Provider Newsletter

Volume 24

Understanding Participant Diversity & Language Access

At **PA Health & Wellness (PHW)**, treating the whole person, not just their conditions, is central to delivering high quality healthcare. Understanding who our Participants are, including their language and cultural needs, helps ensure care is accessible, equitable and responsive.

Diversity of our Participants

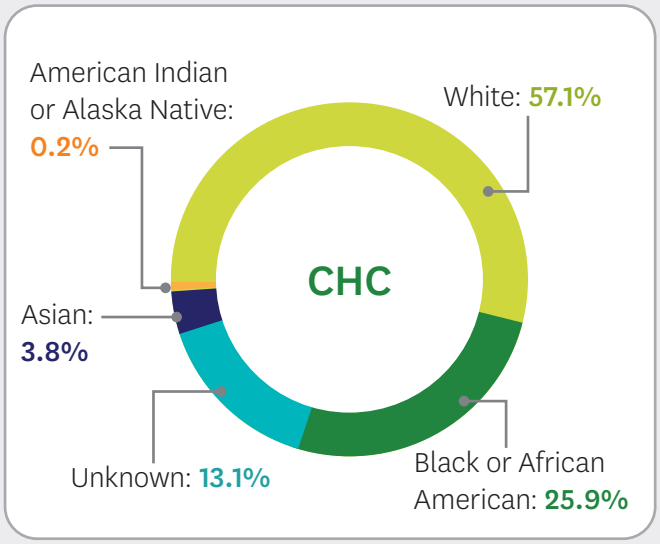
PHW Participants speak **more than 42 languages**, with increasing diversity year over year. Spanish remains the most reported non-English language, followed by Russian, Vietnamese, Nepali, Arabic and Nepali.

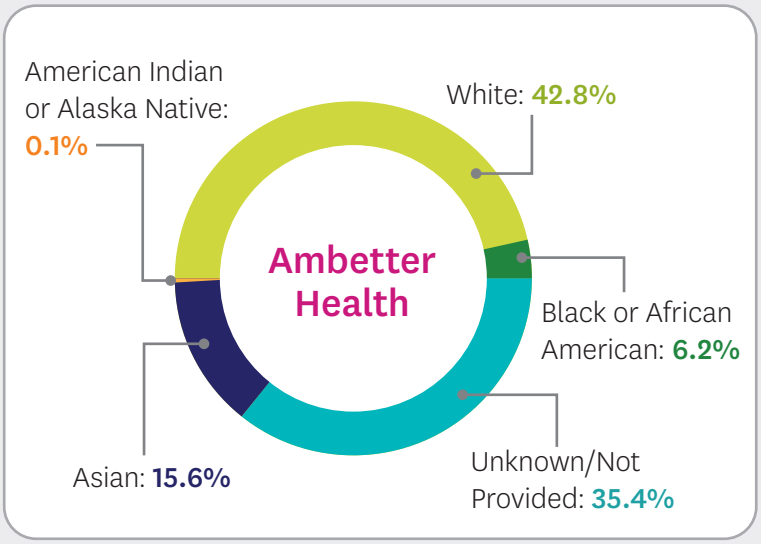
2025 KEY LANGUAGE HIGHLIGHTS

Community HealthChoices (CHC)	
Spanish	4.79%
Russian & Vietnamese	0.27% each
Nepali	0.20%
Central Khmer	0.13%
Participants have unknown language, indicating an opportunity to improve documentation.	20.42%

Ambetter Health	
Spanish	18.48%
Arabic	.06%
Vietnamese	.04%
Russian	.03%

PARTICIPANT DEMOGRAPHICS SNAPSHOT





Understanding Participant Diversity & Language Access, continued to page 2

Understanding Participant Diversity & Language Access, continued from page 1.

What Providers Need to Do

- **Provide Language Support**
  Providers must offer interpreter services at no cost to Participants. Participants cannot be required to bring their own interpreter.
- **Use Qualified Interpreters**
  Bilingual staff acting as interpreters must meet quality standards and have documented proficiency. Interpretation must be accurate and include appropriate medical terminology. Minors may not be used as interpreters except in emergencies.
- **Document Language Services**
  Providers must document interpreter use in the medical record and must document when a Participant declines interpreter services.

