Clover Health

Provider Manual 2024

A guide to working better, together.

Clover Health

We are a Medicare Advantage company changing the way people are cared for by capturing and analyzing patient data in powerful new ways.

Our goal is to improve quality of life for our members by offering providers like you the resources and support they need.

By establishing a close, collaborative partnership, we can share and exchange rich health data about your patients—our members. We can then start to identify conditions earlier and move closer to preventing them.

Working together, we can drive continuous improvements in patient care and help Medicare patients live longer, healthier, more fulfilling lives.

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We accept Clover Health!

Quick Reference Guide

Visiting **cloverhealth.com/providers** is the simplest, quickest way to check member eligibility and benefits, submit or check on a prior authorization request, check the status of a claim, find other Clover providers, access documents, policies and forms, and much more. Be sure to have your National Provider Identifier (NPI) handy.

FREQUENTLY USED SERVICES	QUICK LINKS	
To submit a claim If you need to make any changes to an original claim, **you can submit a corrected claim using one of the channels to the right**.	Interconnect via Change Healthcare: Payer ID#: 13285	via mail: Clover Health P.O. Box 21164 Eagan, MN 55121
To find an in-network provider	**cloverhealth.com/findprovider**	
To view prior authorization criteria	**cloverhealth.com/pre-auth-tools**	
To set up electronic payments	Go to **changehealthcare.com** or call **1-866-506-2830** and select option 2 to set up an account. Enter Clover Health's payer ID #13285.	
To verify patient eligibility, benefits, and copays	**cloverhealthprovider.healthtrioconnect.com**	
For all other routine forms and documents	**cloverhealth.com/providerforms**	
For Part D prior authorization criteria	**cloverhealth.com/members/formulary**	
To submit a Part D prior authorization electronically	**covermymeds.com**	
For any Clover Assistant inquiries/support	Email: **cloverassistantsupport@cloverhealth.com**	

If you need additional assistance, you can call or fax using the numbers below.

DEPARTMENT	CONTACT	
Provider Services	T: **1-877-853-8019**	F: **1-866-201-3008**
Care Management	T: **1-888-995-1689**	
Authorization Requests (UM)	T: **1-888-995-1690**	F: **1-800-308-1107**
Pharmacy (CVS Caremark®) **CVS Caremark Coverage Determinations & Appeals**	T: **1-855-479-3657** (PPO) **1-844-232-2316** (HMO) T: **1-855-344-0930**	F: **1-855-633-7673**
Appeals & Grievances	T: **1-888-657-1207**	F: **1-732-412-9706** (Appeals) F: **1-551-227-3962** (Grievances)
Member Services	T: **1-888-778-1478**	

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INN Claims Payment Disputes If you have attachments (e.g., medical records) **you will need to mail or fax in the Claims Payment Dispute form and supporting documents** regardless of when the claim was processed. **THIS ADDRESS IS NOT FOR CLAIM SUBMISSIONS.**	Clover Health Attn: Claims P.O. Box 21164 Eagan, MN 55121 Email: submitclaims@cloverhealth.com Fax: 1-888-240-7243
OON Claims Payment Disputes If you have attachments (e.g., medical records) **you will need to mail or fax in the Claims Payment Dispute form and supporting documents** regardless of when the claim was processed. **THIS ADDRESS IS NOT FOR CLAIM SUBMISSIONS.**	Clover Health Attn: Appeals P.O. Box 21672 Eagan, MN 55121 Email: submitclaims@cloverhealth.com Fax: 1-732-412-9706
Payment Integrity (Pre-Pay) Please include a copy of the audit letter you received with your dispute.	Clover Health Attn: Payment Integrity – Pre-Pay P.O. Box 21862 Eagan, MN 55121 Email: prepay.paymentintegrity@cloverhealth.com Fax: 1-912-662-0673
Payment Integrity (Post-Pay) Please include a copy of the audit letter you received with your dispute.	Clover Health Attn: Payment Integrity – Post-Pay P.O. Box 21852 Eagan, MN 55121 Email: postpay.paymentintegrity@cloverhealth.com Fax: 1-866-509-4325
General mailing Please use only when the recipient is unknown.	Clover Health P.O. Box 21164 Eagan, MN 55121 Email: medadvantage@cloverhealth.com Fax: 1-866-508-0865

Legal Overview

Except where otherwise indicated, this Provider Manual is effective as of January 1, 2024 for providers currently participating in the Clover Health network.

This Provider Manual will serve as a resource for navigating Clover Health's operations and processes. As an in-network provider, you are expected to be familiar with this manual and to abide by the operations and processes contained herein. In the event of a conflict or inconsistency between this Provider Manual and the express provisions of your Provider Services Agreement with Clover Health, including any regulatory requirements appendices attached to it, the provisions of your Provider Services Agreement will prevail. We reserve the right to periodically update this Provider Manual.

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Clover Health Members

We believe that doctors care best for their patients when their time together is efficient and productive. This section outlines the benefits, rights, and responsibilities of Clover members, and shows you how to verify member eligibility.

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IDENTIFICATION OF CLOVER HEALTH MEMBERS AND ELIGIBILITY

You (or your office staff) are responsible for verifying the eligibility of each member before rendering nonemergency services or treatment. Clover issues identification cards that you can use to verify member eligibility. When a Clover member arrives in your office, you should confirm the member's eligibility: You can determine eligibility by logging on to **cloverhealth.com/providers/portal**. See the Appendix for a **sample Clover member card**.

Some Clover members have additional insurance coverage, like Medicaid. Clover members who have dual eligibility should present identification cards for each of their coverages, including any Medicaid benefits that might be administered by another payer. Additional coverage can pay for costs that are not covered by the Clover Health plan as long as all services and items are covered by each plan. Members should refer to Evidence of Coverage (EOC) documents for both their Clover plan and their other insurance to learn what's covered by each plan.

COVERED SERVICES

Clover offers PPO plans in select counties of New Jersey, Texas, Georgia, Pennsylvania, South Carolina, and HMO plans in select counties of New Jersey.

Our PPO plans don't require a referral by a PCP to access care, but we anticipate that the providers our members trust for their primary care will help them understand how to access care within our network to maximize their plan benefits.

Our HMO plans also don't require a referral, but access to care is limited to providers who are in-network or contracted with Clover Health, except for services outlined in **Chapter 4 of the Medicare Managed Care Manual**.

Clover members enjoy a comprehensive benefits package, including the primary, preventive, and specialty care necessary for good health. Covered services must be medically necessary and appropriate. We do not pay claims for services excluded from Original Medicare. You can learn more about Medicare-excluded services in this **Medicare Learning Network booklet**. You can obtain Clover member benefit information:

Online

- Go to **cloverhealth.com/members/plan-documents/plan-details**.
- Enter the applicable ZIP code and plan year and click Search.
- Select the plan documents you would like to view.

A member who elects to receive medical care for services not included in the contract or for services that are determined by Clover Health not to be medically necessary will be responsible for payment. In those instances, direct the member to the Evidence of Coverage and documented prior approval from the member for such out-of-pocket expenses or **submit an organizational determination**. All services may be subject to applicable member share-of-cost.

COORDINATION OF BENEFITS (COB)

Coordination of benefits and services is intended to avoid duplication of benefits, and at the same time, preserve certain rights to coverage under all plans in which the member is covered. COB is an important part of Clover's overall objective of providing healthcare to members on a cost-effective basis. Clover members cannot be billed for covered services rendered except for any copays for which the member can be responsible. Clover members who have Medicaid with the QMB (Qualified Medicare Beneficiary) program as other coverage are not responsible for cost-shares. Your contract with Clover Health requires you to accept Clover's payment as payment in full, or you can bill the appropriate state Medicaid source for the balance.

Definitions

Primary plan: Determines a member's health benefits without taking into consideration the existence of any other plan.

Secondary plan: Can pay the remaining costs after the primary plan has paid for services or items covered by both payers.

All Clover members must follow these procedures:

- All Clover members will be responsible for paying copays at the time of their office visit. If the member has additional coverage (like Medicaid), that coverage can reduce or eliminate the amount owed if the service rendered is billable to the other payer.
- If Clover is the secondary insurance, attach the explanation of benefits from the primary carrier and send the claim to Clover Health for consideration of the remaining balance.
- Under no circumstances can members be directly billed beyond the amount due for their cost-share.

COB for Medicare Advantage Members with Medicaid

Clover Health members who have limited income and resources can receive help paying out-of-pocket medical expenses from Medicaid. If a member is identified as having secondary insurance coverage through Medicaid, you should obtain a copy of the member's Medicaid card and/or the card for the plan that administers the benefit to bill Medicaid after receiving the EOP from Clover Health.

No share of the cost should be collected at the time of the visit from a member with Medicaid coverage. For more information, your office can call Provider Services at **1-877-853-8019 from 8 am to 5:30 pm ET**, Monday through Friday, or call the number on the member's Medicaid card.

COB for Medicare Advantage Members with Multiple Payer Sources

If a member has coverage from more than one payer or source, we coordinate benefits with the other payer(s) in accordance with the provisions of the member's benefits. If you have knowledge of alternative primary payer(s), you must bill the other payer(s) with the primary liability based on such information prior to submitting claims for the same services to Clover.

You are also expected to provide us with relevant information you have collected from members regarding COB and to bill payer(s) with the primary liability based on such information prior to submitting bills for the same services to Clover. To the extent permitted by law, if Clover is not the primary payer, your compensation by Clover will be the difference between the amount paid by the primary payer(s) and your applicable rate, less any applicable copays or coinsurance.

Because members accept Clover benefits through their participation in the COB program, they are legally responsible for adhering to the rules and regulations required of all Clover members, such as use of a PCP and/ or prior authorization for out-of-plan services.

Clover cannot deny a claim, in whole or in part, on the basis of "coordination of benefits" unless we have a reasonable basis to believe that the member has other primary insurance coverage for the claimed benefit. In addition, if we request information from the member regarding other coverage and do not receive the information within 45 days, we must adjudicate the claim. However, the claim cannot be denied on the basis of nonreceipt of information about other coverage.

SUBROGATION

If a third party is responsible for the cause of a member's injury or illness, Clover Health reserves the right to recover benefits previously paid to a provider for related healthcare services. Recoveries can be pursued by Clover Health or its contracted vendors to the extent permitted under applicable law.

EXTRA BENEFITS, PROGRAMS, AND SERVICES

Most Clover plans offer the following supplemental benefits and extra programs and services that are not covered by Original Medicare. Refer to each plan's Evidence of Coverage for specific details.

Dental

All Clover Health plans include coverage for preventive dental services (e.g., oral exams, cleanings, and x-rays). Most Clover Health plans include an allowance for comprehensive dental services (e.g., fillings, crowns, and dentures).

We partner with **DentaQuest** to provide supplemental dental services. For more information, please see the Evidence of Coverage, which can be found at **cloverhealth.com/members/plan-documents/plan-details**.

DentaQuest requires providers to submit claims on the member's behalf.

Dental claims can be sent to DentaQuest online, by fax, or by mail. Claims must be submitted on ADA-approved claim forms (2006 or newer).

- **Online:** Get more information at **dentaquest.com/dentists**.
- **Fax:** 1-262-834-3589
- **Mail:**
  DentaQuest

P.O. Box 2906
Milwaukee, WI 53201-2906

Procedures normally offered by a physician in a hospital that involve the conditions listed below are not covered through DentaQuest and should be billed under Part B.

- Conditions involving the jaw or related structures
- Setting fractures of the jaw or facial bones
- Extraction of teeth to prepare the jaw for radiation treatments of neoplastic (cancer) disease and other related services

Refer to the **Claims and Billing** section of this manual for more information about Part B claim submission.

Dental care that is not covered includes routine dental care procedures that are performed after the underlying health condition has been treated, such as:

- Tooth removal due to facial injury from a car accident
- Any dental care related to the car accident that can arise at a later time
- Some dental-related hospitalizations (for example, we can cover treatment for a member who develops an infection after having a tooth extraction or requires observation during a dental procedure because of a health-threatening condition)

If you have questions or concerns, please call DentaQuest Dental Provider Services:

- **Georgia:** 1-800-516-0124
- **New Jersey:** 1-855-398-8409
- **Pennsylvania:** 1-855-343-7401
- **South Carolina:** 1-800-685-2371
- **Texas:** 1-888-308-9345

Supplemental dental benefits are subject to the same **appeals process** as any other benefits.

Vision

All Clover Health plans offer routine vision exams and eyewear through our partner **EyeQuest**. Supplemental vision benefits are subject to the same **appeals process** as any other benefits.

Vision claims can be sent to EyeQuest electronically, by fax, or by mail.

- **Online:** Get more information on the **EyeQuest website** at **www.dentaquest.com/en/members/member-vision**.
- **Fax:** 1-888-696-9552
- **Mail:** Vision claims can be sent to the following address or faxed to the number above. Be sure to include a copy of the member's Clover ID card:
  EyeQuest
  Attn: Vision Claims Processing

P.O. Box 433
Milwaukee, WI 53201-0433

If you have questions or concerns, please call EyeQuest Vision Provider Services at:

- **Georgia:** 1-800-516-0124
- **New Jersey:** 1-844-824-2014
- **Pennsylvania:** 1-844-824-2014
- **South Carolina:** 1-844-824-2014
- **Texas:** 1-844-824-2014

Hearing

All Clover plans include a routine hearing exam and access to state-of-the-art hearing aids through **TruHearing**. Supplemental hearing benefit includes:

- One routine hearing exam per year, $0 copay
- Two TruHearing hearing aids, one per ear, per year:
    - Advanced aid, $699 copay for each hearing aid, or
    - Premium aid, $999 copay for each hearing aid

TruHearing hearing aid purchase includes:

- Three TruHearing provider visits for evaluation and fitting within the first year of the hearing aid purchase
- 45-day trial period and 3-year extended warranty
- 80 batteries per aid (for non-rechargeable hearing aid models)
- 3-year warranty for repairs
- 3-year replacement warranty for loss or irreparable damage (manufacturer and reprogramming fees may apply)

If you have questions or concerns, please call TruHearing Provider Relations at **1-866-581-9462**. To use the TruHearing benefit, members must call TruHearing at **1-855-205-5570**.

Gym/Fitness

Each Clover Health member will receive one **SilverSneakers®** membership, which includes access to thousands of fitness centers as well as online classes and other wellness services.

Members who misplaced their SilverSneakers ID card can request a new card by calling SilverSneakers Customer Service at **1-888-502-0836 from 8 am to 8 pm ET**, Monday through Friday.

Over-the-Counter (OTC)

We give members an allowance of at least $120 per year** to shop from thousands of approved over-the-counter (OTC) items, including bandages, cough medicine, and vitamins. Plus, they can purchase OTC items at leading retail locations, by phone, or online.

**The allowance is at least $30 per quarter and expires at the end of each quarter (March 31, June 30, September 30, and December 31).

Members can shop three ways:

- **Online: cloverhealth.com/livehealthy**
  Once a member has logged in, they will be directed to the Healthy Benefits+ website. There, they can access online shopping at walmart.com.
- **By phone: 1-800-608-2348 (TTY 711) 8 am–8 pm local time**, 7 days a week, October to March, and Monday through Friday, April to September
- **In store** Participating stores can be found on the Healthy Benefits+ member portal and mobile app.

Clover LiveHealthy Rewards Program

Healthy activities should be rewarded! Our rewards program allows members to earn up to $400 reward dollars a year while taking a path to their best health. Members can receive:

- $150 reward dollars for completing a LiveHealthy Visit (a one-time visit with a Clover Assistant empowered provider)
- $100 reward dollars for answering Getting to Know You (health assessment survey) questions
- Up to $50 reward dollars for receiving preventive care
- Up to $100 reward dollars for getting active

To view details and requirements for each reward, visit cloverhealth.com/livehealthy.

LiveHealthy Flex Plus Card
1 Card for 2 Great Programs

The Flex Plus Visa card is used for both the OTC benefit and rewards earned through the LiveHealthy Rewards program.

Note: These funds cannot be converted to cash. Other limitations may apply. Members should contact Clover Health for details.

Check Balances, Find a Store, and More

Members can go to **cloverhealth.com/livehealthy** or download the Healthy Benefits+ mobile app—or both! On the website or app they can:

- Get more details on using the OTC benefit
- Check account balances for both their OTC allowance and rewards earned through the Clover LiveHealthy Rewards program
- Find participating stores

Telehealth

Clover has partnered with Teladoc to provide alternative services for common health issues like sinus problems, respiratory infections, allergies, urinary tract infections, pink eye, common cold and flu symptoms, and many other non-emergency illnesses. In addition to general medical services, members can communicate with a doctor via phone, web, or mobile app 24 hours a day, 7 days a week, 365 days a year, for a $0 copay. Teladoc also offers behavioral health services to our members, including psychiatry and therapy.

Teladoc is not intended to replace the care of a primary care physician or provide an ongoing relationship between the member and one of their doctors. All Teladoc doctors are board-certified and state-licensed and go through rigorous training and credentialing.

MEMBERS' RIGHTS AND RESPONSIBILITIES

We ensure the following rights and responsibilities for our members.

Members' Rights

- Protection and privacy of personal health information
- Timely access to covered services and drugs
- Clear, simple presentation of health-related information
- Fair and respectful treatment
- Opportunity to make complaints and ask that we reconsider decisions we have made
- Opportunity to make their own decisions about their care
- Opportunity to ask for reconsideration of claim payment
- To be provided with information about the plan, its network of providers, and covered services

Members' Responsibilities

- Familiarity with covered services and the rules required to receive them
- Full disclosure of plans enrolled in, and of changes in health status, geography, and other pertinent

health-related personal information

- Full and/or timely payments toward any and all amounts owed
- Understanding of their health problems and participation in developing treatment goals mutually agreed upon with their healthcare providers

Members can contact Member Services for help or with questions or concerns. For additional details on members' rights and responsibilities, they can refer to their Clover Health **Evidence of Coverage** or call Member Services at **1-888-778-1478 (TTY 711) from 8 am to 8 pm local time**, 7 days a week. From April 1 through September 30, alternate technologies (for example, voicemail) will be used on the weekends and holidays.

MEMBERS' PRIVACY RIGHTS

Protecting and securing our members' personal information is one of our top priorities at Clover Health. Our members rely on us to protect the privacy of their Protected Health Information ("PHI"). Clover Health has developed internal privacy policies and procedures that address applicable privacy laws and regulations.

Additionally, our Notice of Privacy Practices describes how member medical information may be used and disclosed and how our members can obtain access to relevant information, including copies of their health information and an accounting of disclosures. A copy of our **Notice of Privacy Practices** can be found on our website.

