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Conway PHO Insurance Forum

March 3, 2026

Agenda

- Disclaimer
- Secure Provider Portal Updates
- Availity Essentials Key Points
- Appointment Availability Times
- Clinical& Payment Policies
- ORP Editing
- New Arkansas Medicaid ID Requirement
- 2026 Ambetter Other Insurance Coverage Changes for ARHOME
- Sober Sidekick Program
- Wellcare by Allwell
  Important Prior Authorization Updates
- Upcoming Webinar Dates
- Contact Information

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Disclaimer

- Arkansas Health and Wellness has produced this material as an informational reference for providers furnishing services in our contract network Arkansas Health and Wellness employees, agents and staff make no representation, warranty, or guarantee that this compilation of information is error-free and will bear no responsibility or liability for the results or consequences of the use of this material.
- The presentation is a general summary that explains certain aspects of the program,but is not a legal document.
- Although every reasonable effort has been made to assure the accuracy of the information within these pages at the time of publication, the program is constantly changing, and it is the responsibility of each provider to remain abreast of the program requirements. Any regulations, policies and/or guidelines cited in this publication are subject to change without further notice.
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Availity Essentials

What is Availity Essentials?

Availity Essentials is a secure online portal that helps healthcare providers manage transactions with multiple health plans. It includes tools for eligibility and benefits, claims, and prior authorizations.

Features

- **Eligibility and benefits**: Check eligibility and benefits in real time, including coverage information, co-insurance, and deductibles
- **Claims**: Submit claims,& track claim status
- **Prior authorizations**: Submit and follow up on authorization requests

Availity Essential Tips

- To access Availity's self-service tools, popups must be enabled in your browser tab.
- Availity Essentials is compatible with the following browsers - Mozilla Firefox, Microsoft Edge, and Google Chrome.
- Have a question when in an application? Select the field level-help icon. This will provide you with detailed information about that section and may even include health plan specific information.
- Fields with an asterisk (*) are required. However, some payers might require other fields not indicated by an asterisk.
- Add providers to Manage My Organization (MMO) for easy data entry on a form. Your organization's Availity Administrator must complete this setup.
- Some health plans will have a payer space where you can access specific health plan resources, applications, news & announcements and more. This is where you can frequently find the health plan's provider manual and contact information.
- Run an Eligibility & Benefits Inquiry prior to using other applications in Availity. This confirms the patient's eligibility and the patient's information will be saved for you to access in other applications.
- For additional help visit www.availity.com

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Secure Provider Portal

Secure Portal Features

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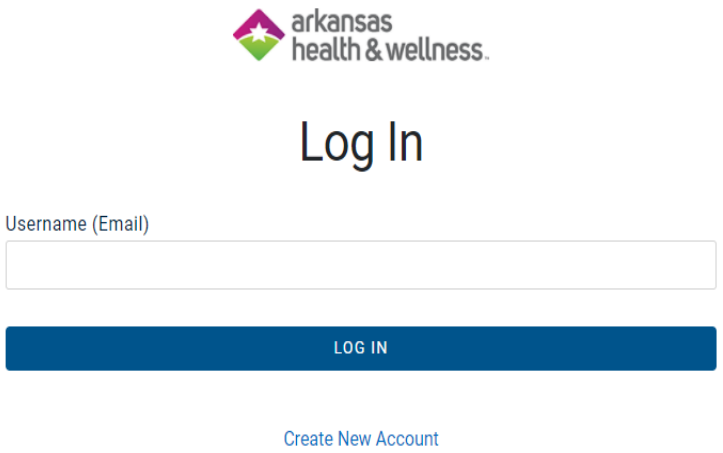
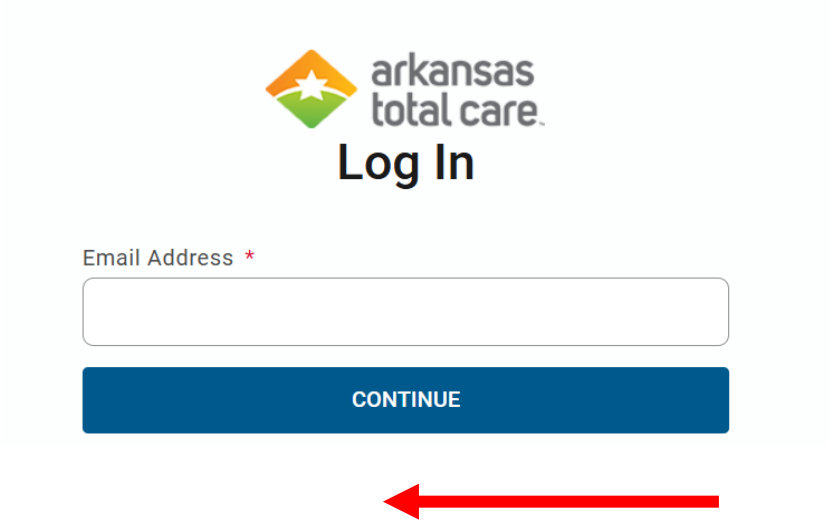
- A member eligibility overview page that reflects all critical data in a single view.
- Ability to submit and track the status of claim reconsiderations online.
- Expanded free text fields for reconsideration comments and explanations.
- Attach required documentation when filing a reconsideration.
- Upload records for care gap information.
- Receive push notifications regarding reconsideration status changes.
- Void/Recoup option on claims already adjudicated by the health plan. The manual inside the portal has instructions for this feature.

