

2026 Conway PHO Insurance Forum

March 03, 2026



Agenda

- ▶ Member ID Cards
- ▶ Provider Gold Card
- ▶ Using *My Account – Tools for Providers*
- ▶ Medical Policies
- ▶ Prior Authorization Check Tool
- ▶ Online Authorizations
- ▶ Clear Claim Connection
- ▶ Modifier Usage
- ▶ Top Denials and How to Prevent Them
- ▶ Appeal vs. Request for Reconsideration
- ▶ Provider Newsletters and Quick Alerts
- ▶ Important Contacts
- ▶ Provider Relations Representatives

Member ID cards



**New Member
ID: 080808080**

**Coverage: Employee and Family
Effective Date: 01/01/2011**

In Network: Ind Ded\$1000/\$2000 Fam
MOOP: Ind \$3000/\$6000 Fam
Out of Network: Ind Ded \$1000/\$2000 Fam
MOOP: Unlimited

Find providers in the QualChoice network at QualChoice.com or by calling **800.235.7111**. Services received outside the QualChoice network will be covered at the out-of-network benefit level. For emergencies while traveling outside Arkansas, call QualChoice National Network at 800.235.7111 for provider information.
800.235.7111 (TTY 711) QualChoice.com

Call QualChoice for:

- Pre-authorization of any hospital admission to an out-of-network facility or a facility outside of Arkansas. In the case of an emergency, you must call within 2 business days.
- Pre-authorization of procedures as specified in your official plan documents.
- Verification of benefits, eligibility or claim status.

Note:

- If you do not get pre-authorization when required, your benefits may be reduced or denied.
- If you do not present this ID card to all providers you may have to pay all charges.
- Out-of-network reimbursement is subject to Maximum Allowable Payment.

Submit claims to:

QualChoice, P.O. Box 25610, Little Rock, AR 72221
QualChoice EDI Payor ID 35174



This plan is insured by QCA Health Plan, Inc.:
501.228.7111 (TTY 711) or 800.235.7111 (TTY 711) • www.QualChoice.com The unauthorized or fraudulent use of this card to obtain medical services or prescription drugs is punishable by law.

Prior Authorization Gold Card Status

- ▶ Effective January 1, 2026, providers with a historical Prior Authorization (PA) approval rate over 90% will receive a PA Gold Card. This status will exempt them from obtaining PA for medical services.
- ▶ Providers who meet the criteria will be notified of their Gold Card status by letter.
- ▶ Providers that do not have a Gold Card will be required to obtain PA as required today – nothing changes.
- ▶ Provider Gold Card status is reviewed and updated annually.
- ▶ Gold Card status will apply to any medical services that require PA.
- ▶ If you have a Gold Card from previous years, you will keep that Gold Card.

My Account – Home page



My Account

Provider Home Patient Inquiry Claim Center Pre-authorizations Resources

DANIELLE_W@QCPR

Provider Home

What's New for Providers

For successful 270/271 eligibility requests, be sure to include the following:

- Member ID
- Member date of birth
- Member first and last names

Click on link in news feed below for more information.

Prenatal and Postpartum Care

Fri, 28 Jul 2023 13:38:23 -0500

Bonnie Pruett Promoted to Statewide Account Manager

Mon, 26 Jun 2023 12:21:50 -0500

Individual and Small Group Metallic Plans Chart Chase Program

Tue, 30 May 2023 17:28:26 -0500

2020-2021 Community Impact Report

Wed, 01 Mar 2023 10:18:12 -0600

Post-Payment DRG Clinical Validation Audits

Tue, 21 Feb 2023 10:51:27 -0600

Provider Snapshot: QCA Health Plan, Inc.-DUMMY PORTAL ACCESS

Provider: QCA Health Plan, Inc.-DUMMY PORTAL ACCESS

Provider ID: 710794605PT

Provider NPI:

Type:

Specialties: Hierarchy

Primary Address

12615 Chenal Pkwy Ste 300
Little Rock, AR 72211

Remit Address

12615 Chenal Pkwy Ste 300
Little Rock, AR 72211

Manage Patients

Manage information, referrals and pre-authorizations for your patients.