Obtaining Interpreter Services

- **Contact Provider Services** (Must Provide Participant ID):
  - CHC: 1-844-626-6813 (TTY: 711)
  - Ambetter Health: 1-833-510-4727 (Relay 711)
- Complete and Email Interpreter Request form to InterpreterRequests@centene.com. This form is located on the Resources page of the website.
- If you are unsure of your Participant's language:
  - Use "Language Assistance" tool located at the bottom of each website, and you can have the Participant point to their designated language.
  - You can also find a Patient's language by logging on to our Secure Provider portal and downloading your Patient list.

For additional support, you may also contact your Provider Representative directly.

Complete your annual Home & Community Based Services (HCBS) Training before time runs out!

The 2026 HCBS Provider Training is available now! This is an annual training requirement for all Home and Community Based Services (HCBS) Providers, **Type 59 Only,** contracted with PHW's Community HealthChoices (CHC) Plan. At least one person from each organization (Tax ID#) must complete this training annually. Credit for completion will be given when attestation is received.

2026 Home and Community Based Services Provider Annual Training
2026 HCBS Training Attestation
2026 Annual HCBS Training Handout (PDF)

Adolescent Depression Screening: Supporting Early Identification and Quality Reporting

Depression screening is a critical component of preventive care for adolescents and plays an important role in identifying behavioral health needs early. For CHIP Enrollees ages 12–17, this care is measured through the CMS Child Core Set (CDF-CH), which evaluates whether a standardized depression screening is completed and whether a follow-up plan is documented when results are positive.

Bright Futures guidelines reinforce this expectation by recommending that behavioral health screening, including depression screening, be incorporated into annual adolescent well-care visits. These guidelines emphasize the use of validated, age-appropriate tools and support routine screening as part of comprehensive preventive care. Alignment with Bright Futures, EPSDT requirements, and CHIP quality measures ensure that adolescents receive consistent, evidence-based care focused on early identification and intervention.

Providers play a key role in ensuring both the completion and documentation of adolescent depression screening meet measure requirements. As a best practice, providers are encouraged to review workflows for adolescent well-care visits to ensure depression screening and follow-up documentation are consistently incorporated, supporting both quality care and accurate performance reporting.

For ongoing CHIP Quality resources please visit:
https://www.pahealthwellness.com/providers/quality-improvement/hedis.html.

Sources: Centers for Medicare & Medicaid Services. Screening for Depression and Follow Up Plan: Ages 12–17 (CDF CH). Child Core Set of Health Care Quality Measures for Medicaid and CHIP.
https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/child-core-set/index.html

From Care Plans to Career Paths: How Healthcare Providers Can Drive Employment for Better Health

Each day, many are either working or looking for work. Aspects of work – including financial compensation, access to healthcare and other employer benefits, job security, the environment – may affect health. There are also folks who are not in the labor force due to reasons such as current health, in school, or simply discouraged and have given up. Research shows how unemployment and underemployment can impact health. How you navigate conversations about and integrate employment into your everyday practice of a person's health has the potential to impact those you serve today and their future health.

Here are 5 ways you can further explore:

- July is the anniversary of the signing of the Americans with Disabilities Act (ADA). Remind folks of their rights, especially as it relates to work: https://archive.ada.gov/ada_title_I.htm
- Further your knowledge by accessing this FREE webinar titled **The Impact of Employment on Health: Insights for Clinicians.** You can earn continuing credit or opt for the attendance/participation certificate: https://lms.centenetraining.com/content/impact-employment-health-insights-clinicians#group-tabs-node-course-default3
- Encourage accessing the local **PA CareerLink®** that can connect folks with more than jobs including but not limited to **paid** training, virtual and in person workshops, resource referrals, and more!
  - https://www.pacareerlink.pa.gov/jponline/individual
  - Specific resources based on population are available for Youth, Veterans, Returning Worker, Mature Workers, and Individuals with Disabilities.
- Prepare your team for **National Disability Employment Awareness Month** (NDEAM) in October. Whether it is hanging the 2026 Poster in your office for your staff and patients, hosting a lunch and learn for your team, or you want to explore ideas, PA Health & Wellness is here to support. Contact Theresia.Kody@PaHealthWellness.com if you would like to discuss ideas.
- Connect with your local school district or PA CareerLink® to **host a workshop** about careers within your organization or practice. This exposure can help build your future talent pipelines and may even be an opportunity for a person to have a paid internship through workforce development or PA Office of Vocational Rehabilitation (OVR).