Secure Provider Portal

- Registration is free and easy
- A registration video and PDF are available to assist you.
- Contact your Provider Relations Specialist if you have questions.
- https://www.arhealthwellness.com/login.html ; https://www.arkansastotalcare.com/providers.html





Appointment Availability Times

Ambetter Appointment Accessibility Times

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Ambetter follows the accessibility and appointment wait time requirements set forth by applicable regulatory and accrediting agencies. Ambetter monitors participating provider compliance with these standards at least annually and will use the results of appointment standards monitoring to ensure adequate appointment availability and access to care and to reduce inappropriate emergency room utilization. The table below depicts the appointment availability for members:

Appointment Type	Access Standard
PCPs – Routine visits	30 calendar days
PCPs – Adult Sick Visit	48 hours
PCPs – Pediatric Sick Visit	24 hours
Behavioral Health – Non-life Threating Emergency	6 hours
Specialist	Within 30 calendar days
Urgent Care Providers	24 hours
Behavioral Health Urgent Care	48 hours
After Hours Care	Office number answered 24 hours/7 days a week by answering service or instructions on how to reach a physician
Emergency Providers	24 hours a day, 7 days a week

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Appointment Availability Time Frames

Primary Care

- **Emergency:** Same day or within 24 hours of member's call
- **Urgent Care:** Within 24 hours
- **Routine:** Within 30 business days of request
- **Sick Care:** Within seven business days

Behavioral Health

- **Non-Life-Threatening Psychiatric Emergency:** Within six hours
- **Urgent:** Within 48 hours
- **Routine (Initial Assessment):** Within 10 business days
- **Routine Follow-Up Care:** Within 30 business days of assessment
- **Sick Care:** Within seven business days

Specialty Referral

- **Emergency:** Within 24 hours of member's call
- **Urgent Care:** Within 24 hours
- **Routine:** Within 30 business days

ARTC Availability and Wait Times

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The table below depicts appointment availability for members:

Service Type	Time Frame
Emergency care — medical, behavioral health, substance abuse	24 hours a day, seven days a week
Behavioral health service, developmental disability service, mobile crisis service, mobile crisis response	24 hours a day, seven days a week
Urgent care — medical, behavioral health, substance abuse	Within 24 hours
Primary care — routine, non-urgent symptoms	Within 21 calendar days
Behavioral health, substance abuse care — routine, non-urgent, non-emergency	Within 21 calendar days
Prenatal care	Within 14 calendar days
Primary care access to after-hours care	Office number answered 24/7 by answering service or instructions on how to reach a physician
Preventive visit/well visit	Within 30 calendar days
Specialty care — non-urgent	Within 60 calendar days
HCBS — identified as necessary to project the health and safety of the member	Within 90 calendars of completion of the PCSP