CULTURAL COMPETENCY

To help integrate cultures of diverse backgrounds within Clover Health and across the organizations we partner with, we follow Culturally and Linguistically Appropriate Service (CLAS) standards: a collective set of linguistic services, mandates, guidelines, and recommendations issued by the United States Department of Health and Human Services Office of Minority Health.

Healthcare professionals must provide information regarding treatment options in a culturally competent manner, including the option of no treatment. Healthcare professionals must ensure that enrollees with disabilities have effective communications with participants throughout the health system in making decisions regarding treatment options (**Chapter 6, Section 40 of the Medicare Managed Care Manual**).

Learn more at **thinkculturalhealth.hhs.gov**.

ADVANCE DIRECTIVES

In the event that a member becomes incapacitated and/or unable to communicate their needs, we follow the instructions as outlined in the member's advance directive, if the member has one in place. Examples of an advance directive include a living will, durable power of attorney for healthcare, healthcare proxy, or do-not-resuscitate (DNR) request.

In accordance with advance directive guidelines, we look to you to assist your patients in developing advance directives. We recommend that you discuss advance directives with your patients (as appropriate) and file a copy of any advance directive document in the medical record. Each medical record that contains an advance directive should clearly indicate that such a document is included.

You can find more information on advance directives on your state department of health website:

Georgia: **aging.georgia.gov**

New Jersey: **nj.gov/health/advancedirective**

Pennsylvania: **aging.pa.gov/aging-services/caregiver-support/Pages/Caregivers-of-Adults.aspx**

South Carolina: **aging.sc.gov**

Texas: **hhs.texas.gov/laws-regulations/forms/advance-directives**

Provider Responsibilities

Clear and transparent communication is integral to the success of our partnership. We will strive to explicitly articulate our provider expectations and share how we can be a valuable resource for you.

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PROVIDER DATA COLLECTION

Initial Roster and Facility Data Collection

Clover Health requires a fully complete and up-to-date practitioner or facility roster in order to load practitioners, groups, and facilities into our internal systems and provider directory. Inaccurate provider data may result in incorrect claim payment and incorrect representation in our provider directories.

Directory Validation

Clover may conduct outreach to every provider in our provider directory to validate demographic and contact information. Outreach is performed on a regular basis by email or by phone.

For health systems and large groups, Clover Health will request the organization's provider roster by email or phone on a quarterly basis. The organization is responsible for the accuracy of the information sent to Clover, and any inaccurate data discovered by Clover will be quickly communicated back to the provider for verification.

Additions, changes, and terminations should be reported to Clover promptly so internal systems and the provider directory remain current.

Changes to Your Provider Data

It is important to keep your provider data up to date to ensure accurate claim payment and proper representation in our provider directories. **Please let us know if any of the following information about your practice changes:**

- Office or billing address information, including telephone number
- Billing information, including National Provider Identifier(s) or Tax Identification Number
- Group affiliation
- Clover Health participation status
- Medicare participation status
- Sanction information
- Current W-9
- Any other relevant provider information

To submit practice changes, go to **cloverhealth.com/providers/support** and select **Update practice information** to review the information and documentation required for each type of change. Email required documentation to **providers@cloverhealth.com**.

If you decide not to accept additional Clover members, please give us 60 days notice. Email changes to **providers@cloverhealth.com**.

If you have questions or require assistance, please call Provider Services at **1-877-853-8019 from 8 am to 5:30 pm ET**, Monday through Friday.

Changes to Your NPPES Profile

As recommended by CMS, it is important to review, update, and certify your information in the National Plan & Provider Enumeration System (NPPES). Providers are required to keep their NPPES data current, and changes should be made as soon as possible to ensure accurate provider data is displayed. Centers for Medicare & Medicaid Services (CMS) is also encouraging Medicare Advantage Organizations such as Clover Health to use NPPES as a resource for our online provider directories.

If the NPPES database is kept up to date by providers, Clover can rely on it as a primary data resource for our provider directories and potentially reduce outreach for this information. Clover can download the NPPES database and compare the provider data to the information in our existing provider directory to verify accuracy.

When reviewing your provider data in NPPES, please update any inaccurate information in the modifiable fields, including provider name, mailing address, telephone and fax numbers, and specialty, to name a few. Please include all addresses where you practice and actively see patients. Do not include addresses where you do not actively see patients. Please remove any practice locations that are no longer in use. Once you update your information, confirm it is accurate by certifying it in NPPES. Remember, NPPES has no bearing on billing for Medicare Fee-For-Service.

For questions pertaining to NPPES, go to **npiregistry.cms.hhs.gov/search** and click Help.

Changes to Your CAQH Profile

To help ensure accurate provider directory information, it is important to keep your CAQH profile up to date. While you are required to re-attest your CAQH profile every 120 days, we ask that you review and attest your data monthly. Follow these steps to update and re-attest your profile information:

- Log in to **CAQH ProView**.
- Correct any outdated information, and complete other incomplete questions applicable to your Provider Type.
- Confirm there are no errors on your profile and attest to its accuracy.
- Confirm current proof of malpractice insurance is uploaded to the Documents section.
- Review work history to ensure full work history is listed from the time of initial licensure.

If you have questions, please review the materials provided on the CAQH ProView for Providers and Practice Managers page at **caqh.org/solutions/caqh-proview-providers-0**.

Additionally, you may contact the CAQH ProView Help Desk for assistance:

- Log in to CAQH ProView and click the Chat icon at the top of the page or call 1-888-599-1771.
- Please have your CAQH ProView provider ID readily available.

Hospital Privileges

Clover Health reserves the right to require in-network providers to have active admitting privileges to an in-

network hospital. If you or any provider in your practice loses privileges at a hospital, please notify us no later than 10 business days following the date of the termination of privilege.

APPOINTMENTS AND ACCESS STANDARDS

We are dedicated to arranging quality access to care for our members. To help with this process, we ask that you and your office staff adhere to the following recommendations:

- **Telephone coverage after hours:** An answering service or a telephone recording directing a member to call another telephone number or 911 in an urgent or emergent situation.
- **Telephone access during normal business hours:** Immediate responses to any urgent or emergency health events, within 4 hours for non-urgent calls, and within 1–2 business days for routine calls.
- **Covering provider:** When you are on extended leave (vacation, illness, etc.), you must arrange with another participating primary care provider or specialist to provide accessible 24-hour coverage. Coverage must extend beyond 911, except in the event of an emergency or urgent situation.
- **Appointments:** You must make every effort to see a member within the following time frames:
    - **Emergent:** Immediately; members should be directed to call 911 in the event of an emergency or go to the emergency room for treatment.
    - **Urgent:** Within 24 hours
    - **Routine/Symptomatic:** Within 7 days
    - **Wellness/Nonsymptomatic:** Within 30 days
- **Office waiting time:** Should not exceed 15 minutes from the time of the scheduled appointment.
- **Minimum office hours:** You must practice for a minimum of 16 hours a week and must promptly notify Clover of changes in your office hours and locations as soon as this information becomes available, but no later than 3 business days after the change takes effect. The minimum office hour requirement can be reduced under certain circumstances for good cause, with Clover's prior written approval.
- **Accessibility:** You are expected to meet the federal and state accessibility standards and those defined in the Americans with Disabilities Act of 1990. Healthcare services provided through Clover must be accessible to all members.

Clover tracks and evaluates issues relating to appointment waiting times, appropriateness of referrals, and other capacity indications.

MEMBER REFERRALS

In the event that you are responsible for providing or arranging for a covered service, you agree to direct the member to an appropriate participating provider in Clover's network. You may direct a member to a non-participating provider only where:

(a) no participating provider is reasonably available to perform the necessary services;

(b) when a member requires emergency services, and directing such member to a non-participating provider would expedite diagnosis or treatment;

(c) Clover and the provider mutually agree that the member may be referred to a non-participating provider; or

(d) if referral to a non-participating provider is reasonably determined by the provider to be in the best interest of the member.

Refer to your specific Provider Services Agreement for additional details.

ACCESS TO MEDICAL RECORDS

Clinical documentation of disease burden is central to collaborative management and is the cornerstone of care. As needed, Clover will request medical records to ensure an accurate representation of patients' clinical disease and needs. Medical records can also be requested for audits, quality assurance purposes, as well as to ensure proper billing and claim payment practices. Unless otherwise specified in your Provider Services Agreement, medical records shall be provided at no cost and supplied within the time frame requested. (In some situations, expedited delivery may be required.) Medical records must be maintained and protected for 10 years.

MEDICAL RECORD STANDARDS

We believe that updated, complete documentation is an essential component of the delivery of quality medical care and collaboration. We reserve the following rights to ensure our member profiles are comprehensive.

Access and confidentiality

We reserve the right to inspect (at reasonable times) any and all records, specifically any medical records you maintain pertaining to members. This includes, but is not limited to, assessing the quality of care, collecting data for Healthcare Effectiveness Data and Information Set (HEDIS®)[1] reporting, collecting data for risk adjustment reporting, coordinating medical care evaluations and audits, determining on a concurrent basis the medical necessity and appropriateness of any care being provided, and ensuring proper billing and claim payment.

Federal and state regulatory bodies can determine other purposes for having access to members' medical records.

We ask that you safeguard the privacy and confidentiality of our members' information and ensure the accuracy of health records in accordance with applicable federal and state privacy laws and regulations.

For information on member rights as they relate to the above, refer to the Members' Privacy Rights section of this manual.

[1]HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Medical record documentation

- Medical information must be legible and follow a logical and consistent format, with page numbers indicated (e.g., "Page 1 of 2") if an encounter spans multiple pages.
- Please fill out the correct form and submit it with a copy of the letter you received.
- Medical records must be submitted within the time frames outlined in the medical record request.
- Records must contain complete encounter information for each encounter. This includes:
    - Member's full name and date of birth
    - Provider's full name and title
    - Facility name
    - Date(s) of service
    - Documentation of all physician and/or nonphysician services (e.g., physical therapy, diagnostic or laboratory services, home healthcare)
- Records must indicate:
    - All illnesses and medical conditions
    - Medications list
    - Consultations/referrals
    - Present issue
    - Treatment plan
    - Follow-up plan
    - Preventive screenings and health education offered
    - Documentation on advance directives
- Information should be stored within a secure folder in a safe place.
- No record should be altered, falsified, or destroyed. If a correction is introduced, the individual correcting the record should draw a single line through the item to be corrected, and date and initial the correction.
- All telephone messages and consult discussions must be clearly identified and recorded.
- The medical record system should provide a mechanism to ensure member confidentiality.

Electronic Medical Record Integrations

Clover Health partners directly with electronic medical record (EMR) and integration vendors to automate the transmission of member charts via a secure and HIPAA-compliant connection.

Integrations automate the transmission of member charts to Clover without any additional effort or disruption to your practice. Clover does not have access to patient data for non-Clover members as a result of this integration. Benefits of participating in a Clover EMR integration include:

- Enhanced care coordination with Clover through incorporation of EMR data into Clover's advanced analytics platform
- Giving time back to your office staff that would have otherwise been spent responding to traditional medical record requests
- Reduced waste and environmental impact of printing charts, made possible through a paperless medical record retrieval
- Automated identification and transmission of member charts to Clover

Although we encourage participating providers to use EMR to help streamline your administrative processes, help protect your patient's information, and result in faster processing. However, Clover will also accept paper chart submissions and can occasionally request a paper chart to verify the accuracy of EMR data.

NON-ADHERENT CLOVER MEMBERS

We recognize that you may need help in managing non-adherent members. If you have an issue with a member regarding behavior or cooperation with and/or completion of treatment, or if you have a member who cancels or does not appear for necessary appointments and fails to reschedule even after follow-up attempts by you and/or your office, please call Provider Services at **1-877-853-8019 from 8 am to 5:30 pm ET**, Monday through Friday.

MEDICARE RISK ADJUSTMENT PROCESS

Clover understands that meeting members' medical needs is the first step to improving their health. Accurately defining members' risk levels allows us to better meet patients' needs and manage their care. With this in mind, we use standard Centers for Medicare & Medicaid Services (CMS) guidelines to measure our members' health relative to their peers using a risk adjustment model that considers their demographics and diagnoses. We use these measures to assess healthcare utilization needs and cost, allowing both you and payers to organize around these needs.

PROVIDER DATA COLLECTION

Initial Roster and Facility Data Collection

Clover requires a complete and up-to-date practitioner or facility roster in order to load practitioners, groups, and facilities into our internal systems and provider directory. Inaccurate provider data may result in incorrect claim payment and incorrect representation in our provider directories.

COMPLIANCE WITH FEDERAL LAWS AND NONDISCRIMINATION

The Code of Federal Regulations (42 CFR 422.504) requires that Medicare Advantage Organizations have oversight for contractors, subcontractors, and other entities. The intent of these regulations is to ensure

services provided by these parties meet contractual obligations, laws, regulations, and CMS instructions.

The contracted provider represents and warrants to Clover that he or she will not discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, HIV status, source of payment, veteran status, plan membership, or geographic location. Payments received by contracted providers from Medicare Advantage plans for services rendered to plan members include federal funds; therefore, you, as a contracted provider, are subject to all laws applicable to recipients of federal funds, including but not limited to Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, and all other laws that apply to organizations that receive federal funding. In addition, as a contracted provider, you must not discriminate against our members based on their payment status, specifically if they receive assistance from a state Medicaid program.

Treatment of Immediate Relatives or Members of the Household

Clover follows the exclusion of payment guidance for charges imposed by immediate relatives of the provider or members of the provider's household as outlined within Chapter 16, Section 130 of the Medicare Benefit Policy Manual. The intent of this exclusion is to bar Medicare payment for items and services that would ordinarily be furnished gratuitously because of the relationship of the beneficiary to the person imposing the charge. Per this section, providers will not be reimbursed for items and services provided to those who are immediate relatives or those who share the same household.

Immediate relatives include the following:

- Spouse
- Biological or adoptive parent or child
- Sibling
- Stepparent, stepchild, stepbrother, or stepsister
- Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law
- Grandparent or grandchild
- Spouse of grandparent or grandchild

Members of household include the following:

- Persons sharing a common abode with the patient as a part of a single-family unit, including those related by blood, marriage, or adoption; domestic employees; and others who live together as part of a single-family unit (a mere roomer or boarder is not included).

Claims and Billing

We know that you prefer to spend your time with patients, so we do what we can to make it easier to manage billing and paperwork. This section describes our claims process and how we can work together to ensure you're paid accurately and on time.

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CLAIM SUBMISSION

Electronic Submission

We encourage participating providers to submit claims electronically whenever possible. Doing so can help streamline your administrative processes, help protect your patient's information, and result in faster claim processing and payment. Clover supports electronic submission via the HIPAA transaction set (837P and 837I) and upholds Medicare guidance requiring electronic claim submission as defined by the American Simplification Compliance Act.

You should submit claims via Change Healthcare with Clover Health's Payer ID #13285.

Paper Submission

Clover also accepts the **CMS 1500** and the **CMS 1450** paper claim forms.

Paper claims must be submitted to:

Clover Health
P.O. Box 21164
Eagan, MN 55121

Timely Filing of Claims

You should refer to your Provider Services Agreement for filing guidelines and documentation requirements. Unless otherwise specified in your Provider Services Agreement, Clover's standard timely filing limit is 90 days from the claim date of service for in-network providers. As set forth in your Provider Services Agreement, you cannot bill members for services when the denied claim was submitted beyond the timely filing limit. Corrected claims must also be submitted within 90 days from the date of the Clover provider EOP, unless otherwise specified in your Provider Services Agreement.

Claims Processing

We use a combination of guidelines established by CMS and internal claims processing policies to assist in determining proper coding. These guidelines and policies dictate claim edits, adjustments to payment, and/or a request for review of medical records that relate to the claim.

You can refer to one of the following CMS guidance documents on electronic and paper claim submissions:

Medicare Billing: 837P and Form CMS 1500

Medicare Billing: 837I and Form CMS 1450

You can go online to check the status of claims you've submitted:

Log in at **cloverhealth.com/providers/portal**.

Clean Claims

Clover Health uses the **CMS Medicare Advantage definition of *a clean claim***, which consists of a properly completed claim that can be processed as soon as it is received.

Complete and accurate clean claims include all of the essential data elements required to process your claim. Some of the requirements for clean claims are listed below:

- Member Information
- Rendering healthcare provider's name, signature or representative's signature, address where service was rendered, "remit to" address, phone number, NPI, taxonomy, and federal TIN
- Referring healthcare provider's name and NPI, as well as TIN, if applicable
- Complete Service Information, including date of service, place of service, number of services (days/units) rendered, Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS), procedure codes with modifiers where appropriate, current ICD-10 diagnostic codes by specific code to the highest level of specificity, primary diagnosis for the services performed, and all diagnosis codes related to a line item.
- Complete coding
- Current National Drug Code (NDC) 11-digit number, NDC unit of measure (F2, GR, ML, UN,ME) and NDC units dispensed (must be greater than 0) for all claims submitted with drug codes – Enter the NDC information for drug(s) administered in the 24D field of the CMS-1500 Form, field 43 of the UB-04 form, or the LIN03 and CTP04-05 segments of the HIPAA 837 Professional or Institutional electronic form.
- Provider information
- Itemization – There may be times when we request an itemized bill to help adjudicate the claim. In an effort to avoid unnecessary delays, submit itemized bills upon request.
- Billed amounts including charge per service and total charges
- Detailed information about other insurance coverage
- Information regarding a work-related, auto, or other type of accident as applicable
- Substantiating documentation needed to meet the requirements of an encounter with a member

Failure to submit a complete and accurate clean claim may result in a delay of payment and/or rejection of a claim. Common types of errors include incomplete fields, invalid codes, lack of supporting medical records, provider data mismatches, and use of the wrong claim form(s).

Timely Processing of Claims

Clover is required to uphold standard claim timeliness guidelines, which either are stipulated in your Provider Services Agreement or follow **CMS timeliness requirements**. Refer to these guidelines for more information.

Claim Payments

You will be reimbursed according to the compensation provisions outlined in the compensation schedule that is included in your Provider Services Agreement.

Sequestration

All providers are reimbursed using a fee schedule based on the Medicare payment system, percentage of Medicare Advantage premium or Medicare-allowed amount, e.g., resource-based relative value scale (RBRVS), diagnosis-related group (DRG), etc., and will have the 2% sequestration reduction applied.

The amount of the sequestration reduction for each affected claim will be identified as "Other Discount" on the Remittance Advice document that providers will receive from Clover.

Claim Corrections

We will deny a claim if it is determined to be incorrect or incomplete due to missing or invalid information. In this event, you can resubmit a corrected claim within the timely filing period. Unless otherwise specified in your Provider Services Agreement, Clover's standard original claim timely filing limit is 90 days from the date of service for in-network providers. As set forth in your Provider Services Agreement, you cannot bill members for services submitted beyond the timely filing limit. Corrected claims must be submitted within 90 days from the most recent date of the Clover provider EOP, unless otherwise specified in your Provider Services Agreement.