- [Find a Patient or Member](#)
- [MagellanRx Management Clinical Criteria](#)

AutoAuth Pre-authorization

Reduce the time spent on phone calls and faxing! Submit the required information online and get a rapid response.

- Learn More
 - [Available Types of Service](#)
 - [AutoAuth Pre-authorization Made Easy](#)
 - [AutoAuth DRG Notifications](#)
 - [AutoAuth Pre-authorization Frequently Asked Questions](#)
 - [AutoAuth Pre-authorization Procedure Codes](#)
- [Check Patient Eligibility](#)
- [AutoAuth Pre-authorization Tools](#)
- [Get Started](#)

Claims and Services

View patient claims and service details.

- [Search Remittance Advice](#)
- [View Recent Claims](#)
- [View Outpatient Services](#)
- [View Inpatient Stays](#)
- [Provider Relations Representatives Map](#)
- [Clear Claim Connection](#)

Using My Account – Tools for Providers

Sign in to the mobile-friendly provider portal to manage your account.

Within My Account you can:

- ▶ Check member eligibility and benefits
- ▶ Search and view claims and remittance advice (RA)
- ▶ Search and view referrals and pre-authorizations
- ▶ View our Provider Manual
- ▶ Access Clear Claim Connection
- ▶ Read more about important provider updates

Tools for Providers

The screenshot shows the QualChoice Health Insurance website. At the top right, there is a 'My Account' section with links for 'Register' and 'Sign In'. The main navigation bar includes 'Home', 'Shop Plans & Services', 'Already a Member?', 'For Brokers', 'For Providers', 'News & Tips', and 'About'. The 'For Providers' menu is open, listing items such as 'Using My Account', 'COVID-19 Information Center', 'Electronic Transactions', 'Find A Form or Document', 'Medical Coverage Policies', 'Pharmacy', 'Utilization Management & Pre-authorization', 'Pre-authorization List', 'Provider Manual', and 'Provider News'. A red arrow points to the 'Provider Manual' link. Below the navigation is a large banner with the text 'Can Your Gut Health Affect Your Heart?' and a sub-header 'Tips for Gut Health'. At the bottom of the banner are four red buttons: 'Shop for a Health Plan', 'Find a Doctor or Hospital', 'Pay My Bill', and 'Contact Us'.

We Keep it Simple

We're working to make health insurance simple and to improve the health of our members.
And we do that with friendly, reliable, local customer service.



QualChoice Clinical, Payment, and Pharmacy Policies

- ▶ All policies are published at <https://www.qualchoice.com/for-providers/clinical-and-payment-policies>.
- ▶ Search all policies by code.

Information that is not addressed in these policies is payable by QualChoice.

Clinical Policies for CT/CTA/CCTA, MRI, MRA, and Pet scans can also be found at the [Evolent website](#).

Clinical Policies	+	<input type="text" value="Enter Keyword"/>	<input type="button" value="Search"/>
Payment Policies	+		
Pharmacy Policies	+		

Future Policy Updates

- ▶ All future policies are published at <https://www.qualchoice.com/for-providers/policy-updates>

Clinical Coverage/Medical Policy Updates

QualChoice updates a select number of clinical coverage policies each month, ensuring the reviewal of all policies on an annual basis.

Policy Updates Effective August 1, 2025



Policy Updates Effective September 1, 2025



Policy Updates Effective October 1, 2025



Policy Updates Effective November 1, 2025



Prior Authorization Tool

- ▶ Prior Authorization Tool

<https://documents.qualchoice.com/area/shared/preauthorizationlist.aspx>

- ▶ Search all policies by code.

DISCLAIMER: All attempts are made to provide the most current information on the Pre-Auth Needed Tool. However, this does NOT guarantee payment. Payment of claims is dependent on eligibility, covered benefits, provider contracts, correct coding and billing practices. For specific details, please refer to the provider manual. If you are uncertain that prior authorization is needed, please submit a request for an accurate response.

Note: It is the responsibility of the facility, in coordination with the rendering practitioner, to ensure that an authorization has been obtained for all inpatient and selected outpatient services, except for emergency stabilization services. All inpatient admissions require prior authorization. To determine if a specific outpatient service requires prior authorization, utilize the Pre-Auth Needed tool below by answering a series of questions regarding the Type of Service and then entering a specific CPT code.