Have more questions? Please visit PHW - Employment Resources or email Employment@PaHealthWellness.com.

Credit Balance Self-Review and Overpayment Reporting

The Department of Human Services' Bureau of Program Integrity encourages all Provider types to routinely assess their billing and record-keeping practices and voluntarily disclose any overpayments of Medicaid (or Medical Assistance [MA]) funds. For additional information, please visit: Credit Balance Self-Review Guidance.

The objective of the credit balance self-review is to identify payments made to Providers that should not have been made by PHW. In alignment with DHS expectations, Providers should conduct a quarterly credit balance self-review, including a comprehensive review of billing and payment records.

A credit balance occurs when payment received for a claim exceeds the amount due. If a provider determines that an overpayment has been received from PA Health & Wellness, the provider must notify PA Health & Wellness and return the overpayment within 60 calendar days of identifying the overpayment.

- Provider Self-Audit findings should be disclosed to PA Health & Wellness using the Provider Self-Audit Disclosure Form located at: https://www.pahealthwellness.com/providers/resources/forms-resources.html.
  - Submit by email to PHWFWA@PaHealthWellness.com
  - Or mail to:

    PA Health & Wellness
    Compliance
    1700 Bent Creek Blvd. Suite 200
    Mechanicsburg, PA 17050
- Refund checks for claims overpayments should be made payable to PA Health & Wellness. The submission should also include a list of the claims that were overpaid.

Mail to:

PA Health & Wellness
P.O. Box 3765
Carol Stream, IL 60132-3765

Electronic Visit Verification (EVV) Resources

The 21st Century Cures Act mandated Electronic Visit Verification (EVV) for all Medicaid personal care and home health care services that require in-home visits.

HHA exchange offers many resources to help make EVV easier and more efficient for agencies; while helping you embrace best practices to meet compliance requirements. These include webinars, articles and videos. If you haven't already checked these resources out and shared them with your caregivers, please do so today!

Additional information regarding all EVV resources can be found at:

- https://www.hhaexchange.com/solutions/providers/electronic-visit-verification
- https://www.pahealthwellness.com/providers/resources/electronic-visit-verification--evv-.html

For those of you who may be struggling to meet those monthly/quarterly compliance rates please attend the following webinar opportunity: **Raising the Bar: How to Reach A 90% (or Higher) EVV Compliance Rate**.

Home-Delivered Meals Reminders

Home-delivered meals provide nutritionally balanced meals to Participants who are unable to prepare or obtain adequate food. The service must be included in the Participant's service plan to support health, safety, and independence. Meals may be delivered as singles or multiples, as long as the number of planned daily meals does not exceed two meals per day and the participant has appropriate storage and support to ensure that meals last as intended.

All meals must be consistent with a prescribed menu approved by a dietician and, in accordance with the menu:

- May consist of hot, cold, frozen, dried, canned, fresh or supplemental foods
- Can either be a hot, cold, frozen or shelf-stable meal

Home delivered meal providers may not use commercially purchased frozen or 'TV dinner'–style meals, as these options do not meet required menu standards.

The Importance of Accurate Medical Record Documentation

Accurate and complete medical record documentation is essential to delivering high-quality, coordinated, and compliant care. PHW requires Providers to maintain records that support services rendered, demonstrate medical necessity, and meet regulatory standards.

Medical records are a critical communication tool that supports patient safety, care coordination, and appropriate reimbursement. Incomplete or inaccurate documentation may lead to gaps in care, claim denials, or audit findings.

