions related to ancillary care.)***		
How can I review claim status?	• Online[1] • Within Michigan: **800.942.4765** • Outside of Michigan: **833.300.3628**	See the back of the patient's ID card. Cigna Customer Service: **800.882.4462**
How do I submit an appeal?	See the Provider Manual[2] for information on claims and authorization appeals by plan type.	• See Cigna's Appeal Policy and procedure[3] • Contact Cigna's Provider Service line at **800.882.4462** • Complete Cigna's online appeal form[4] • **Through the mail:** Attn: Cigna Appeals Unit PO Box 188011 Chattanooga, TN 37422 If the Cigna ID card indicates GWH-Cigna or 'G' on the front of

[1] prioritynhealth.com/provider/manual/billing/status-claims
[2] prioritynhealth.com/provider/manual/appeals
[3] static.cigna.com/assets/chcp/resourceLibrary/clinicalReimbursementPayment/medicalClinicalReimbursePoliciesProcedures.html
[4] static.cigna.com/assets/chcp/pdf/resourceLibrary/medical/RequestForHealthCareProfessionalPaymentReview.pdf

Question	Priority Health member	Cigna member
		the card, use the following address: Attn: Cigna Appeals Unit PO Box 188062 Chattanooga, TN 37422-8062
Who do I contact for prior authorization or for medical management services?	• See the patient's ID card for instructions • Online[1]	• Visit Cigna for Health Care Professionals[2] > Patients > View and submit precertification (To use this tool, you must be a registered user with precertification access.) • Cigna's Provider Service Line: **833.300.3628** • To find out which services require an authorization, visit Cigna for Health Care Professionals > Useful links > Precertification policies
How do I request prior authorizations for high-tech radiology?	In Michigan: Login to your provider account and Request an Authorization[3]	• eviCore.com • Call eviCore at **888.693.3297**

[1] priorityhealth.com/provider/manual/auths
[2] cignaforhcp.cigna.com/app/login
[3] provider.priorityhealth.com/providers

Question	Priority Health member	Cigna member
	Outside Michigan: Use our provider manual[1]	
Who do I contact if I have a question on a Behavioral Health claim for a Cigna member?		Behavioral Health providers are excluded from the Alliance. Contact Cigna's provider service line at **800.433.5768** to review the status of the claim.
Who do I contact if I have issues with payment from Cigna?		Call Cigna Provider Services line: **800.882.4462** **Haven't received payment?** Cigna will need your claim number, patient name and date of birth, date of service and Member ID number Remittance amount doesn't match fee schedule? Call the number above or complete Cigna's online appeal form[2].

[1] priorityhealth.com/provider/manual/auths
[2] static.cigna.com/assets/chcp/pdf/resourceLibrary/medical/RequestForHealthCareProfessionalPaymentReview.pdf

Out-of-state provider information

Providers outside of Michigan[1]

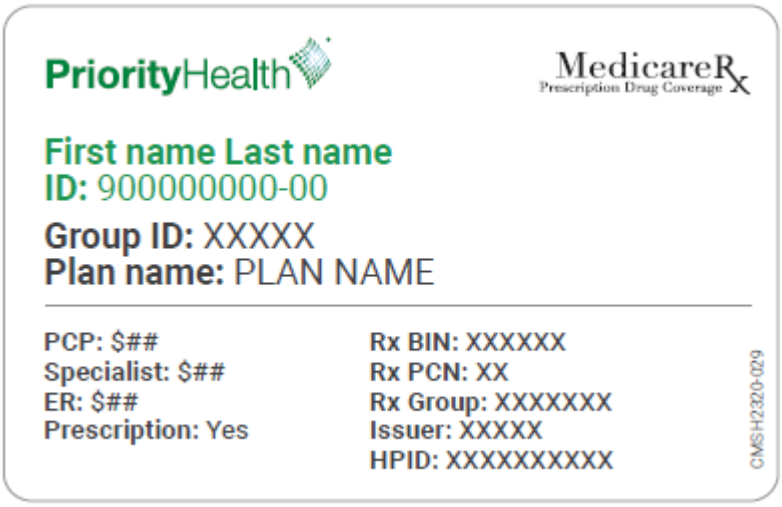
We're Michigan's smart choice for beneficiaries who are seeking quality, affordable health insurance. For many of our members, that includes out-of-state coverage. We value the care and service you provide our members when they're traveling and want to make sure working with us is an easy and convenient process.