Any anesthesiology, pathology, radiology or hospitalist services related to a procedure or hospital stay requiring a prior authorization will be considered downstream and will not require a separate prior authorization.

Are services being performed in the Emergency Department?

Yes No

In which plan is the individual requesting services enrolled/covered?

▼

Complex Imaging, MRA, MRI, PET and CT Scans need to be verified by **Evolut.**

<i>Types of Services</i>	<i>YES</i>	<i>NO</i>
Is the member being admitted to an inpatient facility?	<input type="radio"/>	<input checked="" type="radio"/>
Are anesthesia services being rendered for dental surgeries?	<input type="radio"/>	<input checked="" type="radio"/>
Is the member receiving gender reassignment services?	<input type="radio"/>	<input checked="" type="radio"/>

Enter the code of the service you would like to check:

CHECK FOR PRE-AUTH

Online Authorizations

For these elective inpatient procedures:

- ▶ Spine, Joint Replacements and Fractures
- ▶ Cardiovascular, Thoracic and Pulmonary
- ▶ Gastroenterology
- ▶ Urology
- ▶ DRG Notifications
- ▶ Maternity Notification
- ▶ OB Ultrasound
- ▶ Home Health requests available for nurse and therapy visits (up to 20 visits)
- ▶ Wound Care in home
- ▶ Sleep Study in lab

AutoAuth Pre-authorization

Reduce the time spent on phone calls and faxing!
Submit the required information online and get a rapid response.

- Learn More
 - [Available Types of Service](#)
 - [AutoAuth Pre-authorization Made Easy](#)
 - [AutoAuth DRG Notifications](#)
 - [AutoAuth Pre-authorization Frequently Asked Questions](#)
 - [AutoAuth Pre-authorization Procedure Codes](#)
- [Check Patient Eligibility](#)
- [AutoAuth Pre-authorization Tools](#)
- [Get Started](#)

Submitting Auth Authorization Request

Submitting Auto Authorization Requests



Auto Authorizations Made Easy

Complete the request as prompted by each field. Please note that DRG submissions will appear within the portal with an "approved" status. All other request types will display as "pending review" and you will be notified by a member of the Utilization Management team once the review is complete.

Authorization Request Details

* Request Type: DRG Notification

DRG Notification should only be selected for acute medical admissions. Do not use for other admission types including:

- Maternity (use Maternity Notification for deliveries)
- Mental Health
- Rehab
- Elective Procedures

Your account type will determine which options you see in the portal. Only facilities with a DRG contract will see the DRG option in the Request Type drop-down.

Other options are:

- DRG Notification
- Outpatient Surgical Request
- Home Health Request
- Inpatient Admission — Non-DRG Request
- Maternity Notification
- Inpatient Admission Surgical Request

* Admission Date: mm/dd/yyyy

Please note, when entering Admission Date, you will not have the option to select future service dates for acute admissions. Other service types will allow future admission dates.

Who is the patient for this submission?

Name: QualChoice Member
Address: Member's Address

Date of Birth: 01/01/1970
Benefit Plan: Silver PPO
Eligibility: Eligible

* Current Phone: []

Please provide member's current phone number, in case the number we have is no longer valid.

There are mandated premium grace periods which may result in the retro-termination of eligibility for members who are eligible for coverage under Federal COBRA or FMLA.

Who is the reviewer completing this submission?

* Name

* Phone

* Fax

* Email



This should be the person completing the notification, or the person we should contact regarding the admission.

At which facility does the service need to be performed?

Servicing Hospital: Facility Name
ID: 9999999999
Address: Facility Address

This will show the information for your facility.

What is the patient's diagnosis?

*

Search for diagnosis by description or code, then add it by clicking here.



Add Diagnosis Code

Primary Code	Description	Documentable	Action
<input checked="" type="radio"/>	I219 Acute myocardial infarction, unspecified	<input type="checkbox"/>	
<input type="radio"/>	E11 Type 2 diabetes mellitus	<input type="checkbox"/>	

To remove a diagnosis, just click the trash can.



What is the clinical reason for admission?

* Clinical Reason for Admission

Submit to complete the notification of admission.



Cancel Submit

You can print the approval letter at this point. 