Providers must ensure medical records are accurate, complete, and timely for every patient encounter, including:

- Legible, dated, and signed entries
- Complete Participant identification and demographics
- Up-to-date diagnoses, medications, allergies, and problem lists
- Documentation of services, screenings, and clinical history

Tips for Improving Documentation

- Be specific: Include all relevant clinical details—avoid vague language
- Document in real time: Capture information as close to the visit as possible
- Ensure clarity: Records must be readable and easy to understand
- Date, Time, and Sign All Entries: Every entry must clearly identify the author and when the service was documented
- Maintain Updated Problem Lists and Medication Records: Keep diagnoses, medications, allergies, and adverse reactions current
- Support medical necessity: Clearly explain why services were provided

Accurate medical record documentation is a foundational requirement for delivering high-quality care, ensuring regulatory compliance, and supporting appropriate reimbursement. By maintaining clear, complete, and timely records, providers help improve outcomes for Participants and reduce the risk of audit findings or claim denials.

Join our 2026 Clinical Documentation Webinar Series!

PA Health & Wellness offers a variety of training sessions covering key clinical documentation and coding improvement topics. Explore available sessions and topics here: View Training Opportunities.

Provider Data Management Updates

PA Health & Wellness (PHW) is committed to maintaining accurate and up-to-date provider information for our Members. Providers are responsible for promptly reporting all demographic and practice updates to PHW. Updates should be submitted directly to the Provider Data mailbox at PHWproviderdata@pahealthwellness.com.

PHW will be performing audits via phone calls to verify the information in the Find-A-Provider directory. To support the integrity of the Find a Provider directory, please ensure the following:

- **Keep Contact Information Up to Date**
  Reported office phone numbers must be the numbers Members use to schedule appointments.
- **Timely Status Updates**
  Notify PHW promptly of any provider status changes (e.g., leaving the group, retirement).
- **Billing Address Updates**
  Please report all new billing address updates to phwproviderdata@pahealthwellness.com with a copy of your W-9 along with associated Billing Phone and Fax information, if applicable.
- **Ensure Credentialing Documents are Submitted Accurately**
  - Groups: When submitting information for initial credentialing and recredentialing, ensure that documents are not expired or will not expire within 60 days of submission
  - Practitioners: CAQH must be attested every 60 days and remain current at the time of Credentialing or recredentialing. Provider specialties need to be listed with CAQH and/or NPPES. This information must be kept up to date to ensure necessary outreach occurs timely.
  - If the above requirements are not met credentialing may be closed for insufficient information.
- **Panel Updates**
  PHW must be advised of any changes to provider panels, such as age or gender restrictions, open or closed panels, or hat code (Primary Care Provider vs. Specialist).
- **Practitioner Enrollments**
  New Practitioner Enrollment forms can be found at: https://www.pahealthwellness.com/providers/become-a-provider/CredentialingForms.html.
- **OLTL/HCBS Contracted Providers**
  To submit changes or updates please utilize the OLTL Change Form found here: https://www.pahealthwellness.com/providers/become-a-provider/CredentialingForms.html and include a copy of your W-9.
- To submit enrollments or updates on existing contracted groups, please reach out to phwproviderdata@pahealthwellness.com.

Thank you for your partnership in maintaining accurate provider information and supporting access to care for our Members.

CoC+ Bonus Program

Enhance outreach for annual visits, chronic disease management, & patient insights

Components of an Appointment Agenda

The layout of the printable Appointment Agenda has been updated, based on feedback received on the Workflow Summary document

The Appointment Agenda will feature a table-style format offering a more streamlined display of available insights

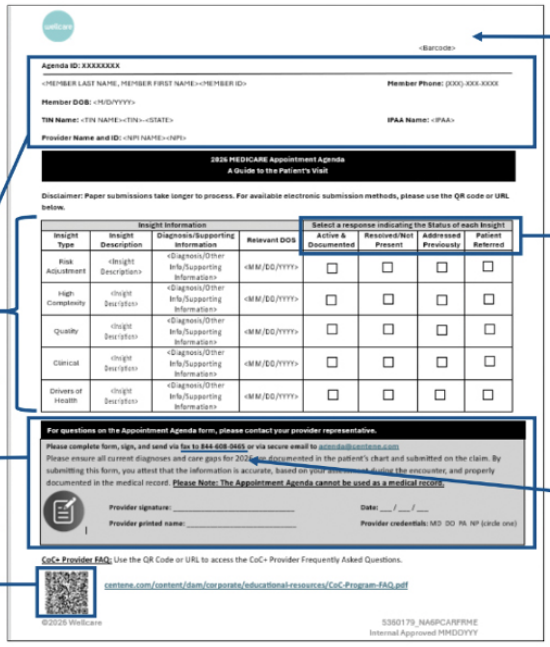
Checkbox responses have been expanded to four columns