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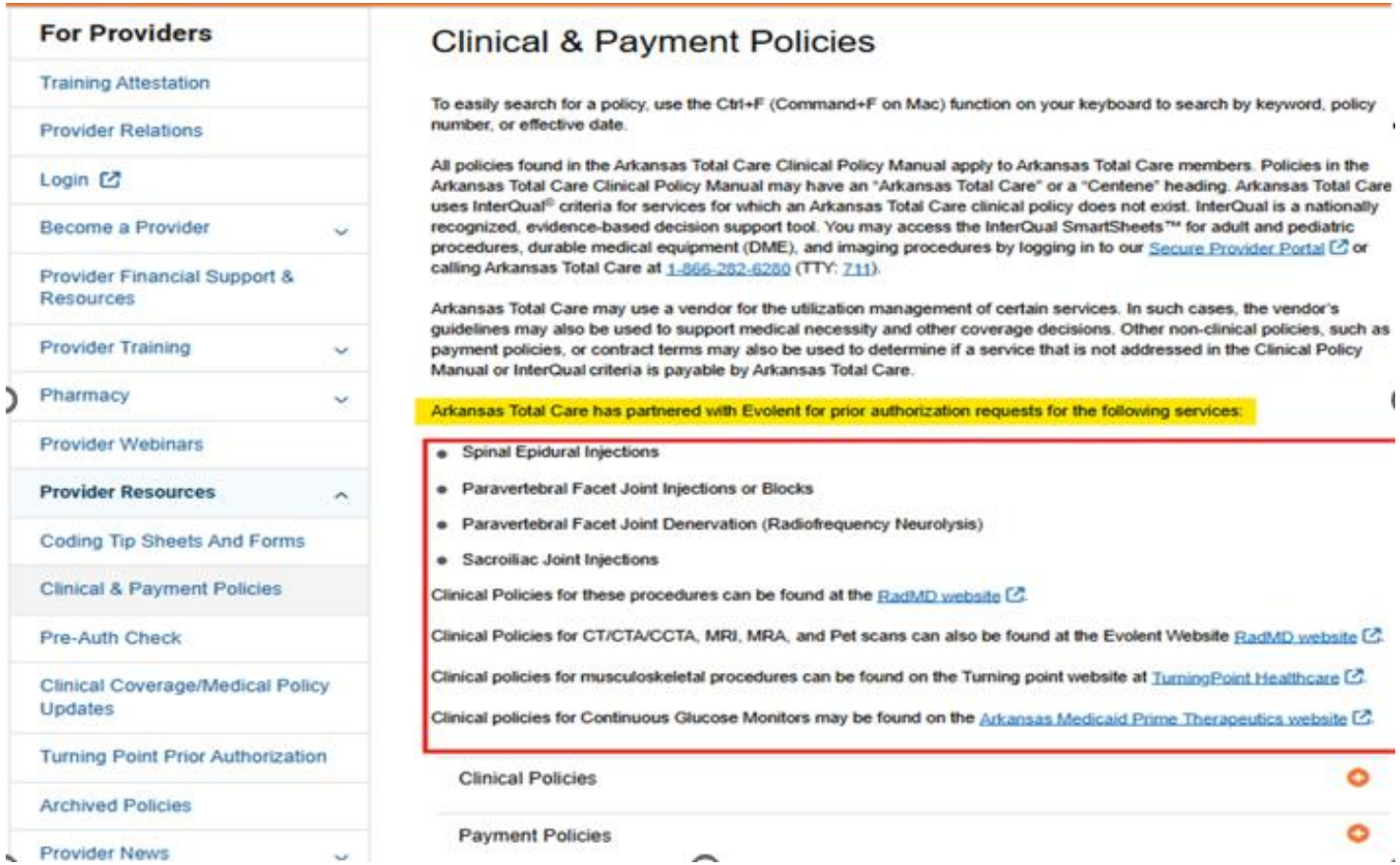
Clinical & Payment Policies



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- The Clinical, Payment and Pharmacy policies can be found by going to:

  Arkansastotalcare.com or arkansashealthandwellness.com
  - Hover over the "For Providers" tab at the top of the screen
  - Select "Provider Resources" from the drop-down menu
  - Select Clinical and Payment Policies on the left.
- Use the Ctrl+F (Command+F on Mac) function on your keyboard to search by keyword, policy number or effective date.

If you have questions, please call 1-866-282-6280.

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ORP Editing

(Ordering, Referring, Prescribing NPI)

Ordering, Referring, Prescribing NPI

To align with a Medicaid requirement, we have begin denying claims immediately if they are billed with an Ordering, Referring, or Prescribing NPI that is not an individual. The denial code used will be EXig (ORP PROV NOT ELIG TO BE PAID AS NOT Individual, Group OR Office ENROLLMENT TYPE).

*****This only applies to ARTC*****

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New ARTC Medicaid ID Requirement

Effective **October 15, 2025**, providers that meet the below criteria will be required to submit their Arkansas Medicaid ID to Arkansas Total Care on each claim submission.

1. All atypical providers and practitioners that bill for the following provider types:

   67, 70, 71, 72, 73,74, 75, 82, 84, 86, 87, 95, 96, 97

2. All providers that bill under a single NPI number with multiple associated Medicaid IDs.

Beginning **October 15, 2025,** all claims meeting the above criteria will be denied, when the Arkansas Medicaid ID is not billed.

2310B — Rendering Provider Secondary Identification			
2310B — Rendering Provider Secondary Identification	REF	For healthcare rendering providers, submit the Medicaid Provider ID in REF02 and submit the NPI and Taxonomy in Loop 2310B.	
		REF01	Value=G2 (Provider Commercial Number
		REF02	Length = 9 Value = Rendering Provider Secondary Identification (Medicaid Provider ID)
2010BB—Billing Provider Secondary Identification			
2010BB – Billing Provider Secondary Identification	REF	For healthcare providers, submit the Medicaid Provider ID in REF02, the NPI in Loop 2010AA, and taxonomy in Loop 2000A. For atypical providers, submit the Medicaid ID only in REF02.	
		REF01	Value=G2 (Provider Commercial Number
		REF02	Length = 9 Value = Billing Provider Secondary Identification (Medicaid Provider ID)