You should submit claim corrections via Change Healthcare with Clover's Payer ID #13285.

Paper claim corrections must be submitted to:

Clover Health
P.O. Box 21164
Eagan, MN 55121

Correcting or Voiding Electronic Claims

- **Professional claims (837P):** Enter Frequency Code 7 for corrections or Frequency code 8 to void in Loop 2300 Segment CLM05-3. Enter the original claim number on the 2300 loop in the REF*F8*.
- **Institutional claims (837I):** Submit with the last character of the Type of Bill as 7, to indicate Frequency Code 7 for corrections, or Type of Bill as 8, to indicate Frequency Code 8 to void.

Correcting or Voiding Paper Claims

- **Professional claims CMS 1500:** Stamp "Corrected Billing" on the CMS 1500 form. Complete box 22 when resubmitting a claim. Enter the appropriate bill frequency code left-justified on the left-hand side of the field:
    - 6 – Corrected claim
    - 7 – Replacement of prior claim
    - 8 – Void/cancel prior claim

- **Institutional claims UB-04**: Submit with the last digit of 7 in the Type of Bill for corrections, or last digit of 8 for void claims.

Corrected claims should be submitted with all line items completed for that specific claim, and should not be filed with just the line items that need to be corrected. Please share this information with your practice management software vendor as well as your billing service or clearinghouse, if applicable.

The following CMS guidance can help you to determine what information to include on claim submissions:

- **Physician and Nonphysician Practitioner Services**
- **National Correct Coding Initiative**
- **CMS Fee Schedule Administration and Coding Requirements**
- **Medicare Administrative Contract (MAC)—Jurisdiction H (Texas)**
- **Medicare Administrative Contract (MAC)—Jurisdiction L (New Jersey)**
- **Physician Fee Schedule (Georgia)**
- **CMS Transmittals**
- **DMEPOS Fee Schedule**
- **Items and Services Not Covered Under Medicare**

PROGRAM INTEGRITY

Accurate payment is important to us at Clover Health. We strive to ensure that the care you provide to our members is effectively administered and fairly paid—by the responsible party, for eligible members, according to contractual terms, not in error or duplicate, and free of wasteful or abusive practices. To ensure that claim payments are issued in accordance with CMS guidelines, the integrity of our payment programs is overseen by dedicated staff and can include the use of contracted vendors. All claims can be subject to prospective, concurrent, or retrospective review for both billing and payment accuracy.

Readmissions Review Program

Clover reviews the following as part of the Readmissions Review Program:

- Same-day readmission for a related condition
- Same-day readmission for an unrelated condition
- Planned readmission/leave of absence
- Unplanned readmission less than 30 days after the prior discharge

If a patient is readmitted to a facility within 24 hours of a prior discharge for the same or a related condition, CMS and Clover Health require the facility to combine the two admissions on one claim. Clover will deny both the initial and subsequent admissions for payment as separate DRGs. The facility must submit both admissions combined on a single claim to receive reimbursement. For a same-day readmission to qualify for separate reimbursement, the medical record must support that the conditions are clinically unrelated.

Consistent with CMS billing requirements, two properly coded claims must be submitted to Clover if a patient is readmitted during the same day for an unrelated condition.

If a patient is readmitted to a facility as part of a planned readmission or leave of absence, the admissions are not considered two separate admissions. Clover Health requires the facility to submit one claim and receive one combined DRG payment for both admissions because they are for the treatment of the same episode.

Reimbursement for readmissions may be denied (see **Chapter 4, Section 4240 of the Medicare Quality Improvement Organization Manual**) if the readmission:

- Was medically unnecessary
- Resulted from a premature discharge from the same hospital
- Was a result of circumvention of the PPS by the same hospital

For a complete description of the program, visit **cloverhealth.com/providers/provider-clover-policies**.

Overpayment Recovery

We abide by **CMS guidelines for overpayment recoupments**, including provider notification, opportunity for rebuttal, and the possibility of automatic recoupments from future claim payments. Clover Health can reopen and revise its initial determination or redetermination on a claim on its own motion:

- Within 1 year from the date of the initial determination or redetermination for any reason; or
- Within 4 years from the date of the initial determination or redetermination for good cause as defined in CMS Medicare Handbook §10.11; or
- At any time if:
    - There exists reliable evidence that the initial determination was procured by fraud or similar fault as defined in the Code of Federal Regulations (42 CFR §405.902); or
    - The initial determination is unfavorable, in whole or in part, to the party thereto, but only for the purpose of correcting a clerical error on which that determination was based. Third party payer error does not constitute clerical error or similar fault as defined in the **Code of Federal Regulations (42 CFR§ 405.986)**.

We will provide written documentation that identifies affected claims and justifies the reimbursement request. Overpayments can stem from coding edits, improper coordination of benefits, technical denials, and medical necessity review among other reasoning outlined by applicable law.

Clover can collect a monetary penalty against a reimbursement request, including, but not limited to, an interest charge.

Except as expressly otherwise stated in the Provider Services Agreement, Clover Health attempts to collect overpayments according to the following guidelines:

- Clover generally initiates recoupments 41 days after the date of our refund request letter if no refund check or written dispute is received.

- If you submit a written dispute to us, we will not initiate recoupment activity (or will cease recoupment activity) to the extent administratively feasible while the dispute is under review.
- If we uphold our original determination, we will provide written notification. We will also retain any recoupments already processed and/or proceed with recoupments previously put on hold.
- If we overturn our original determination, we will provide written notification. We will also repay any recoupments already processed and/or remove claims from the recoupment process.

When refunding an overpayment by check, in order to help us identify the overpaid claim, be sure to include all appropriate information:

- Clover member name
- Clover member ID number
- Claim number
- Date of service
- Billed and paid amounts
- Provider remittance advice that you received for the claim and/or the refund request letter you received from Clover or one of our contracted vendors

Overpayment refund checks can be sent to:

Clover Health
Attn: Payment Integrity
P.O. 21852
Eagan, MN 55121

If we determine upon investigation that our overpayment was a result of fraud you have committed, we will report the fraud to the appropriate state and federal regulators as required by law. We can then take action to collect an overpayment by assessing it against payment of any future claim submitted by you.

If you have any questions about Overpayment Recoveries, please call Provider Services at **1-877-853-8019 from 8 am to 5 pm local time ET**, Monday through Friday.

Fraud, Waste, and Abuse

We trust that our providers will work ethically to deliver the highest-quality medical care and abide by the proper administrative guidelines. In the rare event that a provider compromises this integrity, we support the laws put in place to combat fraud, waste, and abuse.

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CLOVER HEALTH'S FRAUD, WASTE, AND ABUSE OBLIGATIONS

As a partner of CMS, Clover is obligated to monitor for signs of fraud, waste, and abuse and to ensure well-managed care through a payment integrity review both before and after payment is issued. Furthermore, Clover has a fiduciary responsibility to its members to ensure the appropriate disbursement of plan dollars.

Clover's Special Investigations Unit aims to prevent, detect, and correct instances of fraud, waste, and abuse. The Special Investigations Unit will investigate and resolve suspicious behavior and material misrepresentations to ensure reimbursements are appropriate.

DEFINITIONS

Fraud

Knowingly and willfully executing or attempting to execute a scheme or artifice to defraud any healthcare benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any healthcare benefit program. 18 U.S.C. § 1347.

Waste

Overutilization of services or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally considered to be caused not by criminally negligent actions but rather by the misuse of resources.

Abuse

Actions that can, directly or indirectly, result in unnecessary costs to the Medicare program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment, and the provider has knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent, prior knowledge, and available evidence, among other factors.

Material Misrepresentation

A misrepresentation on a claim or member record occurs when the claim or documentation does not accurately reflect the services performed or the necessity/appropriateness of the services to be performed. A misrepresentation is material when the claim or documentation results in a payment that would not have otherwise occurred.

PROGRAM EXPECTATIONS

A successful fraud, waste, and abuse prevention plan requires a partnership between Clover Health and providers. Providers, facilities, and suppliers are required to implement compliance measures to minimize risk to beneficiaries and Clover.

Clover expects that providers, facilities, and suppliers will implement controls to ensure:

- All services are accurately and completely documented in the patient's medical record prior to a claim being submitted for reimbursement.
- Records are legible, signed, and dated and accurately identify the rendering and referring provider.
- Prescriptions are not false or misrepresentative and meet all dispensing guidelines.
- Coding and billing are accurate and true; services are not unbundled, upcoded, medically unnecessary, duplicative or false.
- All applicable laws and regulations are adhered to.
- Records are retained in a safe, secure manner and available upon request.

STATE AND FEDERAL LAWS

Clover Health recognizes the importance of preventing, detecting, and investigating fraud, waste, and abuse (FWA) and is committed to protecting and preserving the integrity and availability of healthcare resources for members. Clover must ensure that First Tier, Downstream, and Related Entities (FDR) receive general compliance training, as well as fraud, waste, and abuse training.

There are numerous federal and state fraud, waste, and abuse laws that attach to the provision of healthcare services. Violations of federal and/or state law can result in nonpayment of claims, civil monetary penalties, exclusion from federal healthcare programs, criminal liability, etc.

REVIEW PROCESS

If a claim, provider, or facility is identified for review, further investigation into the possible fraud, waste, abuse, or misrepresentation is conducted by Clover. The investigation into possible inappropriate billing will usually include a review of the related medical records. An investigation may also include patient or provider interviews and onsite reviews. The provider will be notified of the findings at the completion of the review and provided an opportunity to respond to the findings. Clover will collect any associated overpayments that were identified. The Special Investigations Unit (SIU) may provide education to providers on appropriate coding, billing, and policy adherence. Should fraud, waste, abuse, or a material misrepresentation be identified, Clover will collect any associated overpayments and make any needed referrals to the appropriate law enforcement agency.

In order to ensure reimbursement of services is appropriate, Clover may place providers or facilities under prepayment review at any point; providers will be notified of this status in writing. Providers shall submit their claims as usual and submit the documentation required to support the claim reimbursement. Providers

must submit records within 90 days of the request for documentation; records received outside of this window will not be reviewed.

REPORTING FRAUD, WASTE, ABUSE, AND MISREPRESENTATIONS

Anyone suspecting healthcare fraud, waste, abuse, or misrepresentation is required to report it. A report can be anonymous but should include all pertinent information so that we may sufficiently review the situation at hand. If you believe that you have submitted claims that could be identified as (or connected to) fraud, waste, and/or abuse, you should immediately cease all possibly problematic billing and contact Clover Health. Reports can be made directly to Clover at **1-877-284-6962** or by email at **siu@cloverhealth.com**.

You can also report fraud, waste, and abuse to Health and Human Services:

OIG Fraud Hotline:

1-800-HHS-TIPS (1-800-447-8477)

TTY 1-800-377-4950

oig.hhs.gov/fraud/report-fraud

Compliance Training

CMS requires Medicare Advantage (MA) organizations and Part D plan sponsors, including Clover Health, to annually communicate specific compliance requirements and FWA requirements to their "first tier, downstream, and related entities" (FDRs), which include contracted physicians, healthcare professionals, facilities, and ancillary providers, as well as delegates, contractors, and related parties. This training may be completed by accessing the General Compliance Training available on the **Medicare Learning Network® at cms.gov**. You can download this training material and add information specific to your organization, but you cannot alter the CMS training material. This training must be completed annually. You must retain a record (e.g., training materials, sign-in sheets of the completed training, etc.) for 10 years.

Medical Records

Access to medical records is central to our assessment of payment integrity and the evaluation of medical necessity. In the processing of claims, if more clinical data is required, our team or a trusted third party requests medical records and pends the processing of the claim until the records are received and evaluated. Providers are required to respond to all medical record requests by the identified date and provide the requested records.

Cloning and Copying Forward

Providers, facilities, and suppliers must ensure that patient files are accurate and unique to the member. Cloning, copy and paste, copy forward, carry forward, etc., are techniques that create inaccuracies in the patient file. Clover Health prohibits these practices as they create the potential for inaccurate coding, medical errors, and a false description of the service/visit provided.

MEMBER COST-SHARE

As a provider, you play a critical role in our network and in the provision of healthcare services to our members. In accordance with CMS regulations and as included in your Provider Services Agreement, you can only bill or collect payments for applicable copays, coinsurance, or deductibles. You cannot bill members directly or request additional payment from our members beyond the cost-share stipulated in the member's plan for covered services rendered.

Clover encourages you to collect all applicable copays at the time services are rendered but to defer the collection of coinsurance and outstanding deductibles until Clover has processed the claim and an explanation of payment (EOP) has been received. The primary care physician and emergency room copays are printed on the member's Clover ID card; alternatively, all member copays can be obtained as follows:

Online

Log in at **cloverhealth.com/providers/portal**.

Phone

Call Provider Services at **1-877-853-8019 from 8 am to 5:30 pm ET**, Monday through Friday.

If the amount you collect from a member exceeds that member's payment responsibility, you must reimburse the excess amount to the member within 60 days or within the time frame specified in your Provider Services Agreement with Clover Health. To determine the member's responsibility, refer to the EOP. If a correction to a claim or a payment must be made, the result of which indicates that the original amount collected in member cost-share exceeds the member's actual responsibility, it is your responsibility to reimburse the excess amount to the member. Furthermore, you must advise members of any charges that will accrue that are not covered by Clover and must obtain prior approval from the member before requesting payment for such out-of-pocket expenses.

Balance Billing and Inappropriate Billing of Members

If you are a Medicare-participating provider or if you contract with Clover, you cannot balance bill or inappropriately bill members. Any such billing is a violation of the Provider Services Agreement, applicable state laws, and the No Surprises Act. Providers who willfully or repeatedly balance bill members will be referred by Clover to the relevant regulatory agency for further action.

Inappropriate member billing includes billing members for services where payment from Clover has not been obtained due to claim cleanliness or other billing issues.

Utilization Management

Our goal at Clover Health is to help provide the right care to Clover members at the right time. Our Utilization Management (UM) program applies CMS Medicare criteria and guidelines, along with evidence-based criteria, to our clinical decision making to ensure members have access to quality care that is medically necessary.

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PRIOR AUTHORIZATION REVIEW

Prior authorization is required for inpatient admissions and elective procedures and services. The goal of Utilization Management is to ensure Clover members receive quality healthcare services that are a covered benefit, meet CMS clinical criteria and guidelines, are medically necessary and appropriate for the individual member's condition, and are provided at the most appropriate level of care.

Utilization Management does not accept prior authorization requests after the service has been provided. As a contracted provider, if you do not obtain prior authorization before providing the service, the claim for services can be denied, and you, as the provider, can be held financially responsible.

Clover does not apply prior authorization requirements and utilization controls that effectively withhold or limit medically necessary services or establish prior authorization requirements and utilization controls that might result in a reduced scope of benefits for a member.

Clover's approval of a prior authorization does not guarantee payment of all procedure codes that are submitted on your claim.

Prior Authorization Submission

Prior authorization requests can be submitted 24 hours a day, 7 days a week. Clover staff are available to respond to authorization requests 8 am to 5:30 pm ET, Monday through Friday.

Our online prior authorization tool lets you securely submit new requests and check the status of requests on our website. There's no need to wait on hold or to send documents by fax. Then you can log in any time to check the status of your request.

To check if a prior authorization is needed, submit a new prior authorization or check the status of a prior authorization request:

To submit a new prior authorization request or to check if a prior authorization is needed:

1. Go to **cloverhealthprovider.healthtrioconnect.com**.
2. Click **Start a new auth request**.
3. Enter the required information about the procedure and the patient, and upload any documentation.
4. Click the "**Start Request**" button.
5. Be sure to write down the prior authorization ID number.

Alternatively, you can call or fax your prior authorization request to Clover:

- Call: **1-888-995-1690**
- Fax: **1-800-308-1107**

eviCore will review the following authorization requests:

1. Advanced Imaging

2. Cardiac Imaging
3. Medical Oncology
4. Radiation Therapy
5. Musculoskeletal - Interventional
6. Pain, Spine and Joint Surgery
7. Sleep Covered Services and Related Equipment
8. Outpatient Therapy (Physical Therapy, Occupational Therapy, Speech Therapy)

To submit a new prior authorization request to eviCore or to check if a prior authorization is needed, log in at **evicore.com**.

Alternatively, you can call or fax your prior authorization request to eviCore Health:

- Call: **1-800-421-7592**
- Fax:
    - Radiology (Imaging), Cardiology, MSK, Medical Oncology: **1-800-540-2406**
    - Sleep: **1-866-999-3510**
    - Radiation Therapy: **1-866-699-8160**
    - Outpatient Therapy (PT, OT, ST): **1-855-774-1319**

CVS Caremark Part B Drug Reviews

CVS Caremark will review all part B drug prior authorization requests.

To submit a new prior authorization request to CVS Caremark for a part B drug, go to the Provider Portal at **cloverhealthprovider.healthtrioconnect.com**. Alternatively, you can call or fax your prior authorization request to NovoLogix:

- Call: **1-800-932-7013**
- Fax: **1-833-866-2893**

Timeliness of Prior Authorization Requests

Prior authorizations can be requested 24 hours a day, 7 days a week (including holidays). Prior authorizations can be requested as expedited or standard based on the member's health needs.

Clover resolves urgent or expedited prior authorization requests per CMS organization determination guidance. Failure by Clover Health to make a determination within the required time periods constitutes an adverse organization determination and can be appealed.

Urgent or Expedited Prior Authorization Time Frames

EXPEDITED AUTHORIZATION REQUEST	PROCESSING TIME FRAME
Pre-Service	**72 hours**
Part B Drug	**24 hours**

Providers will be notified of the determination by phone and/or in writing in the case of urgent or expedited requests. If a phone call or fax notification is unsuccessful or a phone number or fax number was not provided, notifications will be mailed.

Written notification of adverse determinations includes instructions regarding reconsideration options, an explanation of the reason for the determination, and other rights and information.

Standard Prior Authorization Time Frames

ROUTINE AUTHORIZATION REQUEST	PROCESSING TIME FRAME
Pre-Service	**14 calendar days**
Part B Drug	**72 hours**

Determinations for standard prior authorization requests for items and services, excluding Part B drugs, are communicated to providers within a time frame appropriate to the medical exigencies of the case but not more than 14 calendar days after the request for prior authorization was received. You are notified of the determination by fax in the case of standard requests. If a fax notification is unsuccessful or a fax number is not provided, notifications will be made by phone and/or mail.

Written notification of adverse determinations includes instructions regarding reconsideration options, an explanation of the reason for the determination, and other rights and information.

Request for Information

If Clover requires additional information to make a determination, we will notify the provider by phone, fax, email, or other means of written communication within the time frame for issuing a determination and will identify the specific information required.