Agenda, Patient & Provider Details

Insight Information

Signature
Any person in the practice who supports the completion of the Agenda at the point of care may sign and submit the completed Agenda

QR Code
Providers may scan the QR Code or click on the URL for additional resources, Provider Survey and a Provider Facing FAQ document



Barcode
Agendas may show "Not Risk Eligible" or "Not Comp Eligible" under the barcode in the upper right-hand corner for those Agendas not eligible for compensation

There are four available responses for each insight listed on the Appointment Agenda:

Active & Documented
- Condition remains active, or insight is clinically relevant and should be documented on a claim using appropriate coding standards, when applicable

Resolved/Not Present
- The condition is resolved, inactive, or the insight is not relevant to the patient's current clinical status

Addressed Previously
- The insight was resolved in a prior visit (during current year) and does not require further action

Patient Referred
- The insight requires evaluation by a specialist or another provider

New Fax Number

	Risk Adjustment	High Complexity	Quality	Clinical	DOH
Medicare	✓	✓	✓	✓	X
Marketplace	✓	✓	✓	✓	X

2026 Risk Adjustment Incentive Payout		
Threshold % of Agendas Completed	Bonus Paid Per Paper Agenda Submission	Bonus Paid per Electronic Agenda Submission
<50%	$50	$100
>=50% TO 80%	$100	$200
>=80%	$150	$300

2026 Comprehensive Insight Incentive Payout
Medicare $150
Marketplace $100

NOTE:

- **The CoC+ program is in addition to our health plan's other provider compensation programs and does not replace them.**
- **See below tables for compensation amount.**
- **All Appointment Agendas must be submitted by January 31, 2027 to qualify (eligible members must have a DOS by 12/31/2026).**

Contact Information

- Please reach out to PHW_RiskAdjustment@PaHealthWellness.com for any questions.
- Your PHW Risk Adjustment Specialist will manage the bonus calculation, reconciliation, and payment processing.
- You may also email or fax paper agendas to
  - Agenda@centene.com / Fax: (844)-608-0465

Clinical Documentation Improvement (CDI) Q3 2026 Webinars

Learn more about: Risk Adjustment methodologies, accurate and compliant documentation practices, and coding strategies aligned with regulatory standards. Webinars are open to providers, non-physician practitioners, coders, billers, and administrative staff involved in clinical documentation and coding.

Advance registration is required. Please scan the QR Code below to review the 2026 CDI Webinar Schedule.

Good News! CEUs are available for Medical Coders for certain webinars!

Topics include:

- From Complexity to Clarity: Coding Diabetes Complications
- Documenting with Purpose: Supporting Diagnoses for Risk Adjustment Accuracy
- Dementia, Mental Illness, and Substance Use Disorders in Older Adults: A Guide to Accurate Coding and Complete Documentation.
- Breaking Down HCC Coding for Behavioral Health and Substance Use
- Risk Adjustment Essentials Across Multiple Lines of Business
- Provider Best Practices for Value-Based Risk Adjustment
- The Three C's of Risk Adjustment: Code, Capture, and Compliance – Best Practice
- Coding the Breath of Life: Accurate Capture of Respiratory Conditions
- Risk Adjustment Integrity: Strengthening Coding and Documentation Accuracy
- Risk Adjustment in Action: Understanding and Documenting Acute Conditions Effectively.
- From Documentation to Coding: Cancer in Risk Adjustment Part 1 – Cancer Coding Foundations for Risk Adjustment.
- From Documentation to Coding: Cancer in Risk Adjustment Part 2 – Advanced Cancer Coding and Case Studies.
- Diabetes Coding Mastery: Capturing Accuracy and Closing Missed Opportunities.
- Medicare Risk Adjustment: A Practical Guide

NEW On-demand Risk Adjustment Training for Providers available 24/7!