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2026 Ambetter Other Insurance Coverage Changes for ARHOME

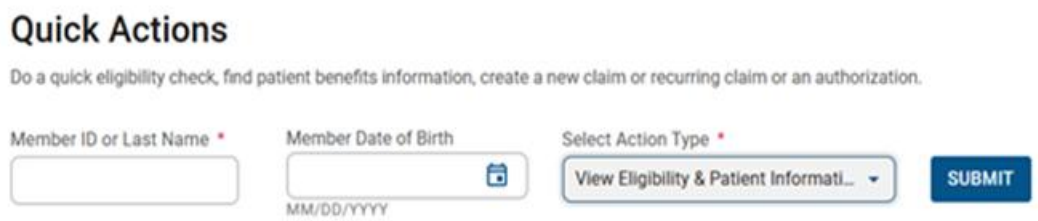
Effective January 1, 2026, Ambetter's ARHOME coverage will become the payer of last resort for coordination of benefits purposes. This means that if members have any other insurance, it must pay first and Ambetter will pay claims as secondary.

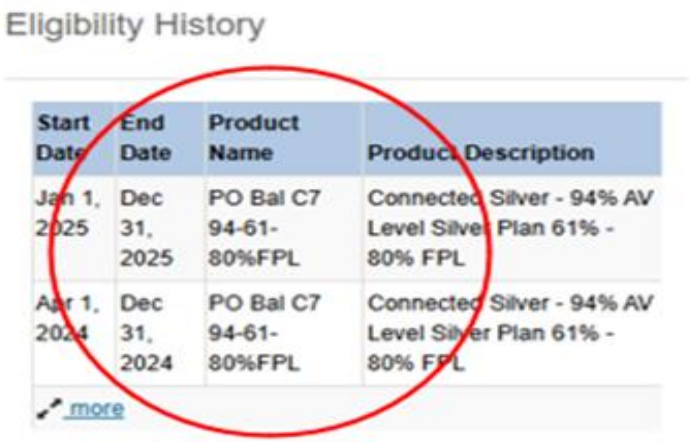
How do I verify whether a member has an ARHOME plan?

There are three main ways you can check to see if a member has an ARHOME plan.

1. Secure Provider Portal

Log in to your Ambetter Provider Portal at Provider.ARHealthWellness.com and use the Quick Actions tool to search for the appropriate member. If they have an ARHOME plan, the plan product name will start with a "PO Bal" identifier:





2. Member ID Card

Check the member's Ambetter ID card. If it has a blue ARHOME logo on the front, beside the Ambetter logo, that member is part of an ARHOME plan.

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3. Call Center

Our call center is available to assist you in reviewing a member's plan division to determine whether they are an ARHOME member. Give us a call at 1-877-617-0390 (TTY: 1-877-617-0392).

What do I need to do?

For Ambetter members with ARHOME coverage, file claims with the primary insurance carrier first. You should file with Ambetter only after the claim has been filed with the primary carrier.

Thank you for your continued partnership in helping Arkansas live better. If you have any questions or concerns, please contact us at 1-877-617-0390 (TTY: 1-877-617-0392).

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Sober Sidekick Program

Sober Sidekick Program

Sober Sidekick is a virtual platform designed to empower addiction by connecting individuals with tools and resources in their communities. This includes creating opportunities for connection, encouragement, and shared experiences through its peer-driven community.

By gathering and analyzing behavioral insights, the partnership will enable a deeper understanding of challenges and opportunities, allowing for more proactive and supportive care for those in recovery.

- **Bridging Gaps in Care**
- **Reducing Relapse Rates**
- **Scalable Recovery Support**
- **Available to all Arkansans**

This resource is available to all Arkansas residents in partnership with Ambetter from Arkansas Health & Wellness.

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Wellcare by Allwell
Important Prior Authorization Updates
(Effective Apr. 1, 2026)

Prior Authorization Updates (Effective Apr. 1, 2026)

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As part of our ongoing work to improve the prior authorization (PA) process for both providers and members, Ambetter from Arkansas Health & Wellness wants to share some important updates to our PA requirements. Our goal is to reduce administrative burden, simplify submission and approval processes, and facilitate timely access to appropriate, high-quality care.

Code change details can be found below. These changes may include:

- Removing PA requirements based on criticality of review and clinical need.
- Creating a more uniform set of prior authorization requirements across our markets and lines of businesses, including adding and changing some PA requirements, to simplify processes, reduce confusion for providers, and support future efforts to expand real-time responses to requests.

If you have questions about specific prior authorization codes or how these changes affect your practice, please reach out to your local Provider Engagement representative.