Medicare members[2]

With national coverage, our Medicare Advantage[3] members can have peace of mind knowing they'll have access to care wherever life takes them.

How does out-of-state coverage work?

Most Priority Health Medicare Advantage plans include coverage outside of Michigan. When a member with one of these plans sees a provider outside of Michigan who participates with Original Medicare or is included in the Multiplan Medicare Advantage network, we'll cover those services at the in-network benefit level.



The back of the card will include a MultiPlan logo. Members are **not** limited to providers in the MultiPlan Medicare provider network.

[1] prioritynealth.com/provider/out-of-state-providers
[2] prioritynealth.com/provider/out-of-state-providers/medicare
[3] prioritynealth.com/medicare

Members will also receive a Travel Pass card that they may show you. We value the care you provide our members while they're out-of-state and want to make sure working with us is easy and convenient. Follow the directions on the Travel Pass card to learn more about the member's ID card and how to submit claims.

Rest easy knowing your claims will be paid.

As a Medicare-participating provider, you can have peace of mind knowing you'll be reimbursed for the services you provide our Medicare Advantage members while they're away from home.

- We reimburse providers at the National Medicare Physician Fee Schedule allowed rate, using the associated relative value unit (RVU) file provided by the Centers for Medicare and Medicaid Services (CMS).
- We process claims quickly. In 2020, our average processing time for claims was within 7 days of receipt.
- We send payments in the way that's most convenient for you. We process and mail hard-copy checks weekly. We also offer electronic funds transfer (EFT) for even quicker payment. Review our EFT requirements and get set up.[1]

Register for a prism account.

When you create a prism account[2] with us, you'll get access to our Member Inquiry tool. This tool is a quick, self-service option that lets providers check patient eligibility and see important plan information without having to call our provider helpline. You don't need to be a contracted Priority Health provider to create an account.

With an account, you'll be able to:

[1] prioritythealth.com/provider/manual/eft
[2] provider.prioritythealth.com/providers/s/provider-selfservice

- Check eligibility and contract history
- See out-of-pocket limits, deductible balance(s), copays and coinsurance
- Check the status of claims quickly

Non-Medicare members[1]

The Cigna OAP network is our preferred network for out-of-state coverage for participating commercial plan members. These members have access to Cigna's quality health care network that features nearly one million health care providers nationwide when the member travels outside the state of Michigan.

Members with Cigna OAP network coverage will have the Cigna logo on their member ID card. For eligibility and benefits information or treating a Priority Health member with an HMO plan for a non-emergent service, providers should call the Priority Health out-of-state helpline at **833.300.3628.**

Looking for Cigna OAP participating providers? Do a Cigna OAP provider search.[2]

Authorizations

Providers outside of Michigan should visit our authorizations page[3] or call the Priority Health out-of-state helpline at **833.300.3628** to determine authorization requirements.

Billing

- **Electronic claims submission:**
  Use Priority Health payer ID 38217
- **Submit paper medical claims:**
  Priority Health Claims
  P.O. Box 232
  Grand Rapids, MI 49501

Remember to submit claims for Priority Health members to Priority Health, *not to Cigna*.

[1] priorityhealth.com/provider/out-of-state-providers/commercial-out-of-state-information
[2] hcpdirectory.cigna.com/web/public/consumer/directory/search?consumerCode=HDC042
[3] priorityhealth.com/provider/manual/auths

FAQs

Does Priority Health have a provider portal, and what can I do through that portal?

Yes! Priority Health does indeed have a portal specific to providers and provider organizations, groups and hospitals. This portal is called prism[1] and it is your access to verifying member eligibility and benefits, submitting authorization requests, checking claim statuses, filing appeals and submitting other questions.

How do I create and manage a prism account with Priority Health?