COA Functional Status Assessment (FSA) – Best Practices for Providers

Measure Overview:

The Care for Older Adults – *Functional Status Assessment* (COA-FSA) is a HEDIS® measure tracking the percentage of Special Needs Plan (SNP) members age 66+ who receive a documented comprehensive functional status assessment at least once annually.

This assessment evaluates a patient's ability to perform Activities of Daily Living (ADLs) and Instrumental ADLs (IADLs) and helps identify early functional decline, enabling timely interventions to preserve independence. COA-FSA is a key quality metric for SNPs and contributes to Medicare Stars performance.

Best Practices & Documentation Tips:

- Incorporate Functional Assessments into annual visits or Annual Wellness Visits (AWVs) for older adults.
- Use a standardized tool or checklist to assess key ADLs (bathing, dressing, eating, transferring, toileting, walking) and IADLs (medication management, shopping, cooking).
- Document the assessment date, domains evaluated, tool used, and any functional limitations in the medical record.
- Bill CPT II 1170F (functional status assessment completed) with the visit to ensure HEDIS compliance is captured through claims.
- Many EHRs allow CPT II 1170F to be added during AWV billing, helping prevent missed opportunities to close care gaps.

COA Medication Review – Best Practices for Providers

Measure Overview: The Care for Older Adults – *Medication Review* (COA-MR) measure requires that each SNP Special Needs Plan (SNP) member 66+ has at least one comprehensive medication review with an updated medication list every year. The review must be conducted by a prescribing practitioner or clinical pharmacist and documented by a signed, dated medication list in the medical record. This process is critical because most older adults take multiple medications, putting them at risk for medication errors, adverse drug events, and hospitalization if regular reviews are not done. COA-MR is part of SNP quality measures.

Best Practices & Documentation Tips:

- Include an annual medication review during Annual Wellness Visits (AWVs) or routine chronic care visits for SNP patients.
- Review all prescription medications, OTC products, and supplements for duplications, interactions, and unnecessary therapies.
- Document the review date and confirm the medication list was reviewed, updated, and signed by the appropriate provider.
- To receive HEDIS credit, submit CPT II 1159F (medication list documented) and 1160F (medication review performed) on the same claim.
- Reporting both codes through claims confirms COA medication review requirements were met and reduces reliance on medical record audits.

HEDIS Measures:
Right Code, Right Measure, Right Outcome

Clear, complete documentation and correct coding support appropriate measure exclusions and ensure accurate representation of care quality.

Accurate documentation and coding are essential to ensure patients are properly excluded from HEDIS measures when appropriate. Missing or incorrect coding can result in patients being included in measures when exclusions should apply, which may negatively impact quality performance rates.

Measure	Exclusion Criteria	Best Practice
Eye Exam for Patients with Diabetes (EED) **Breast Cancer Screening (BCS)**	Hospice encounter anytime during the measurement year	• Clearly document hospice status in the medical record • Submit claims using appropriate hospice HCPCS codes (e.g., G9473–G9479, Q5003–Q5010, S9126, T2042–T2046) ***Tip:*** *If hospice care is documented but not billed correctly, the patient may still be included in the measure.*
Colorectal Cancer Screening (COL) **Kidney Health Evaluation for Patients with Diabetes (KED)**	Hospice care Palliative care encounters	• Document hospice or palliative care services in encounter notes Bill using appropriate codes: • Hospice: G0182 • Palliative care encounters ***Tip:*** *Documentation alone is not sufficient—appropriate billing codes must be submitted for exclusions to apply.*
	Members age 66+ with BOTH: • Frailty • Advanced Illness	• Document both frailty and advanced illness in the medical record • Ensure appropriate diagnosis and HCPCS/CPT codes are submitted ***Tip:*** *Both conditions must be documented and coded—missing one will not qualify the patient for exclusion.*

Clear, complete documentation and correct coding support appropriate measure exclusions and ensure accurate representation of care quality.

Learn More

For additional guidance, refer to the HEDIS Quick Reference Guide.