If you fail to respond to Clover's request for additional information necessary to render a determination, the request for authorization may be denied.

CONCURRENT REVIEW

Concurrent review is conducted on certain hospitalizations and other services that require review for continued care, specifically, skilled nursing facilities (SNF), acute rehab, LTACH, inpatient psych, and inpatient detox. Concurrent review includes utilization management activities that take place during inpatient-level care or an ongoing outpatient course of treatment. The concurrent review process includes obtaining necessary clinical information from facility staff, practitioners, and providers to determine medical necessity and the appropriate level of ongoing care.

If a member's discharge is expected to be greater than the length of stay as determined in the preceding decision, clinical documentation must be provided to support the continued stay.

Notifications

When an adverse determination is issued, Clover will notify the member and provider of the results. Notices made in writing meet the CMS language and format requirements and are written to ensure understanding.

The Integrated Denial Notice is used for denials of pre-service authorization requests and indicates the following for both the member and provider:

- The effective date of the denial, reduction, stoppage, or termination of service, or other medical coverage determination
- The action taken by Clover on the request for prior authorization and the reason for such action, including the clinical review criteria, relied upon to make the determination and a clinical rationale
- A member's right to a standard or expedited appeal and the right to appoint a representative who will act on the member's behalf
- A member's right to a standard or expedited appeal and the right to appoint a representative who will act on the member's behalf

The Notice of Denial of Covered Services is used for denials of authorization requests where the member is receiving or has received services and indicates the following for the provider:

- The effective date of the denial or other medical coverage determination
- The action taken by Clover on the request for prior authorization and the reason for such action, including the clinical review criteria relied upon to make the determination and a clinical rationale
    - To dispute a Notice of Denial of Covered Services, refer to your provider contract or the payment dispute instructions in the **Disputes, Appeals, and Resolutions** section of this manual.
- For discontinuation of covered services that require concurrent review in regard to an SNF, comprehensive outpatient rehabilitation facility, and home health, the Notice of Medicare Non-Coverage and Detailed Explanation of Non-Coverage are used to inform the member of the last covered day for services to be rendered; the rationale, specific to the member's condition, as to why the service is being discontinued; and the member's right to file a fast appeal with the appropriate Quality Improvement Organization (QIO). Providers are responsible for ensuring the notice is delivered to the member in a timely manner.

Administrative Denials

If, based upon review of member enrollment, eligibility status, and benefits coverage, the member is found to not be eligible for the requested service, an Integrated Denial Notice will be issued with one of the following statements of administrative denial:

- The member was not enrolled in a benefit plan on the date(s) of service in question
- The service being requested is not covered by the benefit plan in which the member is enrolled (e.g., benefit exclusions)

The denial notification clearly and directly addresses the member or designee to ensure the member/designee can make an informed judgment about filing an appeal or grievance with Clover. The denial notification includes the following:

- Appeal or grievance filing instructions
- Time frames within which an appeal or grievance determination must be made
- A stipulation of the member's right to designate a representative to file an appeal or grievance on his or her behalf

Peer-to-Peer Review for Organization Determinations

Providers or the Clover Health Medical Director can initiate a peer-to-peer (P2P) review prior to rendering a decision on an organization's determination. This provides the opportunity to discuss the case with the Clover Health physician reviewer responsible for the determination. To initiate a P2P review request, please call **1-888-798-1728 from 8:30 am to 5 pm ET**, Monday–Friday.

- For pre-service requests: The adverse determination that is issued on the Integrated Denial Notice (IDN) cannot be reversed (overturned) by a P2P discussion if conducted after the determination has been made by the Clover Health Medical Director.
- For inpatient hospitalizations: Notice of Denial of Coverage for Services (NDCS) must be based on medical necessity to qualify for a P2P review.
    - For hospital providers, P2P requests should be received before the member leaves the hospital. In cases where Clover issues an adverse determination after the member is discharged, a P2P may be requested and conducted if the facility has provided all pertinent clinical information.
- P2P is not available for non-hospitalization retrospective requests.
- For SNF, home health, and CORF:
    - A P2P review can be initiated after a Notice of Medicare Non-Coverage (NOMNC) is issued if the P2P is requested to discuss a change in the member's medical condition requiring ongoing medical care. The P2P must be requested before the last covered date stated on the NOMNC.
    - A signed copy of the NOMNC must also be on file with Clover before the P2P can be scheduled.
    - Appeals should be filed with the Quality Improvement Organization (QIO) if there is no change in the member's medical condition after the NOMNC is issued.

- The appeal request must be submitted to the QIO no later than 12 pm local time the day after the NOMNC is issued.
- An appeal request may be submitted to Clover's Appeals team if the member misses the time frame for filing an appeal with the QIO.

RETROSPECTIVE REVIEW

Utilization Management does not accept prior authorization requests after the service has been provided. For retrospective reviews, please refer to the **Clover Health Part C Retrospective Review Policy**.

DECISION-MAKING CRITERIA

The Clover Health Medical Management Committee and Quality Improvement Committee review and approve clinical criteria on a yearly or ad hoc basis. Clover's medical necessity review hierarchy includes applying CMS criteria and guidelines, National and Local Coverage Determinations (NCD/LCD), Clover Health Utilization Review Policies, and MCG Criteria. This suite of guidelines covers the spectrum of inpatient, outpatient, rehabilitation, and care for medical, surgical, and behavioral health issues. In addition, our team partners with vendors who provide clinical expertise for specific services. All medical review guidelines are available on the Clover provider website, **cloverhealth.com/providers/provider-clover-policies**.

Clover Health consults with participating providers in adherence to Clover Health's medical policies, treatment protocols, medical management policies, and the like, as determined by Clover Health.

STEP THERAPY FOR PART B DRUGS

Clover may require a trial of a Part B preferred drug to treat a medical condition before covering another non-preferred Part B drug. Note: The step therapy requirement does not apply to members who've already received treatment with a non-preferred drug within the past 365 days. Clover's Part B Preferred Drug List can be found at **cloverhealth.com/part-b-st**.

MEDICARE OUTPATIENT OBSERVATION NOTICE (MOON)

Hospitals and CAHs must provide the MOON to Clover members who receive observation services in the outpatient setting for more than 24 hours. The MOON is intended to inform beneficiaries who receive observation services for more than 24 hours that they are outpatients receiving observation services and not inpatients, and the reasons for such status, and must be delivered no later than 36 hours after observation services begin.

This also includes members in the following circumstances:

- A member who is subsequently admitted as an inpatient prior to the required delivery of the MOON

- A member who is transferred or discharged after having received outpatient services for more than 24 hours
- A member for whom Medicare is either the primary or secondary payer

The start time of observation services, for purposes of determining when more than 24 hours of observation services have been received, is the clock time at which observation services are initiated (furnished to the patient), as documented in the patient's medical record, in accordance with a physician's order. This follows the elapsed clock time, rather than the billed time, associated with the observation services.

Hospitals and CAHs must issue the CMS-approved MOON and follow all notice instructions published by CMS online at **cms.gov/Medicare/Medicare-General-Information/BNI**. In general, the MOON must remain two pages unless the inclusion of additional information per section 400.3.8 or state-specific information per Chapter 30, Section 400.4 of the Medicare Claims Processing Manual results in additional page(s). The pages of the notice can be two sides of one page or one side of separate pages, but must not be condensed to one page.

PARTICIPATING SKILLED NURSING FACILITY (SNF) REFERRAL FOR HOSPITAL DISCHARGE PLANNING

In accordance with CMS hospital discharge planning requirements, providers are reminded discharge planning must include options for post-acute care (PAC) providers when transfer to an SNF, IRF, or LTCH is planned. The list of PAC provider options must include providers that participate with Clover (i.e. are in network with Clover) . The hospital must make reasonable attempts, based on information from the Clover provider directory, to limit the list to HHAs and SNFs that participate in Clover's network of providers. Hospitals requesting authorization from a non-participating PAC provider may be requested to detail their attempts to seek care from a participating PAC provider.

Additional reading: CFR 482.43, CMS Memo – Section A-0823, **CMS' Discharge Planning Rule Supports Interoperability and Patient Preferences**

NOTICE OF MEDICARE NON-COVERAGE (NOMNC):

CMS requires the Notice of Medicare Non-Coverage (NOMNC) to be delivered to all Medicare Advantage (MA) health plan members at least two days prior to termination of the skilled nursing facility (SNF), home health agency (HHA) or comprehensive outpatient rehabilitation facility (CORF) services. The member must receive the NOMNC per form requirements and instructions published by CMS online at **cms.gov/Medicare/Medicare-General-Information/BNI/FFS-Expedited-Determination-Notices**. No modification of the text on the CMS NOMNC is allowed.

Note: If the member's SNF admission is expected to last less than two calendar days, the NOMNC should be delivered to the member upon admission.

For HHA or CORF services, the notice needs to be given no later than the next-to-the-last time services are furnished. The NOMNC informs members how to request an expedited determination from their QIO if they

disagree with the termination.

Providers must ensure valid delivery of the NOMNC to the member pursuant to CMS standards:

- The notice must be the standardized CMS NOMNC form.
- The member must be able to comprehend and fully understand the notice contents.
- The member or his/her authorized representative must sign and date the notice as proof of receipt.
    - If a member refuses to sign the NOMNC, the member's refusal to sign, the date, time, name of the person who witnessed the refusal and their signature must be documented on the NOMNC.
    - If the member is unable to sign and their authorized representative is not present to sign on the member's behalf, the provider must annotate the NOMNC with the name of the representative, the date and time the representative was informed, and the method of communication (phone, fax, email) by which the representative was informed of NOMNC delivery.
        - » If delivery is made by phone, the representative must be informed of all pertinent information related to the notice including but not limited to, the last approved date, the member's right to appeal and instructions on how to file the appeal.
- Any assistance used with delivery of the notice also must be documented.

For more information about notification of termination requirements, see Chapter 30, Section 260.3.3 of the Medicare Claims Processing Manual.

Disputes, Appeals, and Resolutions

Clover Health wants to ensure that, as our providers, you understand your options if you have questions about—or disagree with—a decision we've made about billing, claims, or prior authorizations. This section will walk you through appeals, disputes, and more.

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PAYMENT DISPUTES

Payments that are made to our in-network providers are based on the terms of the Provider Services Agreement with Clover. Although second-level disputes are not applicable, a payment dispute can be filed for:

- A dispute of medical necessity
    - A denial of services for the requested treatment of a member that does not appear to meet medical necessity criteria and cannot be medically certified based on the information provided by the treating clinician(s)
- A dispute of administrative determinations resulting in no payment, or
- A dispute of the claim payment amount and a request to obtain a higher or lower payment

Payment Dispute Submission

You can create your dispute within the contractually agreed-upon time frame, upon receipt of your remittance notice, or within 60 days from the most recent remittance date if not specified otherwise in your Provider Services Agreement. Submissions can be made through the Provider Portal, mail or fax:

- Log in at **cloverhealthprovider.healthtrioconnect.com** and initiate a claim investigation.
- INN claim payment disputes:
    - If you have attachments (e.g., medical records) you will need to mail or fax in the **Claims Appeal & Dispute form** and supporting documents regardless of when the claim was processed.
    - Fax your dispute to **1-888-240-7243**.
    - Email your dispute to **submitclaims@cloverhealth.com**
    - Mail your dispute to:
      Clover Health
      Attn: Claims
      P.O. Box 21164
      Eagan, MN 55121
- OON claim payment disputes
    - If you have attachments (e.g., medical records) you will need to mail or fax in the **Claims Appeal & Dispute form** and supporting documents regardless of when the claim was processed.
    - Fax your dispute to **1-732-412-9706**.
    - Email your dispute to **submitappeals@cloverhealth.com**.
    - Mail your dispute to:
      Clover Health
      Attn: Appeals
      P.O. Box 21672
      Eagan, MN 55121

Along with your dispute, be sure to submit the following relevant documents:

- A completed Claims Appeal & Dispute form (FX070Q)
- A copy of the original claim form
- A signed **Waiver of Liability Statement**
- Date(s) of service
- The basis for the dispute
- The remittance notice showing the denial
- Any clinical records or CMS documentation supporting your request for reimbursement

We make reasonable efforts to review and resolve a dispute within 60 days of receiving the Claims Appeal & Dispute form and supporting documentation. The resolution can result in reprocessing the claim(s) and issuing an Explanation of Payment (EOP), or if the determination was upheld and no additional payment will be made, a letter will be sent concerning the outcome. All decisions made in connection with our payment dispute reviews are final.

Demonstrating Good Cause for Late Filing of Dispute

If Clover does not receive the dispute within the contractually agreed-upon time frame, or as required under this Provider Manual, the dispute can be resubmitted with a "good cause" reason and supporting documentation added on the **Claims Appeal & Dispute form** for untimely filing. If a "good cause" reason for untimely filing is not shown, Clover can dismiss the dispute as untimely. In such a case, you will be sent a resolution letter explaining the reason for dismissal. If a favorable "good cause" determination is made, Clover will issue a redetermination and send out a notification to inform you.

Medical Necessity Determination Disputes

If the claim determination indicates that the healthcare services for which the claim was submitted were (i) not medically necessary, (ii) experimental or investigational, (iii) cosmetic (rather than medically necessary), or (iv) noncovered dental rather than medical, a Clover physician reviewer will review the dispute within the time frame listed above. In addition, please refer to the **Utilization Management section** of this manual for information on Clover's Retro Authorization Policy regarding provider appeal and dispute rights when a prior authorization was not received prior to the service.

Administrative Determination Disputes

If the claim determination indicates that the services for which the claim was submitted involved issues not related to medical necessity, then Clover's Disputes Management team, in consultation with our Claims team, reviews the dispute within the time frame listed above. The following are the reasons for which an administrative denial is issued:

- Missing/invalid modifier, procedure code, or provider NPI
- The diagnosis is invalid for the submitted procedure

Disputes of Eligibility-Related Determinations

If the claim determination indicates that the person who received the healthcare services for which the claim was submitted is ineligible for coverage because (i) the healthcare services are not covered under the terms of the relevant health benefits plan, or (ii) the individual is not a Clover member, you can submit a complaint directly to Clover's Disputes Management team if you wish to do so.

For more information about the complaint submissions process or payment disputes, please call Provider Services at **1-877-853-8019 from 8 am to 5:30 pm ET**, Monday through Friday.

APPEALS

Pre-Service Appeals

When services have not yet been rendered, a member, a member representative, or you or any other provider acting on behalf of the member with the member's consent can appeal any adverse determination made by Clover's Utilization Management team that resulted in a denial, termination, or other limitation of covered healthcare services. Pre-service appeals must be requested within 60 calendar days from the notice of the initial adverse determination.

For Clover members, the appeal is reviewed internally by Clover (Level 1 appeal). If an adverse determination is upheld, Clover initiates a formal external review (Level 2 appeal) by an Independent Review Entity (IRE). Further stages of appeals include an Administrative Law Judge hearing, a Medicare Appeals Council review, and a judicial review. Detailed instructions about how to file each of these additional levels would be included in the denial notification you or the member would receive.

Pre-service appeals can be submitted in writing or verbally if the member's medical condition requires an expedited decision. Written appeals can be submitted to:

Clover Health
Attn: Appeals
P.O. Box 21672
Eagan, MN 55121
Or email to **submitappeals@cloverhealth.com**

Verbal appeals for expedited pre-service requests can be initiated by calling Provider Services at **1-877-853-8019 from 8 am to 5:30 pm ET**, Monday through Friday.

Appeals (reconsiderations) involving medical necessity are reviewed by Clover staff members who are licensed healthcare professionals. If Clover issues a partial or fully denied determination, that determination is made by a physician who has a current and unrestricted license to practice medicine and who was not involved in the original determination.

Expedited Pre-Service Appeal

You are allowed to submit an expedited appeal when applying the standard time frame could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

If Clover requires information necessary to conduct an expedited appeal, Clover immediately notifies the member and you by phone or fax.

Clover will make a determination on expedited appeals within 72 hours of receiving the request and will communicate the determination to the member and/or the member's designee and you, as a provider acting on behalf of the member. Determination notifications are made within 72 hours, if applicable.

Under certain circumstances, Clover can extend the time frame for an expedited appeal determination by up to 14 calendar days at either the member's or Clover's request. Clover will inform the member of their right to file an expedited grievance, should the member not agree with the request for an extension.

If Clover fails to make an appeal determination within the 72 hours, such failure constitutes an affirmation of Clover's initial adverse determination, and Clover forwards the entire file to the IRE. The IRE will send notice that they are reviewing the case.

If Clover does not accept the request for an expedited appeal, Clover sends notice to the member or member's designee within 24 hours of receipt of the appeal to notify them of the conversion from the expedited to the standard time frame. Clover provides an explanation of the member's right to file an expedited grievance and to submit additional supporting information from you explaining the basis for the expedited request.

Clover does not expedite post-service disputes involving payment.

Standard Pre-Service Appeal

Standard appeals are available for pre-service issues. These appeals must be filed in writing by the member or the member's designee or by you as the provider acting on behalf of the member. A standard appeal can be made within 60 calendar days of an initial adverse determination notice. Clover Health can grant a good cause late filing exception under certain circumstances.

If the plan requires information to conduct the appeal, the plan identifies and requests the necessary information from the member and from you as the member's provider. Clover assigns a clinical peer reviewer who is different from the one who rendered the adverse determination.

The appeal determination is rendered within 30 calendar days from receipt of the request for an appeal. If the initial adverse organization determination is affirmed, the member, the member's designee, and/or you, acting on behalf of the member, will be notified once your case is received by the IRE.

Higher-Level Appeals

Medicare Advantage members' cases are automatically sent to the Independent Review Entity (IRE) when an original adverse determination is upheld as a result of a pre-service appeal process and the member is notified.

Files are sent to the IRE within 30 calendar days of receipt of the request for a standard pre-service appeal and within 24 hours of the final adverse determination for an expedited pre-service appeal.

If the IRE reverses a final adverse determination, Clover must approve or provide the services no later than 14 calendar days from the standard pre-service appeal overturn date or 72 hours from the expedited appeal overturn date.

If the member, the member designee, or you, acting on behalf of the member, are not satisfied with the determination of the IRE, the member, the member designee, or you can request a hearing with the Administrative Law Judge (ALJ) provided the request is within 60 calendar days of receipt of the IRE adverse determination and the minimum monetary threshold is met.

If the member, the member designee, or you, acting on behalf of the member, are not satisfied with the ALJ determination, either party can request, within 60 calendar days of receipt of the ALJ determination, a review by the Medicare Appeals Council (MAC). The request should be sent to the following address:

Department of Health and Human Services
Department Appeals Board, MS6127
Medicare Appeals Council
330 Independence Avenue
S.W. Cohen Building, Room G-644
Washington, DC 20201

If the member, the member designee, or you, acting on behalf of the member, are not satisfied with the MAC determination, either party can request, within 60 days of receipt of the MAC determination, a judicial review, provided that the minimum monetary threshold is met.