Service Category	PA Rule	Services	Procedure codes
DME Services	No PA Required for PAR providers	Beds	E0185
		Orthotic & Prosthetic	L1951
		Supplies and Devices	E0486
DME Services	PA Required	Diabetic Drugs And Supplies	A9276
	No PA Required for PAR providers	Diabetic Drugs And Supplies	A9279
		Wheelchairs	K0004
Drug Codes	No PA Required for PAR providers	Medications	J1096
Genetic Analysis	No PA Required for PAR providers	Genetic Testing	81240, 81256
Genetic Analysis	No PA Required for PAR providers	Genetic Testing	81252
Imaging Services	No PA Required for PAR providers	Nuclear Medicine	77002
Physician Services	No PA Required for PAR providers	Other Services	G3002
Physical Medicine	No PA Required for PAR providers	Orthotic & Prosthetic	L5652
Skin Procedures	PA Required	Muscle Flap Procedures	15734, 15736, 15738
Surgery Procedures	No PA Required for PAR providers	Surgery-Nervous System	64718, 64719
Surgery Procedures	PA Required	Surgery-Musculoskeletal System	25111
	No PA Required for PAR providers	Surgery-Eye and Ocular Adnexa	66982
Vision Services	No PA Required for PAR providers	Vision Evaluation	92004

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PROCEDURE CODES UPDATED AS OF 4/1/26

Upcoming Webinar Dates

Webinar Dates

Webinar	Date	Time
AHW Q1	3/12/2026	10:00am
ARTC Q1	3/12/2026	2:00pm
ARTC Q1	3/17/2026	10:00am
AHW Q1	3/17/26	2:00pm

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Contact Information

Provider Services Call Center

First line of communication

- Ambetter Provider Services — 1-877-617-0390 TTY/TDD: 1-877-617-0392
- Wellcare by Allwell Provider Services — 1-855-565-9518 TTY/TDD: 711
- Arkansas Total Care Provider Services — 1-866-282-6280 TTY/TDD: 1-866-282-6280

Provider Service Representatives can assist with questions regarding:

- Member Eligibility
- Claim Inquiry
- Prior Authorization
- Network Verification
- Appeal Status
- Payment Inquiries
- Check Stop Pay or Check Reissues
- Negative Balance Report
- Provider Demographic Change Request
- Secure Portal Password Reset

Representatives are available Monday through Friday, 8AM to 5PM (Central Standard Time)

Provider Inquiries

- After speaking with a Provider Service Representative, please make sure you obtain a reference number. This will be used to rack the status of your inquiry.

- If you need to contact your assigned Provider Relations Representative, you should have the following when calling or submitting an email inquiry:
  - Reference number assigned by the Provider Services Center
  - Provider's Name
  - Tax ID
  - National Provider Identifier (NPI)
  - Summary of the issue
  - Claim numbers (if applicable)

Join Our Email List Today

Arkansas Health & Wellness provides the tools and support you need to deliver the best quality of care. Please view our listing on the left, or below, that covers forms, guidelines, helpful links, and training.

- For Ambetter information, please visit our Ambetter website.
- For Wellcare by Allwell information, please visit our Wellcare by Allwell website.

Interested in getting the latest alerts from Arkansas Health and Wellness? Fill out the form below and we'll add you to our email subscription.

- Manuals, Forms and Resources
- Eligibility Verification
- Prior Authorization
- Electronic Transactions
- Preferred Drug Lists
- Provider Training
- Negative Balance How-To Guide (PDF)

*Name **

*Position/Title **

*Email **

*Phone Number **

*Group Name **

*Group NPI **

*Tax ID **

*Network**

- [ ] Ambetter
- [ ] [MEDICARE]

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Receive current updates:

- https://www.arhealthwellness.com/providers/resources.html
- https://www.arkansastotalcare.com/providers.html


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Provider relations

Medicare Prior Authorization Summary:

Wellcare requires prior authorization (PA) as a condition of payment for many services. This notice contains information regarding such prior authorization requirements and is applicable to all Medicare products offered by WellCare.

WellCare is committed to delivering cost effective quality care to our members. This effort requires us to ensure that our members receive only treatment that is medically necessary according to current standards of practice. Prior authorization is a process initiated by the physician in which we verify the medical necessity of a treatment in advance using independent objective medical criteria and/or in network utilization, where applicable.