Special Supplemental Benefits for the Chronically Ill (SSBCI)

Special Supplemental Benefits for the Chronically Ill (SSBCI) can be offered to Medicare Advantage (MA) members who have one or more complex chronic conditions, are at high risk for hospitalization or adverse health outcomes and require intensive care coordination. SSBCI aims to improve overall health outcomes for the chronically ill population by addressing social needs beyond traditional medical care such as food, housing, transportation, and gaps in care. The program is designed to support individuals by offering additional services beyond standard Medicare coverage.

Members must qualify for SSBCI benefits

Members must **meet all three criteria** to qualify:

- The member must require intensive care management.
- The member must be at high risk for unplanned hospitalization.
- The member must have a documented and active diagnosis for a qualifying chronic condition.

To begin the SSBCI manual eligibility process, members must schedule an **in-person office visit *or* contact** their healthcare provider to request the attestation be completed. If an office visit is required to complete the attestation, the provider will evaluate the member's health status during the visit and determine if they meet SSBCI criteria.

What Providers Should Do

- Review your patient panel for members with chronic conditions and high utilization risk
- Discuss SSBCI support options during visits with eligible members
- Complete the required attestation to initiate eligibility
- Coordinate with care management teams for ongoing support services
- Reminder: Addressing social drivers of health can improve outcomes and reduce avoidable hospitalizations

For more information on these special supplemental benefits, your role as a Provider in this process and access to the attestation please visit PHW's SSBCI webpage at https://www.pahealthwellness.com/providers/resources/SSBCI.html.

Model of Care 2026 is now available!

The Centers for Medicare & Medicaid Services (CMS) require health plans to provide annual education and training regarding our Special Needs Plan (SNP) Model of Care to providers who treat our SNP members. This applies to our Dual Eligible Special Needs Plan (D-SNP) members, who are eligible for both Medicare and Medicaid, and our Chronic Condition Special Needs Plan (C-SNP) members. As stated in our provider manual, all providers who treat our SNP members, regardless of network participation status, must complete Model of Care (MOC) training annually by Dec. 31. The training is designed to help you better understand our approach to the delivery of care for SNP members.

- Wellcare Model of Care Letter 2026 (PDF)
- Wellcare Model of Care 2026 (PDF)
- Required Model of Care Attestation

For a refresher on the Community HealthChoices program visit: https://www.pa.gov/agencies/dhs/resources/medicaid/chc/chc-provider-trainings.html.

Fraud, Waste and Abuse

There are several things, as a Provider, that can be done to reduce and mitigate the risk of False Claims Act liability. Making sure there is an understanding of the rules that relate to the services and good being billed. The information included in claims should always be as accurate and complete as possible. It is also important to ensure there is awareness of any potential billing problems. Below are resources related to Fraud, Wase, and Abuse:

FALSE CLAIMS ACT:

The False Claims Act establishes liability when any person or entity improperly receives or avoids payment to the Federal government. The Act prohibits:

- Knowingly presenting, or causing to be presented a false claim for payment or approval
- Knowingly making, using, or causing to be made or used, a false record or statement material to a false or fraudulent claim
- Conspiring to commit any violation of the False Claims Act
- Falsely certifying the type or amount of property to be used by the Government
- Certifying receipt of property on a document without completely knowing that the information is true
- Knowingly buying Government property from an unauthorized officer of the Government
- Knowingly making, using, or causing to be made or used a false record to avoid or decrease an obligation to pay or transmit property to the Government.

For more information regarding the False Claims act, please visit: https://downloads.cms.gov/cmsgov/archived-downloads/smdl/downloads/smd032207att2.pdf

STARK LAW:

The Physician Self-Referral Law, commonly referred to as the Stark law, prohibits physicians from referring patients to receive "designated health services" payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship unless an exception applies.

For more information regarding the Stark Law, please visit: https://oig.hhs.gov/compliance/physician-education/fraud-abuse-laws/

ANTI-KICKBACK STATUTE:

The Anti-Kickback Statute prohibits offering, paying, soliciting, or receiving remuneration to induce referrals of items or services covered by Medicare, Medicaid, and other federally-funded programs.

For more information regarding the Stark Law, please visit: https://oig.hhs.gov/compliance/physician-education/fraud-abuse-laws/

Reporting Fraud, Waste and Abuse

If you suspect fraud, waste, or abuse in the healthcare system, you must report it to PA Health & Wellness and we'll investigate. Your actions may help to improve the healthcare system and reduce costs for our participants, customers, and business partners.

To report suspected fraud, waste, or abuse, you can contact PA Health & Wellness in one of these ways:

- PA Health & Wellness anonymous and confidential hotline at **1-866-685-8664**
- Pennsylvania Office of Inspector General at **1-855-FRAUD-PA (1-855-372-8372)**
- Pennsylvania Bureau of Program Integrity at **1-866-379-8477**
- Pennsylvania Department of Human Services **1-844-DHS-TIPS (1-844-347-8477)**
- Mail: Office of Inspector General, 555 Walnut Street, 8th Floor, Harrisburg, PA 17101
- Mail: Department of Human Services, Office of Administration, Bureau of Program Integrity, P.O. Box 2675, Harrisburg, PA 17105-2675

You may remain anonymous if you prefer. All information received or discovered by the Special Investigations Unit (SIU) will be treated as confidential, and the results of investigations will be discussed only with persons having a legitimate reason to receive the information (e.g., state and federal authorities, corporate law department, market medical directors or senior management).

Medical Necessity Appeal

Providers or Participants may request an appeal related to a medical necessity decision made during the authorization or concurrent review process orally or in writing:

Mail to:
PA Health & Wellness
Attn: Complaints and Grievances Unit
1700 Bent Creek Blvd, Suite 200
Mechanicsburg, PA 17055

Email:
PHWComplaintsandGrievances@PAHealthWellness.com

Phone: 844-626-6813 TTY: 711

NOTE: PHW will not accept data stored on external storage devices such as USB devices, CD-R/W, DVD-R/W, or flash media.

We can't wait to meet you!

Provider Relations is your primary contact for PA Health & Wellness, including Wellcare and Ambetter.

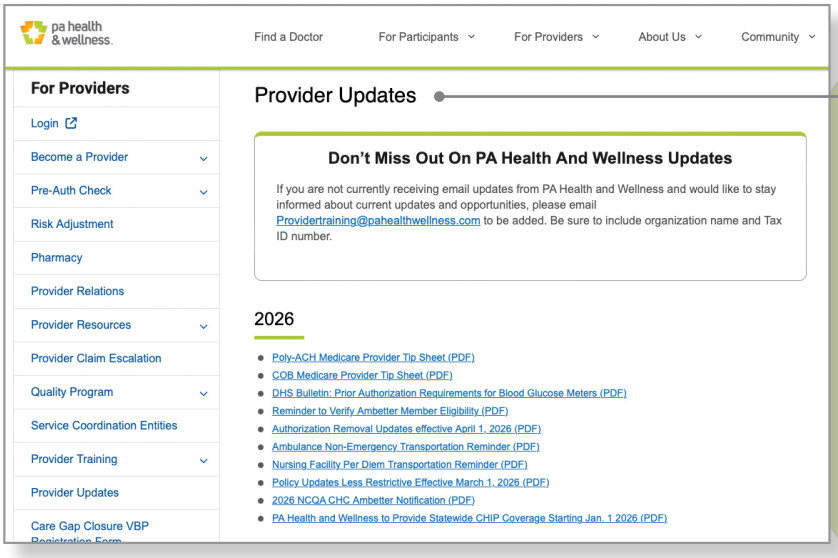
We're here to be your partner. My primary focus is to drive resolution, provider performance, ongoing education and more!

Feel free to reach out with any questions, concerns, or even just to say, "hello!".

Get to know our Provider Relations team even better by visiting https://www.pahealthwellness.com/providers/ProviderRelations.html

Get connected with our Provider Relations Team at PHWProviderRelations@PAHealthWellness.com

Thank you for continuing to provide our Members with high quality and compassionate care. We're looking forward to our continued partnership.



Provider Updates

Please visit https://www.pahealthwellness.com/providers/provider-updates.html regularly to stay up to date on updates from PA Health & Wellness.

If you'd like to be added to our email list to receive updates to your inbox reach out to Providertraining@pahealthwellness.com. Be sure to include organization name and Tax ID number in this request.

Provider Newsletter

1700 Bent Creek Blvd, Suite 200, Mechanicsburg, PA 17050