Furthermore, any reconsideration can be requested to be reopened in 1 to 4 years after final determination, depending on the circumstance.

Documentation for Clinical Appeals

When submitting a reconsideration to Clover for review, clinical information is required to reconsider the original medical necessity determination.

Pre-Service Appeals

If an initial pre-service organization determination was denied due to lack of medical necessity, the most recent and relevant clinical information is required to make a reconsideration of the appeal. Be sure to include the clinical information you believe constitutes medical necessity.

For outpatient procedures, this includes the most recent physician notes and medication lists required for the requested procedures. Similarly, for prospective inpatient procedures, the most recent physician notes and orders relevant to the requested services should be submitted with the appeal. For inpatient

rehabilitation, the most recent physical and occupational therapy, and nursing notes within the last 48 hours are required.

Provider Complaints Not Involving Claim Payment or Medical Necessity Issues

If you have complaints or disputes that are not within the scope of the Claim Payment Disputes sections and do not relate to compensation matters, a claim determination, or a utilization management decision, you should first seek to informally resolve them by calling Provider Services at 1-877-853-8019 from 8 am to 5:30 pm ET, Monday through Friday. A representative will work with you, and if the dispute is not resolved on an informal basis, you can submit a formal written complaint to:

Clover Health
Attn: Director, Network Management & Operations
P.O. Box 21164
Eagan, MN 55121

While the initial, informal channel described above is made available to you, you can also submit formal complaints directly to the address above without having previously tried to resolve the matter informally.

Upon receipt of a formal, written provider complaint, Clover conducts an internal review at no cost to you.

Clover uses commercially reasonable efforts to complete the internal review and communicate the results of such review in writing within 30 business days of receiving the complaint. The written response will include:

- The names, titles, and qualifying credentials of the persons participating in the internal review
- A statement of your complaint
- The decision of the reviewer(s), together with a detailed explanation of the basis for such decision (if applicable)
- A description of the evidence or documentation that supports the decision
- A copy of the call reference number or prior email correspondence of the issue

MEMBER GRIEVANCES

Member Grievances and Resolution Overview

Federal law guarantees Clover Health members the right to file complaints if they are dissatisfied with their coverage. Medicare has established a variety of rules around how members should file complaints and how Clover must process them fairly. A Clover member cannot be disenrolled or penalized in any way for making a complaint. Depending on the subject, a complaint is handled as an organization determination, an appeal, or a grievance.

A grievance is any expression of dissatisfaction regarding the health plan and/or provider, including quality of care, concerns, disputes, and requests for reconsideration or appeal made by the member or the member's representative.

Filing a Member Grievance

Clover members or their representatives—with the member's consent—can file a grievance in one of the following ways:

Phone

Call Member Services at **1-888-778-1478 (TTY 711) from 8 am to 8 pm local time**, 7 days a week. From April 1 through September 30, alternate technologies (for example, voicemail) will be used on the weekends and holidays.

Fax

Fax grievances to **1-551-227-3962**.

Mail

Mail grievances to:

Clover Health
Attn: Grievances
P.O. Box 21672
Eagan, MN 55121

Notification

We are required to notify members of the results of our investigation no later than 30 days after we receive their grievance. However, on some occasions, after the conclusion of the 30 days, Clover can initiate an extension of up to 14 calendar days in order to appropriately resolve the grievance. Clover members are notified in writing if an extension is taken.

Clover members also have the right to file complaints directly with Medicare by filling out the **Medicare Complaint Form**.

Care Management Program

One of the core components of our company is our care coordination program, which includes our telephonic nurse care coordination and clinical care visit teams. Here, you'll see how this vital ecosystem works—in unison with your guidance and expertise—to deliver better patient outcomes.

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PREVENTIVE HEALTH AND CHRONIC CARE MANAGEMENT

Clover works with you to improve your patients' well-being by encouraging them to pursue healthy behaviors. This includes ensuring that your patients obtain needed screenings, stay adherent to their medication regimens, and receive appropriate vaccinations.

As part of these initiatives, Clover focuses on the following clinical areas:

- Breast cancer screening
- Cholesterol management
- Colorectal cancer screening
- COVID-19 vaccination
- Diabetes screening and management
- Drug and alcohol use screening
- Hypertension screening and management
- Influenza and pneumonia vaccinations
- Medication access and management
- Osteoporosis identification and management
- Prevention of hospitalizations and readmissions
- Respiratory assessment (spirometry)
- Rheumatoid arthritis management

These clinical areas are also foci of Clover's Quality Improvement program, which is described in detail in the next section.

CHRONIC CARE COORDINATION AND MANAGEMENT

Clover Health also provides chronic care coordination and management services. These include:

- Telephonic care coordination is delivered by Clover nurses, who can help members access medications and durable medical equipment, provide health education and coaching, and book appointments with both primary care providers and specialists.
- Yearly in-home health assessments, including comprehensive medication reviews, screening for under-recognized health conditions, and evaluation for Clover care coordination and management programs.
- Care transitions support for high-risk members discharged from the hospital, rehabilitation facilities, and skilled nursing facilities to home.

Clover's most medically complex members, many of whom are homebound, frail, and with advanced illness, may also elect to receive care through our Clover Home Care program. Members in Clover Home Care receive primary care visits from a team of physicians, nurse practitioners, medical assistants, and social workers. Visits last up to an hour in duration. Participating members also receive in-home laboratory and

radiology testing services. It is our aim to collaborate closely with network providers to identify appropriate members for the program and coordinate care following member enrollment.

CLINICAL PRACTICE GUIDELINE RESOURCES

Clover has curated the best-practice guideline resources, listed below for your reference. This list includes evidence-based guidelines intended to be utilized in order to provide the best care for our members whom you serve every day and to assist you in making appropriate healthcare decisions based on sound clinical judgment and application of knowledge. Adherence to these guidelines will not ensure successful treatment in every situation. Furthermore, these guidelines should not be interpreted as setting a standard of care or deemed inclusive of all proper methods of care nor exclusive of other methods of care reasonably directed to obtaining the same results. Please be advised that while Clover supports the following guidelines, specifically in the Utilization Management arena, we utilize best practice guidelines from MCG and CMS to reach our final decisions.

All guidelines reflect the most current views of the relevant medical community as gleaned from the scientific evidence, professional standards, and expert opinion from recognized sources. The areas covered by these guidelines include the following conditions, medical calculators, and topics:

- MD Calculator
- Prognosis Calculator
- Shared Decision Making
- Prepare for Your Care
- Adult Obesity
- Asthma
- Atrial Fibrillation: Tools/Anticoagulation
- Chronic Kidney Disease
- Cholesterol Management
- Chronic Obstructive Pulmonary Disease
- COVID-19
- CVD (Cardiovascular Disease) Prevention
- Diabetes Mellitus: Guidelines/Risk Assessment in CVD
- Congestive Heart Failure/AHA Tools
- HIV/AIDS
- Hypertension
- Low Back Pain
- Mental Health: Depression Screening, CAGE Questionnaire, Opioids for Chronic Pain
- Osteoporosis

- Tobacco Cessation
- AAFP Clinical Preventive Services
- USPSTF Screening Recommendations
- MCG Guidelines
- Adult Obesity/ Healthy Diet and Activity for High Risk Adults
- American Psychiatric Association Practice Guidelines
- AGS Beers Criteria for Potentially Inappropriate Medication Use

For the most up-to-date clinical practice guideline resources, go to **cloverhealth.com/providers/clinical-informational-resources**. You can also call Provider Services at **1-877-853-8019 from 8 am to 5:30 pm ET**, Monday through Friday.

Quality Improvement Program

We're a data-driven company focused on helping you provide actionable insights to help you provide better care and treatment plans for your patients. We leverage multiple data points to drive clinical insights that help us understand the real story "behind the numbers" so that we can better support you and your patients with innovative solutions that continually evolve and adapt to meet your needs.

We design our Quality Improvement program to hold ourselves to the highest standards in quality of care and are driven to provide a best-in-class experience for our providers and members.

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GOALS AND OBJECTIVES

We have one goal—to improve every life. We strive to continually improve the quality of care and service our members receive by aligning with providers to reduce doctor-insurer friction and increasing visibility into the health of each member, leading to improved care and member health outcomes. We work to provide strong provider support to build outstanding relationships and provider experience. Our commitment to using member-centered analytics and dedicated complex care programs enables us to identify potential risks a member may face and directly provide preventive care and innovative programs to provide value and optimize their health outcomes. Providers must cooperate with Quality Improvement activities. To that aim, the specific goals of our Quality Improvement (QI) program have been adopted to support Clover Health's vision and values and to promote continuous improvement in quality of care/service and patient safety for our members and providers:

- Maintain a QI program which continuously monitors the quality of care and service provided to beneficiaries
- Comply with Centers for Medicare & Medicaid Services (CMS) requirements regarding QI program activities
- Measure and report QI and other program performance using standard measures and tools required by CMS
- Utilize a data-driven approach to improving care, safety, health outcomes, and service of beneficiaries through the continuous monitoring and evaluation of industry recognized and internally developed key clinical care and service quality indicators
- Evaluate and improve upon the beneficiary experience with care and service through development of improvement actions based on results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[2] survey, the Health Outcomes Survey (HOS), and beneficiary inquiry, grievance, and appeal data
- Identify, prioritize, and pursue opportunities to improve the quality of care and service beneficiaries receive through industry recognized measures such as Healthcare Effectiveness Data and Information Set (HEDIS®)
- Provide beneficiary access to, and the availability of, an adequate network of experienced practitioners, providers, delegates, vendors, and other needed resources
- Develop and implement pharmaceutical quality assurance measures and systems to identify and reduce medication errors and adverse drug interactions, and improve medication use through retrospective and concurrent drug utilization review systems, as well as pharmaceutical policies and procedures
- Promote the effectiveness, efficiency, and compliance of all First Tier, Downstream and Related Entities (FDRs) with Clover Health contractual and CMS requirements
- Ensure that pharmacy network providers comply with minimum standards for pharmacy practice as established by the applicable states where Clover conducts business

[2] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

QUALITY IMPROVEMENT PROGRAM

- Enhance the improvement of beneficiary health outcomes through the use of nationally recognized evidence-based clinical practice guidelines that incorporate individual beneficiary healthcare needs and preferences, including cultural, ethnic, linguistic, and other social determinants of health
- Implement ongoing monitoring efforts to identify instances of questionable quality, including beneficiary quality of care grievances, medication errors, and adverse events, and ensure that corrective actions are implemented timely and monitored to evaluate the effectiveness of corrective actions
- Encourage provider participation in the planning, design, implementation, and evaluation of QI program activities
- Coordinate QI program activities across Clover Health functional areas and with our network providers to improve beneficiary care, safety, and service
- Utilize a reliable and state-of-the-art clinical information system to support beneficiary-centered care that is timely and effective, facilitates effective care coordination, and promotes shared decision-making between beneficiaries and their care team
- Improve the health status of beneficiaries through collaborative care coordination, preventive/wellness activities, care management, and a chronic care improvement program (CCIP)
- Maintain compliance with local, state, and federal regulatory requirements

As part of the QI program, initiatives in key areas include, but are not limited to:

- Provider and Clinical Engagement: Clover focuses on member and provider collaboration for a broad range of areas, such as ensuring members receive a follow-up visit to their PCP after a post-hospitalization discharge, chronic conditions such as diabetes, medication adherence, and preventive health services such as cancer screenings and immunizations. Improvements in these areas are demonstrated in improved clinical metrics, including Healthcare Effectiveness Data and Information Set (HEDIS®), Part D Star ratings, and other quality measures. A full set of Star ratings can be obtained on request by contacting your Network Management team.
- Member Experience: Clover is passionately driven to provide a best-in-class member experience. To that end, we focus on showing members we care in a variety of ways, such as listening to the voice of the member, making it easier for the member to access care and other healthcare services, making care convenient, and supporting cultural competency and health literacy. Clover uses CMS-required Consumer Assessment of Health Plan Survey (CAHPS®) data, which measures a member's experience (not satisfaction) with their health plan and healthcare services (including their providers). Clover also uses data from the Health Outcome Survey (HOS), which measures a member's perception of the improvement/decline of their health and if certain PCP conversations occurred two years after an initial assessment.

Our QI program is designed to harness clinically driven data analytics to assess and continuously improve plan performance and quality, as evidenced in key metric outcomes such as our Medicare Star rating.

The QI Program Description defines the quality infrastructure that supports Clover's QI strategies:

- The QI Program Description establishes QI program governance, scope, goals, measurable objectives, structure, and responsibilities which encompass the quality of medical and behavioral healthcare and services provided to members.
- Annually, a QI Work Plan is developed and implemented, reflecting ongoing progress made on QI activities during the year. The QI Work Plan includes our approach to member safety and improving medical/behavioral healthcare: quality of clinical care, safety of clinical care, and quality of service.
- Annually, the QI Evaluation assesses outcomes of Clover's clinical quality programs, processes, and activities. This evaluation also assesses whether the QI program goals and objectives were met.

MEDICARE FIVE-STAR QUALITY RATING SYSTEM

The Medicare Five-Star Quality Rating System is used by CMS to rate plan performance and quality of Medicare Advantage plans on a scale of 1 to 5 stars (5 representing the highest and best score) to allow members to compare plans.

Clover's program is designed to ensure that the quality-of-care opportunities that are identified as priorities by CMS are comprehensively addressed.

Star ratings are focused on key measures that demonstrate the effectiveness of the quality provision of healthcare, including:

- Outcome measures which reflect improvements in a patient's health and are central to assessing quality of care
- Intermediate outcome measures that reflect actions taken which can assist in improving a patient's health status
- Patient experience measures reflecting patients' perspectives of the care they received
- Access measures that evaluate processes and issues that could create barriers to patients receiving needed care
- Process measures which capture the healthcare services provided to patients which can assist in maintaining, monitoring, or improving their health status

HEDIS®

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a widely used set of performance measures in the managed care industry, developed and maintained by the National Committee for Quality Assurance (NCQA). Clover Health uses its HEDIS® reporting to assess, compare, and report, and to encourage resultant improvements in the quality of care that Clover and its contracted providers, practitioners, and delegated entities provide to Medicare Advantage members. The CMS Five-Star Quality Rating System is based in part on these measures. HEDIS® measures included in the Star rating are:

- Breast Cancer Screening
- Colorectal Cancer Screening
- Osteoporosis Management in Women After a Fracture

- Diabetes Care: A1c, Retinal Eye Exam, Kidney Health Monitoring
- Transitions in Care
- Plan All-Cause Readmissions
- Statin Therapy in Persons with Cardiovascular Disease
- Blood Pressure Control in HTN
- Follow-Up After Emergency Department Visit for People With High-Risk Multiple Chronic Conditions

Clover requests providers adhere to NCQA HEDIS® guidelines and specifications for all patients during each measurement year and collaborate in the data collection process by facilitating Clover staff access to members' medical records. Clover's Clinical Quality HEDIS® team is responsible for collecting clinical information from provider offices in accordance with CMS requirements. Medical record requests to provider offices will occur, and Clover requests that the records be returned within five (5) business days to allow time for the team to abstract the records and request additional information from other providers if needed. Clover will communicate HEDIS® results to members and to you in order to encourage the use of preventive measures and thus improve healthy behaviors and outcomes.

CAHPS®

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) refers to a comprehensive and evolving family of surveys that asks consumers and patients to evaluate the interpersonal aspects of healthcare, including their providers in the past year. CAHPS surveys probe those aspects of care for which consumers and patients are the best and/or only source of information, as well as those that consumers and patients have identified as being important. This includes the member's access to medical care and the quality of the services provided by their providers. Clover analyzes this feedback to identify issues causing member dissatisfaction and works to develop effective interventions to address them. The CAHPS survey is sent to a random sample of members in the spring. Several questions relate to member experience with physicians. CAHPS includes questions about the patient-physician relationship, such as:

- Coordination of care: measures patients' perception of their personal physicians' knowledge about the care received from specialists and other healthcare providers
- Getting care quickly: measures the experiences patients had in receiving care or advice in a reasonable time, including time spent in waiting rooms
- Getting needed care: measures the experiences patients had when attempting to obtain care, treatments, and tests from their PCP and specialists
- Getting needed prescription drugs: measures the experiences patients had when attempting to fill a prescription at a local or mail-order pharmacy
- **Rating of healthcare:** gives patients an opportunity to rate all the healthcare they have received in the last 12 months
- **Rating of health plan:** measures patients' overall experiences with their health plan over the last 12 months
- **Rating of drug plan:** measures patients' overall experiences with their drug plan over the last 12 months

Clover Health encourages providers to assess their own practices to identify opportunities to improve members' access to care and improve interpersonal skills to make the patient care experience a more positive one.

HOS

The Medicare Health Outcomes Survey (HOS) is the first patient-reported outcomes measure used in Medicare managed care. The goal of the Medicare HOS program is to gather valid, reliable, and clinically meaningful health status data in the Medicare Advantage (MA) program for use in quality improvement activities, pay for performance, program oversight, public reporting, and improving health. All managed care organizations with Medicare Advantage contracts must participate. Patients are asked about overall physical and mental health status. Patients are also asked if they talked to their physician and discussed any treatment options about: their physician about:

- Urinary Incontinence
- Physical Activity
- Fall Risk

Pharmacy Quality Measures

The CMS Five-Star Quality Rating System recognizes that improving patient medication adherence and drug safety not only improves patient outcomes, it also saves the healthcare system money. The pharmacy quality measures currently used to determine Star ratings fall into the categories of adherence measures, comprehensive medication reviews, drug safety, and accuracy of drug pricing:

- Pharmacy measures
- Pharmacy measures take into consideration adherence to medications prescribed to treat different disease states, including:
    - Diabetes
    - Hypertension
    - Hypercholesterolemia

Actions taken by physicians to improve medication adherence include:

- Proactively assessing whether the patient is taking medication as prescribed. Many times patients will split pills or take them irregularly. Encourage patients to take medications as you prescribe them, and do not encourage patients to split pills unless instructed to do so as part of the prescription.
- Discussing patient-specific adherence barriers. Patients may have financial problems or issues with getting transportation to a pharmacy. Discussing a cheaper mail-order option may work better for chronic medications.
- Providing up to 100-day prescriptions for maintenance medications.

If you have questions, you can call Provider Services at **1-877-853-8019 from 8 am to 5:30 pm ET**, Monday through Friday.

PROGRAM REVIEW

Clover's star rating strategy is consistent with CMS's aim of better care, healthier people and communities, and lower costs through continuous improvement.