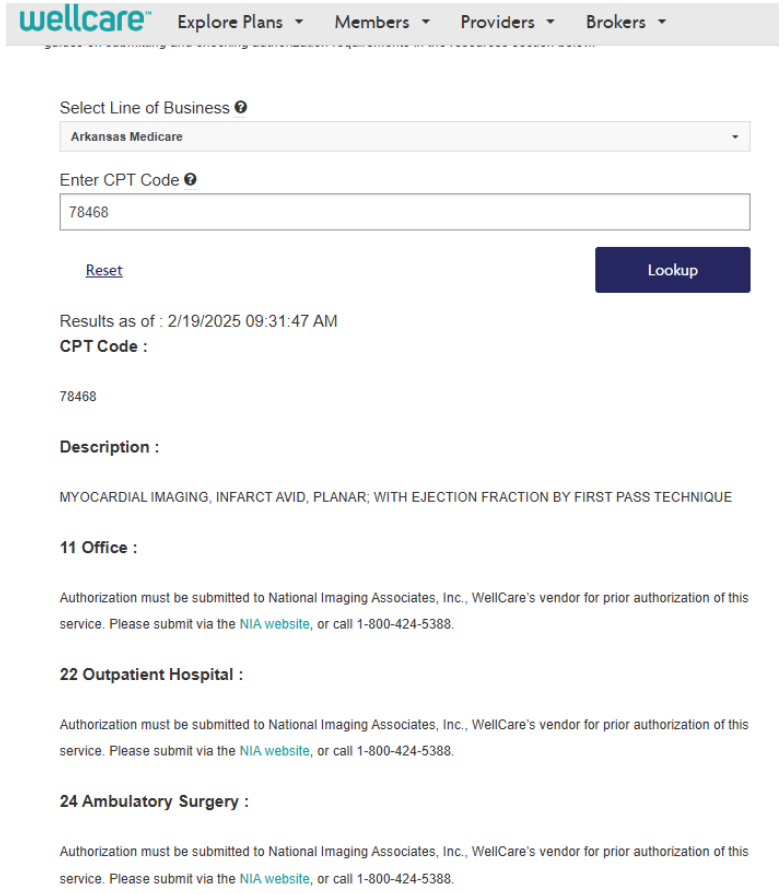
It is the ordering/prescribing provider's responsibility to determine which specific codes require prior authorization. Please verify eligibility and benefits prior to rendering services for all members. Payment, regardless of authorization, is contingent on the member's eligibility at the time service is rendered.

NON-PAR PROVIDERS & FACILITIES REQUIRE AUTHORIZATION FOR ALL HMO SERVICES EXCEPT WHERE INDICATED. For complete CPT/HCPCS code listing, please see Online Prior Authorization Tool on our website at wellcare.com/Authorization-Lookup.

Submitting an Authorization Request:

- Prior Authorization options: Provider portal, via Fax, and phone (emergent or urgent authorizations Only)
- Via Provider Portal- The fastest and most efficient way to request an authorization
- Via Fax- The completed form(s) and any supporting documentation to the fax number listed on the form will be required.
- Via Telephone- Authorization requests that are emergent or urgent should be submitted via telephone. Emergent or urgent requests should only be submitted when the standard time frame could seriously jeopardize the member's life or health.

Authorization Lookup tool:



Timely Claims Submission:

- Unless otherwise stated in the Provider Agreement, participating Providers must submit Clean Claims (initial, corrected, and voided) to Wellcare within 180 calendar days from the date of discharge (for inpatient services) or the date of service (for all other services).

- The start date for determining the timely filing period is the “from” date reported on a CMS-1500 or 837-P for professional claims or the “through” date used on the UB-04 or 837-I for institutional claims.

CMS Prior Authorization Change Summary: Effective January 1, 2026

On January 1, 2026, the Centers for Medicare & Medicaid Services (CMS) will implement new prior authorization (PA) response time requirements for all providers.

- **Standard prior authorization requests** will be completed within 7 calendar days, with a possible extension up to 14 calendar days under certain circumstances.
- **Expedited/Urgent prior authorization requests** will be completed within the lesser of 72 hours -OR- the current BD turnaround time.

With shorter response times for supporting clinical information requests, all necessary clinical information should be submitted at the time of the authorization request.

Additional Information:

- Complete clinicals include Diagnosis, History and Current Condition, Treatment Plan and Interventions, and Relevant Diagnostic Tests.
- Response times can be lessened if all information is submitted with the authorization request.
- Missing clinical information may lead to a denial due to inadequate supporting records.
- Submitting prior authorization requests via the secure Availity portal allows for faster review.

Centene clinical policies and criteria can be found at Availity.

https://essentials.availity.com/availity/help-providers/source/portal_providers/release_communication/2026_01/_topics/c_centene_authorization_dual_membership.html

Disputes and Appeals:

180 days to file claim

Dispute/Appeal: 90 calendar days of the EOP

When submitting a dispute/appeal, the Provider must provide the following information:

- Date(s) of service
- Member name
- Member ID number and/or date of birth
- Claim number
- Provider name
- Provider Tax ID/TIN
- Total billed charges
- Authorization number (if applicable)
- The Provider's statement explaining the reason for the dispute
- Supporting documentation when necessary (e.g., proof of timely filing, medical records)

Claims & Dispute Guide:

Claims, Disputes & Recovery/CCU Guide

The **Provider Portal** is the fastest way to get help with Claims, Claims Disputes, Corrections and Status. In the portal, there's a convenient and easy way to **Chat** with an agent. You can also check status of Claims by calling Provider Services. For more information and Claims forms, please visit **wellcare.com/providers**; select your state and click on *Claims* under Medicare.