Create Authorization Confirmation

Print Confirmation

Save Confirmation

Save Approval Letter

Notification Summary

Authorization Id: AA0000000

Patient Name: Member

← AutoAuth ID's begin with "AA".

Type: DRG Notification

Subscriber Id: 55555555

Status: Approved

Patient

Subscriber ID:

Name:

Address:

Member Info

Date of Birth:

Gender:

Benefit Plan:

Eligibility:

Member Info

Ordering Provider

Provider ID:

Provider Name:

Address:

Business Phone:

Fax Phone:

DRG Facility Info

Servicing Facility

Facility ID:

Facility Name:

Address:

Facility Type:

Business Phone:

Fax Phone:

DRG Facility Info

Reviewer Details

Name:

Email:

Reviewer Info

Phone:

Fax:

Reviewer Info

Diagnosis & Service

Date of Admission : 9/27/2018

Approved Level of Care: Inpatient - Acute Medical

Submit Date: 9/27/2018

Complete Date: 9/27/2018

The Body of the Approval Letter

The Care Management Department has been notified that the above mentioned member has been admitted to the above facility. This authorizes the following:

Approved Service	Inpatient Admission
Date of Admission	9/27/18

Concurrent review may be required during this admission. Based on your DRG contract with QualChoice, subsequent days may or may not fall within the outliers for your facility. If there are outliers on this confinement, QualChoice will request medical records for a clinical review at that time.

Authorization is for medically necessary services only and is not a guarantee of benefits or payment. Benefits or payment is based upon eligibility status and available benefits at the time service is rendered and is subject to all contractual exclusions and limitations. Reimbursement will be based upon the method in which care is accessed. Please note: Payment will be based upon financial responsibility for services provided. Benefits may be verified with the Customer Service Department at 800.235.7111 or 501.228.7111.

Clear Claim Connection

- ▶ This tool enables providers to access the editing tools and clinical rationale used for claims processing.
- ▶ Determine appropriate coding prior to billing a claim or determine correct coding after receiving a denial.

Claims and Services

View patient claims and service details.

- [Search Remittance Advice](#)
- [View Recent Claims](#)
- [View Outpatient Services](#)
- [View Inpatient Stays](#)
- [Provider Relations Representatives Map](#)
- [Clear Claim Connection](#)
- [View Provider Reports](#)


Clear Claim Connection
Sign Out Help

McKesson Edit Development
Glossary
About

CLAIM ENTRY

Claim Type:

Gender: Male Female

Date of Birth:

ICD Code Set: ICD9 ICD10

Diagnosis Codes: 1 2 3 4

Bill Type:

For quick entry, use your Down Arrow key after you enter a procedure code. Qty will default to 1, Billed Amount will default to 100, Date of Service From and To will default to today's date, and Place of Service will default to 11 (Office). Tabbing through these same fields will give you the same defaults.

LINE	PROCEDURE	MOD1	MOD2	MOD3	MOD4	QTY.	REV CODE	BILLED AMT.	DOS FROM	DOS TO	PLACE OF SERVICE	PROVIDER STATE	LINE DIAG. 1	LINE DIAG. 2	LINE DIAG. 3	LINE DIAG. 4	LINE DIAG. 5	LINE DIAG. 6
1	<input type="text"/>	<input type="text" value="__/__/__"/>	<input type="text" value="__/__/__"/>	<input type="text" value="11"/>	<input type="text" value=""/>	<input type="text"/>												
2	<input type="text"/>	<input type="text" value="__/__/__"/>	<input type="text" value="__/__/__"/>	<input type="text" value="11"/>	<input type="text" value=""/>	<input type="text"/>												
3	<input type="text"/>	<input type="text" value="__/__/__"/>	<input type="text" value="__/__/__"/>	<input type="text" value="11"/>	<input type="text" value=""/>	<input type="text"/>												
4	<input type="text"/>	<input type="text" value="__/__/__"/>	<input type="text" value="__/__/__"/>	<input type="text" value="11"/>	<input type="text" value=""/>	<input type="text"/>												
5	<input type="text"/>	<input type="text" value="__/__/__"/>	<input type="text" value="__/__/__"/>	<input type="text" value="11"/>	<input type="text" value=""/>	<input type="text"/>												

Clear Claim Connection



Clear Claim Connection

McKesson Edit Development Glossary About

AUDIT RESULTS

Current Claim

The results displayed do not guarantee how the claim will be processed.