Our interdisciplinary Quality Improvement Committee is tasked with reviewing and analyzing QI activities at Clover for impact and effectiveness. With that focus, we work with our provider network to promote best practices, which employ evidence-based guidelines, and make modifications to our program when opportunities for improvement are identified. Annually, a comprehensive programmatic evaluation is performed to determine effectiveness and areas of opportunity and to guide future strategy.

Clover Assistant for Primary Care Providers (PCPs)

Clover Assistant is designed by doctors for doctors to help you care for your patients at the highest level. Clover Assistant technology identifies items that could have a significant impact on your patient's well-being, like suspected diagnoses and gaps in care.

Think of Clover Assistant as your copilot with you as captain. Clover Assistant aggregates the individual patient's information and makes evidence-based recommendations, but it is you, the patient's physician, who make decisions on their care. Clover Assistant is a complement to you and your staff, and an invaluable aid.

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CLOVER ASSISTANT PROGRAM UPDATES FOR 2024

In-network primary care clinicians now have the opportunity to participate in the Clover Assistant Program or the Clover Assistant Wellness Visit+ Program. Both Programs focus on the practitioner using Clover Assistant during patient visits. Practitioners have the ability to complete a Comprehensive Clover Assistant Visit during a Medicare Annual Wellness Visit or a Clover Assistant Visit during a regular office, telehealth, or audio-only visit. Both programs offer different reimbursement options for utilizing Clover Assistant during your Clover patient visits.

Point of Care Usage

Clover Assistant delivers the most value when the information surfaced in the Visit is reviewed with the patient during the encounter. Participating practices are required to create Clover Assistant visits on or before the date of service and review the information within Clover Assistant before or during the patient visit.

When should I submit a Clover Assistant Visit?

Participating clinicians must submit a Clover Assistant Visit within ten days of the date of service to receive reimbursement for the visit.

How will Clover Assistant impact my billing?

Practices are required to submit an eligible FFS claim to receive reimbursement for the Clover Assistant visit submission. Clover will match the FFS claim with the qualifying Clover Assistant visit and then make the appropriate payment on the FFS claim. Key matching criteria include the Member/Patient name, Practice TIN, Mode of Service, Provider NPI, and Date of Service on both the Clover Assistant Visit and the claim. Submitting claims as timely as possible will allow Clover to match your claim to the Visit so payment can be processed.

What visit codes are eligible for Clover Assistant Visits?

All eligible CA CPT Codes: 9920(2-5), 9921(2-5), 9938(5-7), 9939(5-6), 9944(1-3), G0402, G0466, G0467, G0468, G2025, G0438, and G0439.

The following codes are eligible CA CPT Codes for the Wellness Visit + Program only: 9934(1-5), 9934(7-9), and 99350.

List of Eligible CA CPT Codes for Comprehensive Visit: G0468, G0402, G0438, and G0439

CLOVER ASSISTANT – KEYS FOR SUCCESS

There are three steps to each Visit:

1. Prepare a Visit (on or before the date of service)

When a practice prepares a Visit, a customized list of tasks is created for that patient. The Visit should be prepared on or before the date of the patient visit.

2. Review the Visit Content and Complete the Visit (at the point of care)

In this step, practitioners have access to valuable information at the most impactful time – the point of care.

3. Submit the Visit (within 10 days of the date of service)

After the appointment, practitioners electronically sign and submit the Visit. Users will then download and attach the Clover Assistant Visit Summary to the patient chart.

How Can I Use Clover Assistant to Support My Practice?

- Access dynamically surfaced, up-to-date, patient-specific information, including gaps, medications, and potential diagnoses
- Get a comprehensive view, populated with data on our members from anywhere our members have received care where Clover has received the data
- Update patient information easily and prioritize your care strategy
- Complete an assessment quickly and easily at the point of care
- Securely upload and share patient documents
- Use Clover Assistant online—all you need is internet access

Users of Clover Assistant receive customer support through our dedicated Customer Success managers or by sending an email directly to Clover Assistant support. In addition, every Clover Assistant provider is highlighted as a preferred provider in Clover's directory.

With thousands of PCPs currently utilizing Clover Assistant, we know Clover Assistant is making a difference every day. If you want to learn more or enroll in the program, please contact the Clover Assistant Support team at **cloverassistantsupport@cloverhealth.com**.

FREQUENTLY ASKED QUESTIONS ABOUT CLOVER ASSISTANT

What technology will I need to use Clover Assistant?

Since the Clover Assistant application is web-based, the only requirement is access to the internet. Clover will partner with you to support any technology needs your office may have. There is no software that needs to be downloaded for the use of the tool. For customers on specific EHRs, Clover Assistant offers a range of EHR integration options. If interested, please reach out to your customer success associate or support@cloverassistant.com to learn more.

How will Clover Assistant impact my billing?

In addition to Clover Assistant Visit submission, providers still must submit their claim in the standard format utilizing the appropriate E&M and/or AWV codes. Clear summary reporting on your Visits and their status (i.e., submitted vs. open) can be found within the tool to assist with monitoring billing.

How long will each Clover Assistant Visit take?

Completing Clover Assistant Visit is usually quick and takes place right at the point of care.

How will I receive my Clover Assistant payments?

You will receive your Clover Assistant payments through the same process by which you receive your claim payments today. Clover will process payment once a qualifying Clover Assistant Visit is submitted with a matching Clover Assistant-eligible claim. The best way to ensure timely receipt of payment is to enroll with Change Healthcare to receive EFT payments.

Pharmacy Services

We want to ensure your patients have the most cost-effective prescriptions and drug therapy treatments available to them. That is why, in addition to providing offerings like 100-day prescriptions, we make sure to contract with the highest-quality pharmacies to administer them.

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FORMULARY OVERVIEW

Clover Health contracts with CMS to provide drug coverage for Medicare Part D members using the Medicare Part D Drug Formulary, utilization management programs, and pricing structure. The pharmacy benefit does not cover all medications. Some medications require prior authorization or have limitations on age, dosage, and/or maximum quantities. Clover works with CVS Caremark to administer pharmacy benefits, including the prior authorization process.

The Clover Medicare Advantage Formulary, found at **cloverhealth.com/formulary**, lists all drugs covered by our plans and is organized into sections. Each section is divided by therapeutic drug class, primarily defined by mechanism of action. Products are listed by generic name or by brand name, depending on formulary coverage. Unless exceptions are noted, all applicable dosage forms and strengths of the drug cited are generally included in the formulary.

Medications selected for inclusion in the formulary are reviewed by Clover's Pharmacy Benefit Managers Pharmacy and Therapeutics Committee (P&T). Members of the P&T come from various clinical specialties and are practicing physicians and pharmacists. The P&T meets regularly to keep the formulary current while providing optimal results for our members and controlling the cost of medication therapy.

Real-time prescription benefits provide greater visibility to plan member out-of-pocket (OOP) costs, lower-cost alternatives, and benefit information for members and providers.

- Patient-Specific Prescription Benefits Information at the Point of Prescribing integrated into the prescriber's electronic health record (EHR) and workflow. Contact your EHR vendor or your EHR system administrator to request real-time prescription benefits information.
- Members can use the plan's "Real-Time Benefit Tool" (available through caremark.com or by calling Member Services).

On August 16, 2022, President Biden signed the Inflation Reduction Act of 2022 into law. The following important message applies to plans offering Medicare Part D coverage. This went into effect January 1, 2023.

- **Important Message About What Members Pay for Insulin:** Members won't pay more than $35 for a one-month supply of each insulin product covered by our Medicare Part D plans, no matter what cost-sharing tier it's on, even if the members haven't paid their deductible (if applicable).
- **Important Message About What Members Pay for Vaccines:** Our MAPD plans cover most adult Part D vaccines at no cost to the members, even if the members haven't paid their deductible (if applicable). Call Provider Services for more information.

Medicare Part B covers Diabetic testing supplies. Preferred testing supplies are **Lifescan One-Touch and Roche Diagnostics Accu-Chek** Test Strips & monitors when obtained from any network pharmacy nationwide (including CVS Caremark mail order). Non-preferred blood glucose diabetic testing supplies obtained from a pharmacy will not be covered without an approved coverage authorization requested by the prescriber. The prescriber can request this with our pharmacy benefits manager, CVS Caremark.

CVS CAREMARK MAIL SERVICE PHARMACY™

Clover partners with CVS Caremark Mail Service Pharmacy to provide mail-order maintenance medications for chronic conditions. CVS Caremark Mail Service Pharmacy can send members up to a 100-day supply of medications, with their physician's approval.

With this service, your patients will enjoy the benefits listed below.

- **Safety and peace of mind:** Discreet packages are tamper-proof, weather-proof, and temperature-controlled, if needed. Licensed pharmacists ensure accuracy and safety before shipping and are available to answer medication questions.
- **Convenience:** Medications are delivered by mail with standard shipping at no cost. Members can sign up to receive order status alerts by phone, email, or text message.
- **Flexibility:** Manage medications anytime, anywhere at caremark.com or by using the CVS Caremark mobile app.
- **Savings:** Depending on the Clover pharmacy benefits plan, members may save money by using CVS Caremark Mail Service Pharmacy.

How Your Patients Can Learn More

Encourage members to go to **For Members at cloverhealth.com** and select **Member Resources**, then **Mail Order Medications**. Members can call our Member Services team at **1-888-778-1478 (TTY 711) from 8 am to 8 pm local time**, 7 days a week* or log in at **caremark.com** to get started.

*From April 1 through September 30, alternative technologies (for example, voicemail) will be used on the weekends and holidays.

How to Send Up to 100-Day Prescriptions to CVS Caremark Mail Service Pharmacy

Choose one:

- ePrescribe by mail:

  CVS Caremark
  MAILSERVICE Pharmacy
  NCPDP ID: 0322038
  9501 E Shea Blvd.
  Scottsdale, AZ 85260

- Fax prescriptions to **1-800-378-0323**
- Call in prescriptions using the FastStart toll-free phone number: **1-800-378-5697**

FIND A PHARMACY

Our in-network pharmacies provide prescription drugs to members. In most cases, prescriptions are covered only if they are filled at a network pharmacy or through our mail-order pharmacy service. Find a network pharmacy by visiting cloverhealth.com/find-pharmacy

PART D UTILIZATION MANAGEMENT

Certain prescription drugs on the formulary have additional requirements or limits on coverage. These requirements and limits ensure that members use these drugs in the safest and most effective way and help to control drug costs.

Certain drugs require prior authorization. This means that you will need to get approval from us before a member fills their prescription. If you don't get approval, we cannot cover the drug. Please see the **Part D Coverage Determination section** of this manual for how to submit a prior authorization.

Prior authorization criteria can be found at **cloverhealth.com/formulary**.

Quantity Limits

For certain drugs, there are limits on the amount we will cover per prescription or for a defined period of time.

Step Therapy

In some cases, we require members to try one drug for the treatment of a medical condition before we cover another drug for the same condition. For example, if Drug A and Drug B both treat a certain medical condition, we can require you to prescribe Drug A first. If Drug A does not work for the member, then we will cover Drug B.

More about step therapy can be found at **cloverhealth.com/formulary**.

FORMULARY-LEVEL OPIOID POINT-OF-SALE SAFETY EDITS

Clover's drug management program consists of several pharmacy-based edits to assist in addressing safety concerns regarding opioid prescriptions.

To align with CMS Medicare Part D Opioid Overutilization Policy, we partnered with our pharmacy benefits manager, CVS Caremark, and developed point-of-sale edits to advocate patient safety for our members and encourage appropriate prescription opioid use.

The drug management program or point-of-sale edits are not intended as prescribing limits.

Summary: Med D Opioid Management Requirements

7-day supply edit for opioid-naive patients*

- Designed to identify members with no history of an opioid in the past 108 days and decrease their initial supply to 7 days or less

90 mg/day MME (Morphine Milligram Equivalent) soft reject (Care Coordination Edit)*

- Checks for excessive opioid utilization via cumulative 90 mg/day MME across multiple drugs and prescriptions

Opioid/benzodiazepine POS (point of service) soft reject edit*

- Designed to identify members receiving a medication from both classes of drugs

Duplicate long-acting opioid POS soft reject edit*

- Designed to identify members on two or more long-acting opioids

Additional CVS Caremark opioid changes for standard Med D formularies*

- Immediate Release before Extended Release prior authorization
- Quantity limits for opioid-containing products based on limitations of up to 90 MME/day (when possible) and/or the FDA-approved maximum dose

*Patients in active cancer treatment, patients with sickle cell disease, long-term care (LTC) residents, patients in hospice or palliative care, and patients receiving Buprenorphine for Medication Assisted Treatment (MAT) are exempt from these edits.

We request that you respond promptly to pharmacy requests for additional information related to opioid safety alerts. Please ensure your on-call staff is aware and responds with a sense of urgency to pharmacy outreach. This will avoid delays in needed drug therapy.

If you have questions, please call the CVS Caremark Help Desk number on your patient's Clover member ID card.

For PPO plans, call **1-855-479-3657**.

For HMO plans, call **1-844-232-2316**.

For CVS Caremark Coverage Determinations & Appeals, call **1-855-344-0930**.

MEDICARE ADVANTAGE PART D FORMULARY COVERAGE EXCLUSIONS

The following is a list of noncovered (i.e., excluded) drugs and/or categories:

- Agents when used for anorexia, weight loss, or weight gain (even if used for a non-cosmetic purpose, such as for morbid obesity)
- Agents when used to promote fertility
- Agents when used for cosmetic purposes or to promote hair growth
- Agents when used for the relief of cough or cold symptoms

- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Nonprescription over-the-counter (OTC) drugs
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale
- Agents when used for the treatment of sexual or erectile dysfunction; erectile dysfunction drugs will meet the definition of a Part D drug when prescribed for medically accepted indications approved by the Food and Drug Administration (FDA) other than sexual or erectile dysfunction (such as pulmonary hypertension). However, ED drugs will not meet the definition of a Part D drug when used off-label, even when the off-label use is listed in one of the compendia found in section 1927(g)(1)(B)(i) of the Act: American Hospital Formulary Service Drug Information, and DRUGDEX® Information System.

Medicare Part D Coverage Phases

Medicare Part D prescription drug plans have four coverage stages. How members are affected depends on the prescription drug plan, medication costs, and if members are receiving Extra Help. If the plan has a deductible, the member's responsibility begins at Phase 1. If their plan does not have a deductible, the member's responsibilities begin at Phase 2. The dollar amounts listed below can change each year.

You can log in at **cloverhealth.com/providers/portal** or refer to the **Benefits section** of this manual to determine if the member has a Part D deductible on his or her plan.

The 4 Stages of Medicare Part D Coverage

1: Deductible	2: Initial Coverage	3: Coverage Gap	4: Catastrophic Coverage
• The member pays 100% of the drug cost until the annual deductible is satisfied. • For certain Clover plans, for drugs in tiers exempt from yearly deductible, the member pays the applicable copay during this stage.	• The member and Clover pay medication costs until the shared total equals $5,030. • The member pays the applicable copay and coinsurance during this stage.	• The Coverage Gap is commonly referred to as the "Donut Hole" and begins when the member's total drug costs have reached $5,030. • The member pays a maximum of 25% of the cost of brand name medications, or a maximum of 25% of the cost of generic medications. • Coverage Gap copays do not apply to members who have the Low-Income Subsidy.	• This stage begins when the member's out-of-pocket costs have reached the $8,000 coverage gap limit. • The member pays nothing.

PART D FORMULARY TIERS

Drugs represented in the Clover Health Medicare Advantage Formulary can have varying costs to the plan member. We categorize costs of prescription drugs with the following tiered format:

Tier 1

- The lowest cost-sharing tier
- Includes preferred generic plus adherence generic drugs

Tier 2

- Includes generic drugs
- May have Tier 1 alternatives
- Low- to mid-range cost

Tier 3

- Includes preferred brand drugs and non-preferred generic drugs classified by Clover Health based on safety, efficacy, and cost
- Mid-range costs

Tier 4

- Includes non-preferred brand-name and some non-preferred generic drugs for which alternatives are available at lower tiers
- Mid- to higher-range costs

Tier 5

- The highest cost-sharing tier
- Includes specialty drugs which may require special storage and handling and/or close monitoring

PART D COVERAGE DETERMINATIONS

What Is a Coverage Determination?

A coverage determination is an approval or denial decision made by Clover when members ask for coverage or payment of a drug they believe Clover should provide.

You, as well as members, can ask for a coverage determination. Members can also appoint someone else (such as a relative) to request a coverage determination on their behalf.

Upon receipt of any request, Clover responds to coverage determination requests within 72 hours of routine requests and within 24 hours of expedited requests.

You must provide medical history and/or other pertinent patient information when submitting a **Request for Medicare Prescription Drug Coverage Determination form** for formulary exceptions.

A coverage determination request is required for:

- Drugs not listed on the formulary
- Drugs listed on the formulary with a prior authorization
- Prescriptions that exceed the FDA daily or monthly quantity limits, or prescriptions that exceed the permitted limit noted on the formulary
- Drugs with a step edit, where the first-line therapy is inappropriate
- A request by a member for a lower copay tier for a prescribed drug on a higher copay tier

The goal of the coverage determination program is to ensure that medication regimens that are high-risk, have a high potential for misuse, or have narrow therapeutic indices are used appropriately and according to FDA-approved indications.

Part D Coverage Determination Submission

Follow these guidelines for efficient processing of your Medicare prescription drug coverage determination requests:

1. Complete the **Request for Medicare Prescription Drug Coverage Determination form** found in the Appendix and fax it to CVS Caremark at **1-855-633-7673** or mail it to the address on the form.
2. Coverage determination requests can be submitted telephonically to CVS Caremark at **1-855-344-0930**.
3. Coverage determination requests can also be submitted electronically at **covermymeds.com/main** (with the exception of Tier Exceptions, which must be submitted telephonically, via fax, or by mail).
4. Respond timely to requests for additional information. CVS Caremark will notify you of the decision by fax. If the request is approved, information in the online pharmacy claims processing system changes to allow the specific members to receive this specific drug. If the request is denied, information about the denial will be provided to you.
   In the event you or a member disagrees with the decision regarding coverage of a medication, you can request a free copy of the criteria or guidelines used in making the decision and any other information related to the determination by calling CVS Caremark toll-free at **1-855-344-0930**.

PART D APPEALS

If your prescription drug coverage request is denied, you have the right to file an appeal with our Pharmacy Benefit Manager, CVS Caremark, within 60 calendar days from the date of our first decision. We accept standard and expedited requests by telephone and in writing.