CLAIM SUBMISSION INFORMATION

SUBMISSION INQUIRIES

For inquiries related to your electronic or paper submissions to Wellcare, please contact our EDI team at **EDIBA@centene.com**.

Timely Filing guidelines: 180 days from date of service or as specified in your Provider Contract.

ELECTRONIC FUNDS TRANSFER AND ELECTRONIC REMITTANCE ADVICE

Register online using the simplified, enhanced provider registration process at **payspanhealth.com** or call **1-877-331-7154**.

CLEARINGHOUSE CONNECTIVITY

Wellcare has partnered with Availity as our preferred EDI Clearinghouse. You may connect directly to Availity or continue to use your existing vendor/biller/clearinghouse. If you need assistance in making a connection with Availity or have any questions, please contact Availity client services at **1-800-282-4548**.

FREE DIRECT DATA ENTRY (DDE)

Availity Essentials offers providers a web portal for direct data entry (DDE) claims that will submit to Wellcare electronically at no cost to you. To register, submit the request to **availity.com/Essentials-Portal-Registration**.

PAYER IDs

- **Fee-for-Service (FFS) is defined in the Transaction Type Code BHT06 as CH, which means Chargeable, expecting adjudication.**
- **Encounters (ENC) is defined in the Transaction Type Code BHT06 as RP, which means Reportable only, NOT expecting adjudication.**

Claim Type	FFS (CH - Chargeable) Submissions	Encounter (RF - Reporting only) Submissions
Professional or Institutional	14163	59354

MAIL PAPER CLAIM SUBMISSIONS TO:

Wellcare
Attn: Claims Department
P.O. Box 31372
Tampa, FL 33631-3372

CLAIM PAYMENT DISPUTES

The Claim Payment Dispute Process is designed to address claim denials for issues related to untimely filing, unlisted procedure codes, non-covered codes etc. Examples include Explanation of Payment Codes DN001, DN038, DN039, VSTEX, HRM16 and KYREC. However, this is not an all-encompassing list of Appeals codes. Claim payment disputes must be submitted in writing to Wellcare **within 90 calendar days** of the date on the EOP or as specified in your Provider Contract.

Submit all claims payment disputes with supporting documentation at provider.wellcare.com or by mail.

CLAIM PAYMENT DISPUTES WITH SUPPORTING DOCUMENTATION MAY ALSO BE MAILED TO:

Wellcare
Attn: Claim Payment Disputes
P.O. Box 31370
Tampa, FL 33631-3370
Fax: 1-877-277-1808

NOTE: Please refer to the member ID card to determine appropriate authorization and claims submission process. Wellcare does not accept handwritten, faxed or replicated claim forms. Wellcare does not accept media storage devices such as CDs, DVDs, USB storage devices or flash drives.

APPEALS (MEDICAL)

Any appeals related to a claim denial for lack of prior authorization, services exceeding the authorization, insufficient supporting documentation or late notification must be sent to Appeals (Medical). Anything else related to authorization or medical necessity that is in question should be sent to the Appeals P.O. Box. Include all substantiating information (please do not include image of claim) like a summary of the appeal, relevant medical records and member-specific information.

MAIL APPEALS TO:

Wellcare
Attn: Appeals Department
P.O. Box 31368
Tampa, FL 33631-3368

CLAIM PAYMENT POLICY DISPUTES

The Claims Payment Policy Department has created a new mailbox for provider issues related strictly to payment policy issues. Disputes for payment policy-related issues must be submitted to us in writing within **90 calendar days** of the date on the EOP (refer to your contract for required timing). Please provide all relevant documentation (please do not include image of Claim), which may include medical records, in order to facilitate the review.

Submit all Claims Payment Policy Disputes related to Explanation of Payment Codes beginning with IH###, CE###, CV### (Medical records required) or PD### at provider.wellcare.com or by mail.

IH###, CE###, CV### (MEDICAL RECORDS REQUIRED) OR PD### TO:

Wellcare
Attn: Payment Policy Disputes Department
P.O. Box 31426
Tampa, FL 33631-3426

CPI## 1ST LEVEL (INCLUDE ALL MEDICAL RECORDS AND INITIAL REVIEWS) APPEALS TO:

BY MAIL (U.S. POSTAL SERVICE)
Optum
P.O. Box 52846
Philadelphia, PA 19115
Phone: 1-844-458-6739 | Fax: 1-267-687-0994

BY DELIVERY SERVICES (FEDEX, UPS)
Optum
458 Pike Road
Huntingdon Valley, PA 19006

BY SECURE INTERNET UPLOAD
Refer to Optum's Medical Record Request letter for further instructions.