Claim Type Professional
 Gender Male
 Date of Birth 04/22/1977
 ICD Code Set ICD10
 Diagnosis Codes 1 E78.1 2 3 4

Bill Type

Click on recommendation of "Disallow" or "Review" to obtain clinical edit clarification.

LINE	PROCEDURE	DESCRIPTION	MOD1	MOD2	MOD3	MOD4	QTY.	REV. CODE	BILLED AMT.	DOS FROM	DOS TO	PLACE OF SERVICE	PROVIDER STATE	LINE DIAG. 1	LINE DIAG. 2	LINE DIAG. 3	LINE DIAG. 4	LINE DIAG. 5	LINE DIAG. 6	RVU	PAY %	RECOMMENDATION	
1	99211	OFFICE/OUTPATIENT VISIT EST					1		30.00	02/25/2020	02/25/2020	11 (Office)	Arkansas	E78.1							n/a		ALLOW
2	80061	LIPID PANEL					1		61.00	02/25/2020	02/25/2020	11 (Office)	Arkansas	E78.1							n/a		ALLOW
3	36415	ROUTINE VENIPUNCTURE					1		11.00	02/25/2020	02/25/2020	11 (Office)	Arkansas	E78.1							0		DISALLOW

Click on hyperlinks in the “Recommendations” column to see why a service is allowed or disallowed.

Modifier Usage

- **Modifier 50**: Qualchoice will no longer require mod 50 when billing of bilateral procedures.
- **Bilateral procedures should be billed to allow the 1st procedure at 100% and the second procedure at 50%.**
 - ▶ Bilateral procedures should be billed on two claim lines
 - ▶ Claim Lines should include procedure code and descriptive modifier (Right or left)

For Example:

- ▶ Line 1 64483 LT
- ▶ Line 2 64483 RT

Modifier 25 and 59 Reviews

Providers may have claims with modifier 25 and 59 denied for medical records –

- If you are a statistical outlier in the use of modifier 25 and 59
- If you submit more than 100 claims annually to QualChoice and
- Over 40% of all submitted claims use modifier 25 and 59

Less than 25 network providers meet this criteria

Claims with modifier 25 and 59 will deny for records

Claims will be adjusted if records support appropriate modifier use

Modifier 25 Rules

Appropriate Use	Inappropriate Use
Appended only to E&M	Appended to major procedure
Indicates patient's condition on the day of the procedure a significant, separately identifiable E&M service beyond the usual preoperative/post operative care	Omission of Modifier w/minor procedure
Appended to procedures with 0-10 day global period	Labs or X-Rays are the only services provided about the E/M
If in the global for another procedure, and E&M & minor procedure append both 24 & -25 mod if appropriate	Sole reason for the visit was the procedure
	To bypass an edit
	Per Medicare procedure & office visits do not require sep DX codes.

Modifier 59 Rules

Appropriate Use	Inappropriate Use
Should only be used when there is no other appropriate modifier	E&M codes
Should only be used to identify clearly independent services that represent significant departures from the usual situations described by the NCCI edit	In Lieu of modifier 25 No edit in CCI
When the procedure are performed in different encounters on the same day	Exact same procedure was performed on the same day
For two services described by timed codes provided during the same encounters only when they are performed sequentially.	Lack of supporting documentation Submission of weekly radiation therapy management codes 77427

Top Reasons for Claim Denials and How to Prevent Them

1. Claim Was Not Filed Timely – Must submit clearinghouse report that shows claim was accepted by payer

- ▶ DO NOT submit medical records in lieu of claims. Qualchoice timely filing deadline is 6 months from date of service.

2. Pre-authorization Not Obtained

- ▶ Use prior authorization list and BI associated with prior authorization list.
- ▶ Use AutoAuth within the Provider Portal for a more streamlined prior auth process.

3. Clinical Edits Needed

- ▶ Clear Claim Connection can be used to review edits. You can access Clear Claim Connection on the Provider Portal.

Claim Resolution Tips

1. **Carefully review all notifications regarding the claim:** it is one of the most important steps in claims processing. One you have received your RA, EOB, or other notifications from any insurance regarding a claim, review it carefully.
2. **Be persistent:** If your resubmitted claim is denied and you believe the denial was improper, follow the reconsideration and appeals guidelines according your carrier.
3. **Don't Delay:** It is important to submit and resubmit claims in a timely manner. Qualchoice timely filing guidelines is 6 months.
4. **Get to know the reconsideration/appeals process:** Qualchoice forms are available on qualchoice.com/forms#providers, where you can scroll down to review the forms needed.
5. **Maintain records on disputed claims:** When calling an insurance carrier keep records of information given, name of representative, and reference number.
6. **Remember help is available:** We know that handling claim denials is frustrating. Ensuring billing procedures are consistent with the insurance company's requirements can save you time and money in the long run.

Reconsideration vs. Appeal Request

Request for Reconsideration – Administrative Denials Only

- ▶ Timely filing
- ▶ Clinical edits
- ▶ Coding
- ▶ Reimbursement
- ▶ Use [Request for Reconsideration Form](#), found at QualChoice.com

Appeal – Clinical Denials Only

- ▶ Not medically necessary
- ▶ Experimental and investigational
- ▶ Lack of pre-auth when the amounts are provider liability
- ▶ Use [Provider Appeal Form](#), found at QualChoice.com

Requests received on the wrong form or without the necessary form will not be processed.

Reconsideration vs. Appeal Request

Provider Request for Reconsideration



Request for Reconsideration Do not use as an Appeal Form*

This form to be completed by QualChoice contracted physicians, hospitals or other healthcare professionals requesting claim reconsideration for members enrolled in QualChoice health plans. Please submit a separate form for each claim. Form must be completed and submitted with required documentation. Incomplete forms may be returned. Please attach any additional information applicable to the request. Corrected claims should be submitted electronically. If the claim in question has had no payments to date or you are submitting additional information for initial review of payment, please forward to the address on the back of the patient's ID card.

Mail: QualChoice, P.O. Box 25610, Little Rock, AR 72221 | Email: CLReconsider@QualChoice.com
Form must be on top of all required documents being submitted.

Please check one: Physician Hospital Other Healthcare Provider

Section I. Member Information				
Member ID	Claim # (as listed on the EOB or RA)	Date of Service (as listed on the RA or EOB)	Billed Amount	
Member Name: Last		First	MI	
Street Address		City	State Zip	
Patient Name: Last (if SAME as Member, mark SAME)		First	MI	
Section II. Practitioner/Hospital/Other Healthcare Provider				
Tax Identification Number (TIN)	Phone No.	Email Address		
Physician Name (as listed on RA or EOB): Last		First	MI	
Street Address		City	State Zip	
Facility/Group Name		Contact Person		
Section III. Person Completing this Form				
Name	Phone No.	Email Address		
Section IV. Reason for Reconsideration Request. You must check (✓) one of the following.				
<input type="checkbox"/> Previously denied/closed for additional information <input type="checkbox"/> Duplicate charges (e.g., multiple charges with same CPT)—Provide medical record documentation. <input type="checkbox"/> Global Period Dispute <input type="checkbox"/> Payment received for wrong provider or member—Provide details in Comments section. <input type="checkbox"/> Duplicate payment received. Check One: <input type="checkbox"/> Recover Funds <input type="checkbox"/> Refund Enclosed <input type="checkbox"/> Claim Check/Claim edit denial (i.e., mutually exclusive, incidental, etc.)—Provide medical record documentation. <input type="checkbox"/> Modifier Reimbursement—Provide medical record documentation. <input type="checkbox"/> Medical Record Request—When sending requested medical records, attach the QualChoice request letter or provide claim #.			CLAIMS	
<input type="checkbox"/> Claims Timely Filing—Provide Acceptance Report from EDI Vendor and demonstration of timely follow-up. <input type="checkbox"/> Provider Fee Schedule/Contract Language—Please provide detailed explanation of your reconsideration request in the comments section.				
Comments. Include detailed information as to the nature of your request.				NS

Possible attachments for supporting documentation: • Copy of RA or EOB • Other required attachments as listed above

*Clinical denials (such as not medically necessary, experimental and investigational or when claim amounts are provider liability) are not eligible for the reconsideration process and should be handled via Provider Appeal Form, found at QualChoice.com. Select Providers, Forms/Information.

0730 NS 054_07 10/2016

P.O. Box 25610 | Little Rock, AR 72221 | P: 501.228.7111 or 800.235.7111 | QualChoice.com

Appeal vs. Reconsideration Request

Provider Appeal Form



Network Provider Appeal Form
Adverse Determination

About Network Provider Appeals
 Only denials related to medically necessary, experimental/investigational, lack of pre-authorization (when the amounts are provider liability) or benefit exclusions will be considered in the provider appeal process. Issues such as timely filing, clinical edits, coding disputes, contractual reimbursement, etc., will be handled through the [Provider Reconsideration Process](#).

Appeal requests must be received on the *Network Provider Appeal Form* within the timeframe outlined in your provider agreement. The request must be completed in its entirety and include QualChoice provider number, date(s) of service, claim number(s), reason for the appeal and any written comments, documents, records or other information relating to the case.

The Plan's decision is due within 30 calendar days from the receipt of the appeal request.

Please select the reason the claim or service was denied.

Not Medically Necessary
 Experimental/Investigational
 Lack of Pre-authorization

Benefit Maximum Exhausted
 Benefit Exclusion

Section I: Provider Information			
Provider Name		National Provider Identifier # (NPI)	QualChoice Provider Number
Street Address		City	State Zip
Telephone Number	Fax Number	Contact Name	Contact Email Address
Section II: Patient Information			
Last Name		First Name	
Member Identification Number		Date of Birth (MM/DD/YYYY)	
Section III: Claim Information [Copy of claim(s) or Remittance Advice(s) are required.]			
Claim Number		Date(s) of Services (MM/DD/YYYY)	
		From	To
Section IV: Appeal Explanation			

P.O. Box 25610, Little Rock, AR 72221 | 800.235.7111 | 501.228.7111 | FAX 501.228.9413 | QualChoice.com

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Quarterly eNewsletter and Quick Alerts – update screen shot

Subscribe at QualChoice.com – For Providers, Provider News



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Provider News

Home / For Providers / Provider News

Quality Results

An e-newsletter for doctors, other health care experts and facilities affiliated with QCA Health Plan, Inc., and QualChoice Life and Health Insurance Company, Inc.

Subscribe Today



Add us to your address book so we'll be sure to land in your inbox!

Quality Results

2025

Spring 2025

- Resources and Support for Our Provider Partners
- Speed Up Approvals With Evolent's Conservative Treatment Forms

2023

Winter 2023

- Integrated Data Solutions to Improve Patient Care

Provider Quick Alert

2025

- Medical Coverage Policies Updates for July 2025
- Medical Coverage Policies Updates for June 2025
- Medical Coverage Policies Updates for May 2025
- QualChoice Elevidys Provider Notification
- Medical Coverage Policies Updates for April 2025
- Medical Coverage Policies Updates for March 2025
- Medical Coverage Policies Updates for February 2025
- Pharmacy Benefits Manager Change

Contact info

- **Credentialing: Arkcredentialing@centene.com**
 - All provider credentialing questions
- **Contracting: Arkansascontracting@centene.com**
 - Provider contracting questions
- **Business Service: QC_bu_pr@qualchoice.com**
 - For QualChoice Provider portal questions
- **Claim reconsideration email: CLReconsider@qualchoice.com**
 - For claim reconsiderations (not clinical appeals)
- **Customer Service: Customerservice3@centene.com**
 - General customer service or benefit questions
- **QC PR mailbox: PR@qualchoice.com**
 - All other QualChoice specific questions

Provider Engagement Account Manager

Provider Network Territory Map



Dani Wyrick
501-409-7853

Danielle.Wyrick@centene.com



Shannon Anderson
501-541-4146

Shannon.Anderson@qualchoice.com



	Shannon Anderson shannon.anderson@qualchoice.com 501-541-4146	Dani Wyrick danielle.wyrick@centene.com 501-409-7853
Out-of-State Participating Providers	Mississippi, Missouri, Oklahoma, Tennessee	Texas
Statewide Allied Providers	By Region Location	By Region Location & National Offices

Provider Relations: 501-228-7111, ext. 7004 | Fax: 501-707-6811 | PR@qualchoice.com | QualChoice.com