Part D Appeals Submission

You can submit a Part D appeal in one of four ways:

- Call the CVS Caremark Part D Appeals Department at **1-855-344-0930 (TTY 711) 24 hours a day**, 7 days a week

- Go to **covermymeds.com/main** (excluding tier exceptions, which must be submitted by phone, fax, or mail)
- Fax the completed Request for Redetermination of Medicare Prescription Drug Denial form to CVS Caremark at **1-855-633-7673**
- Mail the completed Request for Redetermination of Medicare Prescription Drug Denial form to:
  CVS Caremark
  Attn: Part D Appeals
  P.O. Box 52000, MC109
  Phoenix, AZ 85072-2000

CVS Caremark will notify you of the decision by fax.

PART D GRIEVANCES

A Part D grievance is any complaint other than one that involves a coverage determination related to prescription drug benefits. A grievance is filed if Clover members have any type of problem with us or one of our network pharmacies that does not relate to coverage for a prescription drug. Medicare Part D grievances related to the following topics are processed by Clover's contracted Pharmacy Benefit Manager (PBM) CVS Caremark:

- Benefits
- Confidentiality and privacy
- Customer service
- Exceptions
- Pharmacy network
- Quality of care
- Mail order

Part D Grievance Submission

Members can contact CVS Caremark at **1-855-479-3657** (PPO plans) or **1-844-232-2316** (HMO plans) to file a grievance, fax a grievance to **1-866-217-3353**, or mail the grievance to:

CVS Caremark
Medicare Part D Grievances
P.O. Box 30016,
Pittsburgh, PA 15222-0330

Part D grievances related to the following are handled by Clover:

- Enrollment/disenrollment
- Fraud and abuse
- Marketing
- Other premium billing
- Provider prescribing

Members can file these types of grievances using the contact information listed in the "**File a member grievance**" section of the Provider Manual.

Laboratory Services

We believe in catching conditions earlier and doing our best to prevent them from developing in the first place—and that the best way to do both is with regular lab work.

We encourage you to refer your patients' samples to LabCorp or Quest, our trusted laboratory partners. Search our Provider Directory for in-network labs at **cloverhealth.com/members/find-provider**.

Credentialing

To ensure that everyone we partner with meets industry regulatory requirements, all Clover Health network providers, physicians, non-physician healthcare professionals, and ancillary providers must be credentialed. This section will explain how credentialing works.

CREDENTIALING PROCESS

You require credentialing to partner with Clover if your services fall under any of the following categories:

- Acupuncturist (ACU)
- Audiologist (AUD)
- Certified nurse midwife (CNM)
- Certified nurse practitioner (CNP), clinical nurse specialist (CNS), nurse practitioner (NP), advance practice nurse (APN), family nurse practitioner (FNP)
- Chiropractor (DC)
- Doctoral-level and master-level psychologist (PhD, MS)
- Master-level clinical social worker (LCSW, MSW, CSW)
- Medical doctor (MD)
- Nutritionists and dietitian (RD)
- Ophthalmologist (MD)
- Osteopathic doctor (DO)
- Physical therapist (PT), occupational therapist (OT), speech/language therapist (ST)
- Physician's assistant (PA)
- Physician (MD)
- Podiatrist (DPM)

Clover's Credentialing Committee is composed of a community of physicians representing several specialties and is responsible for the approval and oversight of all participating providers. The Credentialing Committee recommendations are reviewed and acted upon by our Chief Medical Officer.

Clover can delegate credentialing and recredentialing activities as appropriate. If any portion of the process is delegated, Clover's delegated credentialing and recredentialing policies are followed. We monitor compliance with our policies and procedures of all delegated entities at least annually.

Clover completes credentialing activities for a "clean" file within 90 days of receiving a completed application and signed contract. If additional information is needed, we will reach out to you to amend or correct any incomplete or erroneous information.

INITIAL CREDENTIALING AND APPLICATION SUBMISSION

Physician and Nonphysician Healthcare Professionals

Clovers uses CAQH ProView as its primary credentialing application to process credentialing for physician and nonphysician healthcare professionals. Clover should be notified using our CAQH form or roster submission. At the time of submission, the provider should have a current CAQH attestation. You can submit one of the following application options:

1. Clover uses the Council for Affordable Quality Healthcare (CAQH) application, as it ensures a compliant application and a timelier online process. You only need to provide your CAQH ID.
2. An online credentialing application can be completed if CAQH is not used, but the timeline for review can be significantly longer because the review process is manual. This particular credentialing application must include the following items:
    a. Current valid professional medical license for the practicing state
    b. Current Drug Enforcement Administration (DEA) and Controlled Dangerous Substance (CDS) certificates for the practicing state, required for physicians and, if applicable, for that state (Physicians unable to meet this requirement should provide a letter explaining why a DEA and/or CDS will not be obtained and how prescriptions will be covered).
    c. Current Board Certification or a copy of the confirmation of registration to sit for a board certification, if applicable
    d. Current proof of adequate professional malpractice insurance with a minimum coverage amount set by the appropriate state statute
    e. Summary of professional work history (going back a minimum of 5 years) with explanation(s) for any gaps of 6 months or more
    f. Documentation or certificates of education and training
    g. Summary of hospital privileges if available

In addition to an updated and complete credentialing application, a completed and signed W-9 must also be submitted.

During the credentialing process, we will check the following entities:

1. The National Practitioner Data Bank (NPDB)
2. Applicable licensure agencies for information on sanctions or limitations on licensure
3. The Office of Inspector General (OIG) and the Department of Health and Human Services for the list of excluded individuals/entities
4. The System for Award Management (SAM) for information on providers barred from participation or otherwise declared ineligible to participate in federal procurement or nonprocurement programs
5. Medicare Opt-Out or other federal reimbursement program for excluded or opt-out providers
6. CMS Preclusion List

Ancillary Providers

You must send Clover a completed Facility/Ancillary Provider Credentialing Application that is signed and dated (application is valid for 180 days). In addition to the application, a signed agreement should be returned with the

following supporting documents:

1. Current valid state operational license
2. State/Department of Health/Federal License
3. Accreditation/certification by a governmental accrediting body [e.g., CMS, Joint Commission on Accreditation of Healthcare Organizations (JCAHO)], if applicable
4. Current general liability coverage (i.e., documentation showing the amounts and dates of coverage)
5. Proof of Medicare enrollment
6. IRS W-9
7. CLIA

During the credentialing review, we check the following entities::

1. National Practitioner Data Bank (NPDB)
2. Office of Inspector General (OIG), Department of Health and Human Services for the list of excluded individuals/entities
3. System for Award Management (SAM) for information on providers debarred from participation or otherwise declared ineligible to participate in federal procurement or nonprocurement programs
4. CMS website for Medicare enrollment
5. Medicare Opt-Out List

If an illegible and/or incomplete application packet is submitted, or if required attachments are missing, you will be contacted in an attempt to obtain this information.

When your initial application is approved by the Credentialing Committee, you are sent a credentialing decision letter. If the application is denied, a decision letter that includes the right to appeal the committee's decision is sent out to you following the committee meeting.

RECREDENTIALING PROCESS AND REVIEW

Clover requires you to undergo and complete a recredentialing review every 3 years. To qualify for recredentialing, you must maintain the same minimum qualification requirements as for the initial credentialing.

There is no action required of you if the Council for Affordable Quality Healthcare (CAQH) application is complete and updated, or you can complete an online application with our Credentials Verification Organization (CVO). Failure to respond by your 3-year anniversary, is considered an administrative termination, and the termination process is initiated. If you are terminated as a nonresponder, you will need to undergo the initial credentialing process again, which may include the signing of a new contract.

Recredentialing applications must include the following:

- Signed and dated attestation within 180 days of the recredentialing date
- Current valid professional medical license
- Current DEA and CDS certificate for the practicing state, required for physicians and if applicable for that state
- For physicians, a letter explaining why a DEA and/or CDS will not be obtained and how prescriptions will be covered
- Current board certification or copy of the confirmation of registration to sit for a board certification, if applicable
- Current adequate professional malpractice insurance with a minimum coverage amount set by the appropriate state statute
- Summary of professional work history (going back a minimum of 3 years) with explanation(s) for any gaps of 6 months or more

You are encouraged to maintain up-to-date information on your CAQH profile.

Once the recredentialing is completed and approved, you will remain in the Clover network. If you get denied when presented to the Credentialing Committee for decision making, you are notified in writing within 10 business days of the committee decision. The letter includes the reasons for denial and indicates your rights to appeal the committee's decision.

DELEGATED ENTITIES

Delegation is a formal process by which a health plan provides a provider group with the authority to perform certain functions on its behalf, such as credentialing. A function can be fully or partially delegated. Full delegation allows all activities of a function to be delegated. Partial delegation allows some of the activities to be delegated.

All participating providers or entities delegated for credentialing/recredentialing are to use the same Clover Health policies and procedures as defined in the delegated credentialing agreement. Delegated oversight audits, in person or remotely, are conducted at least annually.

Although Clover can delegate the authority to perform a function, it cannot delegate the ultimate responsibility for fulfilling the service or obligation.

CONFIDENTIALITY

The Credentialing Department is responsible for ensuring the confidentiality of all information received and maintained in the credentialing and recredentialing processes. Information derived from peer-review functions is protected from subpoena and discovery by state immunity laws, except as otherwise provided by law. This includes proceedings, reports, and records of a peer review specialty committee.

NONDISCRIMINATION

Clover Health does not discriminate in the credentialing or recredentialing process on the basis of religion, race, color, national origin, age, gender, sexual orientation, height, weight, familial status, marital status, disability, or any other basis prohibited by law. Additionally, Clover does not discriminate in credentialing and recredentialing based on the types of procedures or the risks of the population that you serve.

REVIEW OF YOUR INFORMATION ON FILE

With the exception of information determined by Clover to be peer-review protected, you have the right to request in writing your file information and to subsequently review and correct any erroneous information obtained by Clover to support its evaluation of your application.

Send written requests to:

Clover Health
Attn: Credentialing Department – Credentialing Manager
P.O. Box 21164
Eagan, MN 55121

ONGOING MONITORING

Clover Health is responsible for offering its members qualified and competent providers who will be accountable for delivering appropriate and medically necessary care and services. Because of this, Clover monitors provider sanctions and limitations. Clover is responsible for regularly informing you of any findings related to performance or practice of care.

The Credentialing Department is responsible for the management of ongoing (monthly) monitoring of:

- Medicare-Medicaid sanctions, which can lead to termination/suspension of Provider Services Agreement
- State licensure/disciplinary actions, which can lead to termination/suspension of Provider Services Agreement
- Quality-of-care issues, which can lead to a corrective action plan or termination
- National Practitioner Data Bank reports, including Adverse Actions and Malpractice Cases

Any findings are discussed during the monthly Credentialing Committee meeting. If the Credentialing Committee denies you inclusion into Clover's network, you are notified in writing within 10 business days of the committee's decision. The letter includes reasons for denial and indicates your rights to appeal the committee's decision.

Provider Termination

While we do everything we can to nurture our partnership with you, there can be times when the only reasonable resolution is to discontinue working together. This section describes what is involved when a partnership must be terminated.

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CIRCUMSTANCE FOR TERMINATION

There can be certain circumstances in which Clover Health decides to terminate its relationship with contracted or participating providers. Depending on the cause, Clover can work with you to address the problem, initiate a termination per the terms of your Provider Services Agreement, or initiate a termination to take effect immediately.

An immediate termination can be initiated for the following reasons:

- Suspension, revocation, condition, expiration, or other restriction of your licensure, certification, and/or accreditation to perform services contemplated under your Provider Services Agreement
- Suspension or bar from participation in federal healthcare programs
- Determination that you engaged in or are engaging in fraud
- Noncompliance with the general and professional liability insurance requirements set forth in your Provider Services Agreement
- State sanctions, indictment, arrest, or conviction, or a felony or any criminal charge
- Clover's reasonable determination that your immediate termination is necessary for the health and safety of members

Clover can also terminate the participation of an individual group provider or can require that an individual group provider cease providing services to members based upon any of the foregoing events, without terminating the Provider Services Agreement in its entirety.

Certain terminations initiated may not take effect immediately (terminations for cause, terminations without cause). Refer to your Provider Services Agreement for details around terminations that cannot take effect immediately and the effective time frames.

In the event of a termination, Clover sends a termination notice to you, your ancillary, or your hospital. Clover can require you, your ancillary, or your hospital to provide continuity of care until a safe transition to another provider has been made.

Your Provider Services Agreement will not be terminated or refused renewal solely because you have:

- Advocated on behalf of a member
- Filed a complaint against Clover
- Appealed a decision made by Clover

Additionally, you can have termination rights of your own. For details about provider termination rights, refer to your Provider Services Agreement.

Appeal Hearing Process

When you, your ancillary, or your hospital requests an appeal of a termination decision, Clover's Credentialing and Termination Committee can form a subcommittee to hear your appeal. The subcommittee consists of no fewer than three members. Here are the rules and regulations for holding an appeals process:

- Peers can be providers or healthcare professionals outside of the Clover network of providers.
- No individuals involved in the investigation of an appeals case can be part of the appeals hearing committee.
- Appeals hearing committee voting can be done in person, via phone, or via email.
- The Medical Director appoints a hearing officer who serves as the presiding officer over the hearing.
- The presiding officer should:
    - Determine the order and decorum of the hearing and deliberations
    - Assure that all participants have opportunity to present oral and documented evidence
    - Provide guidance to the appeals hearing committee during the hearing and deliberations
- The hearing officer does not have voting privileges.

The notice of the final decision of the appeals hearing committee is delivered by certified mail to you, your ancillary, or your hospital 30 days after the close of the hearing. The notice includes the final decision, the basis for that decision (affirm, modify, or withdraw the original proposed action), and the Provider Services Agreement provisions and facts relied upon by Clover during the hearing.

CONTINUITY OF CARE

In the event of a termination, whether initiated by you or by Clover Health, our goal is to ensure that your patients, our members, continue to receive the care they require until they no longer require it or until a safe transition can be made (unless otherwise specified).

In the event that you voluntarily decide to leave the network or Clover terminates with/without cause (i.e., a termination that does not fit the criteria of "immediate" as defined above), you must agree to continue to provide covered services until it is safe to discontinue or safe alternatives have been confirmed.

During this continuity-of-care period, you agree to:

1. Accept Clover's established reimbursement rates as payment in full
2. Adhere to Clover's quality improvement requirements
3. Provide medical information related to the care
4. Adhere to Clover's policies and procedures

Clover's Wellness Management team can assist members with transitioning their care to a new provider. You can reach them by calling 1-888-995-1689.

To ensure Clover stays aligned with its mission to build high-performing, cost-effective provider networks, Clover maintains discretion to select the providers with whom it decides to contract. Clover is able to make changes to these networks at any time during the contract year.

Administrative Procedures and Compliance

We are here to ensure your practice stays aligned with CMS regulations, compliance guidelines, our marketing policies, and other industry-standard regulations. In the following section, we provide some helpful links and overviews to make it easy for you or your staff to reference or access them.

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CMS GUIDELINES

You and any persons involved in the administration or delivery of Medicare program benefits must complete the following training requirements within 90 days of initial hire and annually thereafter:

- CMS Medicare Parts C and D Compliance training
- CMS Medicare Parts C and D Fraud, Waste, and Abuse (FWA) training

CMS has developed a web-based training module that can be used to satisfy these training requirements. It is available on the **Medicare Learning Network at cms.gov**.

Clover recommends that you read and understand the guidelines set forth by the Centers for Medicare & Medicaid Services. For additional information, visit **cms.gov**.

MARKETING PLANS

You cannot develop materials that market Clover Health without Clover's prior written approval, but you can use CMS-approved materials supplied directly by Clover. Under Medicare Advantage program rules, Clover and other Medicare Advantage plans must follow CMS marketing guidelines and obtain CMS review and approval for all marketing materials before making such materials available for distribution to eligible individuals.

You can have Clover marketing materials, including brochures, posters, or notifications, available in your office as long as Clover is not exclusively represented. Materials for other Medicare Advantage plans in which you are a participant must also be available in the same location. Medicare Advantage marketing materials can only be displayed in common areas and not in private patient exam rooms.

Contact your Clover representative if you are interested in Clover Health marketing materials to share with members.

If a member has a question regarding Clover Health, direct the member to call Clover Member Services at **1-888-778-1478 (TTY 711) from 8 am to 8 pm local time,** 7 days a week, to assist you. From April 1 through September 30, alternate technologies (for example, voicemail) will be used on the weekends and holidays.

AUDIT

Providers must ensure compliance with Medicare laws and regulations, and CMS instructions; agree to audits and inspections by Clover, CMS, and/or its designees; cooperate, assist, and provide information as requested; and maintain records for a minimum of 10 years.

CONFLICT OF INTEREST POLICY

Conflicts of interest are created when an activity or relationship renders you unable or potentially unable to provide impartial assistance or advice, impairs your objectivity, or provides you with an unfair competitive or monetary advantage. Many of the relationships discussed in this document are subject to conflict-of-interest disclosure policies. Even if the relationships are legal, you can have an obligation to disclose their existence to **providers@cloverhealth.com**.

Glossary

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Abuse: Actions that can, directly or indirectly, result in unnecessary costs to the Medicare program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment, and the provider has knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent, prior knowledge, and available evidence, among other factors.

Appeal: Any of the procedures that deal with the review of adverse organization determinations on the healthcare services the member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the healthcare services.

Covered services: Medically necessary healthcare services to which the member is entitled under the terms of the member's benefit agreement.

Fraud: Knowingly and willfully executing or attempting to execute a scheme or artifice to defraud any healthcare benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any healthcare benefit program. 18 U.S.C. § 1347.

First-tier, downstream, and related entities: Includes contracted physicians, healthcare professionals, facilities, and ancillary providers, as well as delegates, contractors, and related parties of Clover Health.

Grievance: Any complaint or dispute expressing dissatisfaction with the manner in which Clover or one of its delegated entities provides healthcare services, regardless of whether any remedial action can be taken.

Group/group provider: Employees, affiliates, or any individuals contracted with a group to provide covered services to a Clover member.

Healthcare provider: Physicians, healthcare professionals, and/or other providers licensed and/or authorized under the laws of the state in which services are provided who are employed by or contracted by Clover.

Medically necessary services: Services that are necessary for the diagnosis or treatment of disease, illness, or injury, and without which the member can be expected to suffer prolonged, increased, or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort.

Member benefit agreement: The agreement between Clover and the member that details the benefits to which the member is entitled.

Organization determination: Receipt of, or payment for, covered items or services; the amount Clover requires an enrollee to pay for covered items or services; or a limit on the quantity of covered items or services.

Participating provider: A healthcare provider, hospital, healthcare facility, ancillary provider, or any other person or entity who has contracted with Clover to provide covered services to members.

Pre-service organization determination: When services have not yet been rendered, a member, a member representative, and you or any other provider acting on behalf of the member with the member's consent can submit a request for a pre-service organization determination.