LT###, RVLT# AND CPI## 2ND LEVEL APPEALS TO:

Wellcare
Attn: CCR
P.O. Box 31394
Tampa, FL 33631-3394

RVPI# TO:

PICRA
P.O. Box 31416
Tampa, FL 33631-3416

RECOVERY/COST CONTAINMENT UNIT (CCU)

REFUND(S) in response to a Wellcare overpayment notification should include a copy of the overpayment notification as well as a copy of attachment(s) and sent to:

Wellcare – Comprehensive Health Management
Attn: Recovery/Cost Containment Unit (CCU)
P.O. Box 947945
Atlanta, GA 30394-7945

If you do not agree with this proposed Wellcare overpayment notification related to adjustments **RVXX (Except RV059**, which should refer to the **Claim Payment Disputes** section above), you may request an Administrative Review by submitting a dispute in writing within **45 days** of the recovery letter date or as specified in your Provider Contract. Your request should detail why you disagree with these findings and must include any supporting evidence/documentation you believe is pertinent to your position.

MAIL OR FAX YOUR ADMINISTRATIVE REVIEW REQUEST TO:

Wellcare
Attn: CCU Recovery
P.O. Box 31658
Tampa, FL 33631-3658
Fax: 1-813-283-3284

Additional documentation received after your initial Administrative Review request will not be considered. A Final Determination will be rendered within **30 days** of the date of Wellcare's receipt of your request or as specified in your Provider Contract. If you do not submit a dispute or render payment within the time period referenced above, we will take action to recover the amount owed as allowed by law, or as outlined within the contract between you and Wellcare.

ADMINISTRATIVE REVIEWS RELATED TO EXPLANATION OF PAYMENT CODES AND COMMENTS BEGINNING WITH DN227, DN228 OR RV213 must be submitted in writing and include at a minimum: a summary of the review request, the member's name, member's identification number, date(s) of service, reason(s) why the denial should be reversed, copies of related documentation and all applicable medical records related to both stays to support appropriateness of the services rendered.

YOUR DISPUTE SHOULD BE SENT TO:

Cotiviti
Attn: Wellcare Clinical Chart Validation
HillCrest III Building
731 Arbor Way, Suite 150
Blue Bell, PA 19422
Fax: 1-203-202-6607
Phone: 1-203-202-6107 (Inquiries Only)

PROVIDER-IDENTIFIED REFUND(S) without receiving overpayment notification should include the reason for overpayment as well as any details that assist in identifying the member and Wellcare Claim ID.

Wellcare – Comprehensive Health Management
Attn: Recovery/Cost Containment Unit (CCU)
P.O. Box 947945
Atlanta, GA 30394-7945

NOTE: For single-claim checks, please use the Refund Check Informational Sheet to help Recovery post accurately and timely. For checks in excess of 25 claims, please complete the Refund Referral Grid. Both documents can be found at **wellcare.com/providers**; select your state and click on *Forms* under Medicare.

MAIL ALL SUPPORTING DOCUMENTATION, INCLUDING THE GRID, TO ASSIST WITH EXPEDITED POSTING TO:

Wellcare
Attn: CCU Recovery
P.O. Box 31658
Tampa, FL 33631-3658

Please note that only check referrals will be accepted by this mailbox; anything other than check referrals will not be responded to and will be closed.

Updating Provider Directory Information:

WE RELY ON OUR PROVIDER NETWORK TO ADVISE US OF DEMOGRAPHIC CHANGES SO WE CAN KEEP OUR INFORMATION CURRENT

- To ensure our members and Provider Relations staff have up-to-date provider information, please give us advance
- notice of changes you make to your office phone number, office address or panel status
- (open/closed). Thirty-day advance notice is recommended.

New Phone Number, Office Address or Change in Panel Status:

- Please use our email drobox: wellcarearkansasproviderupdates@centene.com
- Include any necessary attachments (i.e., W-9, letter, roster, provider profile, effective date) for processing.

Provider Access & Support:

Provider Portal Registration:

- https://provider.wellcare.com/Provider/Accounts/Registration

Provider Portal Training:

- https://www.wellcare.com/arkansas/Providers/Medicare/Training/New-Provider-Portal-Overview-Training

Bulletins/Announcements:

- https://www.wellcare.com/en/Arkansas/Providers/Bulletins

RX Affect

- https://auth.rxante.com

Provider Manual & Quick Reference Guide

- Claims/Encounter Guides
- Authorization Instructions
- Disputes and Appeals
- https://www.wellcare.com/arkansas/Providers/Medicare

HEDIS tool Kit

- https://www.wellcare.com/arkansas/Providers/Medicare/Quality

Provider Relations Contact:

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Nickolaus.J.Lovelace@Centene.com
501-551-8768