Priority Health has a page in our provider manual[2] which was been created to show you how to register, navigate and manage your prism account. This page contains a quick start guide as well as FAQs and video tutorials to walk you through how to best leverage the tools available.

Where can I find resources regarding the process of adding providers to our group or changing our group information?

There are resources in our provider manual[3] dedicated to adding or removing providers or changing practice information with Priority Health. These informational resources will advise you on how you can submit these change requests, as well as track the status of your request through prism.

How do I submit an authorization request to Priority Health?

Priority Health's resources can advise you on whether an authorization is required for a certain service as well as how to submit your authorization request and track the status. See our provider manual[4] for more information. Note that certain actions will prompt you to log into your prism account.

Does Priority Health Maintain a list of billing guidelines which I can use to ensure my claims meet processing requirements?

Our billing & payments page on our provider manual[5] covers a wide range of topics from how to submit claims to Priority Health, what information needs to be included in a claim submission, corrected claim procedures and much more.

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[1] provider.priorityhealth.com
[2] priorityhealth.com/provider/manual/prism-resources
[3] priorityhealth.com/provider/manual/standards/credentialing
[4] priorityhealth.com/provider/manual/auths
[5] priorityhealth.com/provider/manual/billing

Once I have submitted my claim, how can I check on the status or file an appeal?

Prism is your go-to place to verify the status of your unpaid claims, or to confirm the payment details of claims which have completed processing. By logging into prism and selecting “Claims” from the navigation bar, you can search for member claims and verify these details. Have questions about your claim or need to file an appeal? Click on “Contact Us” at that top of the claim to submit a question or request to us. Your question will be reviewed and sent back to you through prism. You can also use prism to view your front-end-rejected claims. If you prefer to receive electronic service receipts for your rejected claims you can register for our electronic data interchange (EDI) service here.[1]

How do I register to receive payments through Electronic Funds Transfer (EFT) rather than receiving paper checks?

Prism contains an EFT request form in the "Resources" selection of the prism navigation bar. Just click on Resources and select “Set up EFT." If you would like to review Priority Health’s informational details about EFT, you can click on “Set up electronic funds transfer” in the billing and payments section of our Provider Manual. For more information, visit our provider manual.[2]

Does Priority Health leverage a data exchange for electronic files and reports?

Yes. Priority Health has a data exchange called Filemart where you can access various data files. Visit our provider manual[3] to review setup for Filemart and for information pertaining to setting up and accessing EDI files.

How do I know when to reach out to Priority Health or to my provider group/organization/network?

Any questions related to contracting (including rates), provider enrollments/changes or incentive payments should go through your organization. Anything related to service or payment at the level of your specific building/entity within the organization should be directed to Priority Health. Consult our "Get your questions answered" document (included in the appendices) for more details.

[1] priorityhealth.com/provider/manual/set-up-edi
[2] priorityhealth.com/provider/manual/eft
[3] priorityhealth.com/provider/manual/data-exchange

What are the best times to call the Provider Helpline to avoid a long wait?

The busiest times for the Provider Helpline tend to be between 10:00–noon and between 2:00–4:00. So call early (we start taking calls at 7:30 Monday–Thursday and 9:00 on Friday) or between noon–2:00 for the shortest wait times. However, you can also avoid the wait entirely by checking the "Get your questions answered" document (in the appendices) and finding what you need without picking up the phone.

What are some of the member programs you offer that I can refer my patients to?

We have numerous member programs to help supplement the care you provide our members. See a full list of the member programs we offer here.[1]

How do I find my network effective date?

Your network effective date will come through a comment in prism. (An email will let you know a new comment has been posted.) You can start seeing Priority Health members on this date.

What are the rights and responsibilities of Priority Health members?

Our site lists all member rights[2] and responsibilities.[3]

Where can I learn about a Priority Health member's right to file grievances and appeals?

Priority Health members have the right to file requests, complaints, grievances and appeals. Learn more here.[4]

[1] priorityhealth.com/provider/manual/member-programs
[2] priorityhealth.com/member/center/your-account/your-rights
[3] priorityhealth.com/member/center/your-account/your-responsibilities
[4] priorityhealth.com/member/contact-us/filing-a-complaint

Appendices