Provider Services Agreement: A signed agreement between Clover Health and a provider outlining the obligations of both parties in the delivery of quality care and covered services to members and the compensation for those services.

Provider Manual: A document that explains Clover's operating policies, standards, and procedures for participating providers including, but not limited to, Clover's requirements for claim submission and payment, credentialing, utilization review, care management, quality improvement, advance directives, members' rights, grievances, and appeals.

Quality Improvement Organization (QIO): An organization composed of practicing doctors and other healthcare experts under contract to the federal government to monitor and improve the care given to Medicare enrollees.

Representative: An individual appointed by a member or other party, or authorized under state or other applicable law, to act on behalf of an enrollee or other party involved in an appeal, grievance, or organization determination.

Waste: Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally considered to be caused not by criminally negligent actions but rather by the misuse of resources.

Appendix A: Attachments

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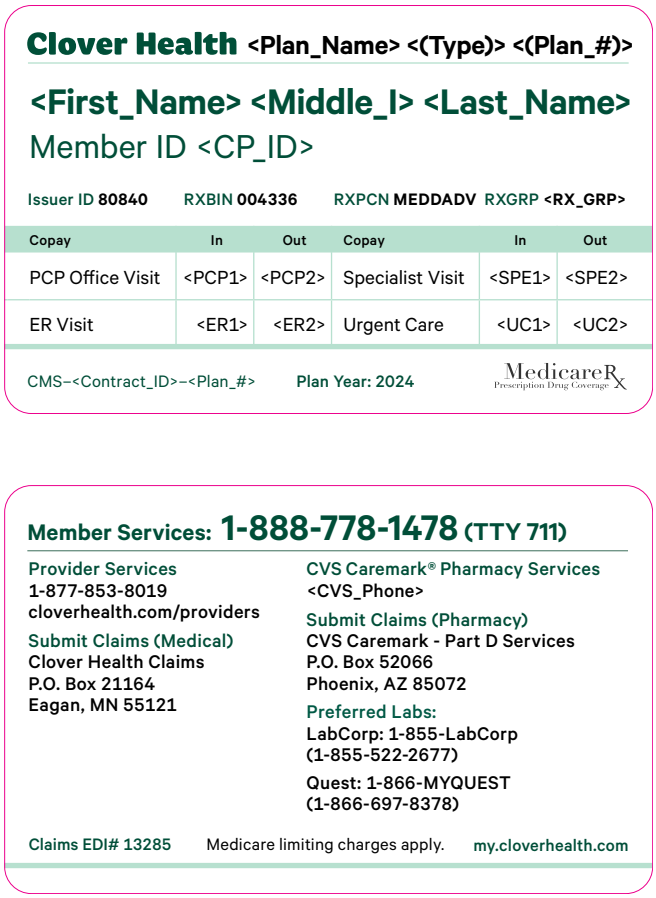
SAMPLE MEMBER ID CARD



Clover Health <Plan_Name> <(Type)> <(Plan_#)>

<First_Name> <Middle_I> <Last_Name>

Member ID <CP_ID>

Issuer ID **80840** RXBIN **004336** RXPCN **MEDDADV** RXGRP **<RX_GRP>**

Copay	In	Out	Copay	In	Out
PCP Office Visit	<PCP1>	<PCP2>	Specialist Visit	<SPE1>	<SPE2>
ER Visit	<ER1>	<ER2>	Urgent Care	<UC1>	<UC2>

CMS–<Contract_ID>–<Plan_#> **Plan Year: 2024** MedicareRx Prescription Drug Coverage

Member Services: 1-888-778-1478 (TTY 711)

Provider Services
1-877-853-8019
cloverhealth.com/providers

Submit Claims (Medical)
Clover Health Claims
P.O. Box 21164
Eagan, MN 55121

CVS Caremark® Pharmacy Services
<CVS_Phone>

Submit Claims (Pharmacy)
CVS Caremark - Part D Services
P.O. Box 52066
Phoenix, AZ 85072

Preferred Labs:
LabCorp: 1-855-LabCorp
(1-855-522-2677)

Quest: 1-866-MYQUEST
(1-866-697-8378)

Claims EDI# 13285 Medicare limiting charges apply. my.cloverhealth.com

Clover Health

Prior Authorization Request

Need a faster turnaround?
Go online: **cloverhealth.com/pre-auth-request**

HOW TO USE THIS FORM:

1. **Complete** all required fields marked with an **asterisk** (*).
2. **Attach** copies of supporting clinical information.
3. **Fax** this form to 1-800-308-1107.
4. **Call our Utilization Management team at** 1-888-995-1690 if you have any questions.

MEMBER INFORMATION (please print clearly)

Member Name*:	Member ID*:	Date of Birth*:
	_ _ _ _ _ _ _ _ _ _	____/____/_____ (MM / DD / YYYY)

REQUESTING PROVIDER / FACILITY INFORMATION

Requesting NPI (Provider or Facility)*:			Requesting Contact Name:	
Requesting MD/Facility Name*:			Title/Dept.:	
Address*:			Email:	
City*:	State*:	ZIP code*:	Phone:	Fax:

SERVICING PROVIDER / FACILITY INFORMATION (If different from requesting provider/facility)

Servicing NPI (Provider or Facility)*		Servicing Contact Name	
Servicing MD/Facility Name*:	Specialty*:	Title/Dept.:	
Address*:		Email:	
City*:	State*:	ZIP Code*	Phone:	Fax:

AUTHORIZATION REQUEST (Please attach copies of required clinical documentation.)

Service Type*	Place of Service*	Start Date or Admission Date*	End Date or Discharge Date
☐ Inpatient ☐ Outpatient	☐ MD Office ☐ Home Health ☐ DME ☐ Amb. Surg. ☐ Other _____	____/____/_____ (MM / DD / YYYY)	____/____/_____ (MM / DD / YYYY)

Primary Procedure Code (CPT/HCPCS)	Unit(s)	Modifier	Diagnosis Code (ICD 10)*	Service Description
Additional Procedure Code(s) (CPT/HCPCS)	**Unit(s)**	**Modifier**	**Diagnosis Code** (ICD 10)	**Service Description**

URGENT REQUEST (If applicable, explain medical need to expedite*)

Routine requests are processed on a 14 calendar day time frame, but this does not necessarily mean we will take the full 14 days as we will process according to the member's needs. Turnaround will take no longer than 72 hours if the physician documents that a delay would place the member's health in danger.

Total Pages:

Clover Health

Professional Update Request

Email: Providers@Cloverhealth.com **Fax: Provider Data Management 1-866-201-3008**

INSTRUCTIONS

Use this form to report provider information changes or updates. ***W9 required for TIN changes or changes to billing address.***
Email form to Providers@Cloverhealth.com or Fax to Provider Data Management 1-866-201-3008

GENERAL INFORMATION

Line of Business ☐ Medicare Advantage

Office Contact	Phone #	Date

Practice Email	Preferred Method of Contact ☐ Phone ☐ Email

Practice Name	Practice NPI	Tax ID

Provider Name	Provider NPI	Provider Type ☐ PCP ☐ Specialist

ADDRESS OR PHONE NUMBER CHANGE

Check all boxes that apply for the type of change and specity what is changing

Change 1 Effective Date:		**Change 2** Effective Date:	
Change Type	**What's Changing**	**Change Type**	**What's Changing**
☐ Add New ☐ Term ☐ Change	☐ Office ☐ TIN ☐ Mailing ☐ Payee/billing	☐ Add New ☐ Term ☐ Change	☐ Office ☐ Mailing ☐ Payee/billing
Old Address		Old Address	
New Address		New Address	
New Phone # New Fax #		New Phone # New Fax #	

NAME CHANGE

For an individual name change, attach copy of marriage license, divorce decree, etc.

Previous Name	New Name	Effective Date

TAX ID CHANGE (ATTACH W9)

Previous Name	New Name	Effective Date

PROVIDER PANEL STATUS CHANGE

Panel Status ☐ Open ☐ Closed Effective Date

SPECIALTY CHANGE

Previous Specialty	New Specialty

Is the provider board certified in this specialty? ☐ Yes ☐ No If yes, attach a copy of board certification

AUTHORIZED SIGNATURE

Person authorized to make change (Print or Type Name)	Email

Signature	Title	Date

Institutional and Ancillary Providers

Clover Health

Email: Providers@Cloverhealth.com

Update Request/Attestation

Fax: Provider Data Management 1-866-201-3008

INSTRUCTIONS				
Use this form to report institutional or ancillary changes or updates. ***W9 is required for TIN changes or changes to billing address.***				
Email form to Providers@Cloverhealth.com or Fax to Provider Data Management 1-866-201-3008				
GENERAL INFORMATION				
Line of Business	Medicare Advantage			
Office Contact	Phone #			Date
Practice Email	Preferred Method of Contact			
		Phone		Email
Institutional/Ancillary Name	Practice NPI		Tax ID	
Doing Business As Name (if applicable)	Provider National Provider Identifier			

ADDRESS OR PHONE NUMBER CHANGE					
Check all boxes that apply for the type of change and specity what is changing					
Change 1	Effective Date		**Change 2**	Effective Date	
Type of Change		**What's Changing**	**Type of Change**		**What's Changing**
Add New		Office	Add New		Office
Term		Mailing	Term		Mailing
Change		Tax ID	Change		Tax ID
		Payee/billing/vendor			Payee/billing/vendor
Old Address			Old Address		
New Address			New Address		
New Phone #		New Fax #	New Phone #		New Fax #

NAME CHANGE		
Previous Name	New Name	Effective Date

TAX ID CHANGE (ATTACH W9 FOR EACH LOCATION)		
Previous Name	New Name	Effective Date

AUTHORIZED SIGNATURE		
Person authorized to make change (Print or Type Name)	Email	
Signature	Title	Date

Clover Health

Claims Appeal & Dispute Form

This form is to be used to request a redetermination if Clover Health overpaid, underpaid, or denied your claim. Please fill out every section of this form – if not, your request may be placed on hold until we recieve the correct information.

Provider Information ☐ INN ☐ OON

Provider/Group Name:

Tax ID or NPI:

Patient Information

Patient Name:

Member ID: CP _____

Attachments

Remittance Advice ☐ Medical Records ☐

Supporting Documentation for Dispute ☐

Waiver of Liability (REQUIRED for OON) ☐

Contact Information

Name:

Address:

Phone #: ( )

Fax #: ( )

Claim Information

Patient Account Number:

Claim Number:

Date of Determination* _____ /_____ /_____

Date(s) of Service:
_____ /_____ /_____ _____ /_____ /_____

Reason for Request (Choose the Reason Below)

Overpayment ☐ Underpayment** ☐ Denial Code(s) ☐ _____

Amount Paid: $ _____ Expected Amount: $ _____

Whole Claim: ☐ CPT Code(s): ☐ _____

Other: (Please Provide a Description and/or a Good Cause Reason)

Return Information

INN providers should submit requests to:
Mail: P.O. Box 21164, Eagan, MN 55121
Email: submitclaims@cloverhealth.com
Fax: 1-888-240-7243

OON providers should submit requests to:
Mail: P.O. Box 21672, Eagan, MN 55121
Email: submitappeals@cloverhealth.com
Fax: 1-732-412-9706

*Please provide good cause above if dispute is filed after 60 days from the date of determination
**Inquiries are considered underpayments only if the whole claim or the code being disputed was initially paid.

Clover Health

Request for Medicare Prescription Drug Coverage Determination

Send form by mail or fax:	**Who may make a request**: Your prescriber may ask us for a coverage determination on your behalf. If you want another individual (such as a family member or friend) to make a request for you, that individual must be your representative. Contact us to learn how to name a representative. **Coverage Determination website:** www.cloverhealth.com **Coverage Determination phone:** (844) 232-2316
Address: **CVS Caremark Part D** MC109; P.O. Box 52000 Phoenix, AZ 85072-2000 **Fax #:** (855) 633-7673	

Enrollee's Information:		
Name:		
Street Address:		
City:	**State:**	**Zipcode:**
Phone Number: (_ _ _) _ _ _ - _ _ _ _	**Birth Date:**	
Enrollee's Plan ID #:		

Complete the following section ONLY if the person making this request is not the enrollee or prescriber:		
Requestor's name:		
Relationship to the Enrollee:		
Street Address:		
City:	**State:**	**Zipcode:**
Phone Number: (_ _ _) _ _ _ - _ _ _ _		
Representation documentation for appeal requests made by someone other than enrollee or the enrollee's prescriber: Attach documentation showing the authority to represent the enrollee (a completed Authorization of Representation Form CMS-1696 or a written equivalent). For more information on appointing a representative, contact your plan or 1-800-Medicare, TTY: 1-877-486-2048, 24 hours per day, 7 days a week.		

Name of prescription drug you are requesting:
(if known, include strength and quantity requested per month)

Type of coverage determination request	
Please choose any that apply:	
☐	I need a drug that is not on the plan's list of covered drugs (formulary exception).*
☐	I have been using a drug that was previously included on the plan's list of covered drugs, but is being removed or was removed from this list during the plan year (formulary exception).*
☐	I request prior authorization for the drug my prescriber has prescribed.*
☐	I request an exception to the requirement that I try another drug before I get the drug my prescriber prescribed (formulary exception).*
☐	I request an exception to the plan's limit on the number of pills (quantity limit) I can receive so that I can get the number of pills my prescriber prescribed (formulary exception).*
☐	My drug plan charges a higher copayment for the drug my prescriber prescribed than it charges for another drug that treats my condition, and I want to pay the lower copayment (tiering exception).*
☐	I have been using a drug that was previously included on a lower copayment tier, but is being moved to or was moved to a higher copayment tier (tiering exception).*
☐	My drug plan charged me a higher copayment for a drug than it should have.
☐	I want to be reimbursed for a covered prescription drug that I paid for out of pocket.

***NOTE:** If you are asking for a formulary or tiering exception, your prescriber MUST provide a statement supporting your request. Requests that are subject to prior authorization (or any other utilization management requirement), may require supporting information. Your prescriber may use the attached "Supporting Information for an Exception Request or Prior Authorization" to support your request.

Additional information we should consider: (attach any supporting documents)

Important Note: Expedited Decisions

If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescriber indicates that waiting 72 hours could seriously harm your health, we will automatically give you a decision within 24 hours. If you do not obtain your prescriber's support for an expedited request, we will decide if your case requires a fast decision. You cannot request an expedited coverage determination if you are asking us to pay you back for a drug you already received.

☐ **CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION IN 24 HOURS**
If you have a supporting statement from your prescriber, attach it to this request.

Signature:	**Date:**

Supporting information for an Exception Request or Prior Authorization:	
FORMULARY and TIERING EXCEPTION requests cannot be processed without a prescriber's supporting statement. PRIOR AUTHORIZATION requests may require supporting information.	
☐	**REQUEST FOR EXPEDITED REVIEW:** By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Prescriber's Information:		
Name:		
Street Address:		
City:	State:	Zipcode:
Office Phone:	Fax:	
Office Contact Person:		
Prescriber's Signature:	Date:	

Diagnosis and Medical information:	
Medication:	Frequency:
Strength and route of administration:	
Date started: ☐ NEW START	
Expected length of therapy:	Quantity (per 30 days):
Height/Weight:	Drug Allergies:

DIAGNOSIS – Please list all diagnoses being treated with the requested drug and corresponding ICD-10 codes. (If the condition being treated with the requested drug is a symptom e.g. anorexia, weight loss, shortness of breath, chest pain, nausea, etc., provide the diagnosis causing the symptom(s) if known):	ICD-10 Code(s)
Other RELEVANT DIAGNOSES:	ICD-10 Code(s)

DRUG HISTORY: (for treatment of the condition(s) requiring the requested drug)		
DRUGS TRIED: (if quantity limit is an issue, list unit dose/total daily dose tried)	**DATES of Drug Trials:**	**RESULTS of previous drug trials FAILURE vs INTOLERANCE (explain):**

What is the enrollee's current drug regimen for the condition(s) requiring the requested drug?

DRUG SAFETY

Any FDA NOTED CONTRAINDICATIONS to the requested drug? ☐ YES ☐ NO

Any concern for a DRUG INTERACTION with the addition of the requested drug to the enrollee's current drug regimen? ☐ YES ☐ NO

If the answer to either of the questions noted above is yes, please 1) explain issue, 2) discuss the benefits vs potential risks despite the noted concern, and 3) monitoring plan to ensure safety

HIGH RISK MANAGEMENT OF DRUGS IN THE ELDERLY

If the enrollee is over the age of 65, do you feel that the benefits of treatment with the requested drug outweigh the potential risks in this elderly patient? ☐ YES ☐ NO

OPIOIDS (please complete the following questions if the requested drug is an opioid)

What is the daily cumulative Morphine Equivalent Dose (MED)? mg/day

Are you aware of other opioid prescribers for this enrollee? If so, please explain. ☐ YES ☐ NO

Is the stated daily MED dose noted medically necessary? ☐ YES ☐ NO

Would a lower total daily MED dose be insufficient to control the enrollee's pain? ☐ YES ☐ NO

RATIONALE FOR REQUEST
☐ **Alternate drug(s) contraindicated or previously tried, but with adverse outcome, e.g., toxicity, allergy, or therapeutic failure** [Specify below if not already noted in the DRUG HISTORY section earlier on the form: (1) Drug(s) tried and results of drug trial(s) (2) if adverse outcome, list drug(s) and adverse outcome for each, (3) if therapeutic failure, list maximum dose and length of therapy for drug(s) trialed, (4) if contraindication(s), please list specific reason why preferred drug(s)/other formulary drug(s) are contraindicated]
☐ **Patient is stable on current drug(s); high risk of significant adverse clinical outcome with medication change** [A specific explanation of any anticipated significant adverse clinical outcome and why a significant adverse outcome would be expected is required – e.g. the condition has been difficult to control (many drugs tried, multiple drugs required to control condition), the patient had a significant adverse outcome when the condition was not controlled previously (e.g. hospitalization or frequent acute medical visits, heart attack, stroke, falls, significant limitation of functional status, undue pain and suffering), etc.]
☐ **Medical need for different dosage form and/or higher dosage** [Specify below: (1) Dosage form(s) and/or dosage(s) tried and outcome of drug trial(s); (2) explain medical reason (3) include why less frequent dosing with a higher strength is not an option – if a higher strength exists]
☐ **Request for formulary tier exception** [Specify below if not noted in the DRUG HISTORY section earlier on the form: (1) formulary or preferred drug(s) tried and results of drug trial(s) (2) if adverse outcome, list drug(s) and adverse outcome for each, (3) if therapeutic failure/not as effective as requested drug, list maximum dose and length of therapy for drug(s) trialed, (4) if contraindication(s), please list specific reason why preferred drug(s)/other formulary drug(s) are contraindicated]
☐ **Other:** (explain below)
Required Explanation: