PCOT
Physicians Contracting Organization of Texas

Committed to patient advocacy.
Quality healthcare. Independent physicians.

August 1, 2009

To All PCOT Providers

Ladies and Gentlemen:

The PCOT's Board of Directors executed a contract with HealthSpring Life & Health Insurance Company, Inc. for the Medicare Advantage Plan.

The summary of contract terms are attached with other pertinent information. Please check the zip code list attached to see if your clinic can be included in this contract. This health plan follows CMS guidelines, but offers patients a broad range of services other than the standard Medicare plan.

Please indicate your practice's plans to participate in this Medicare Advantage Plan by checking one of the boxes below. CMS requires a new participation agreement stating that you will abide by the CMS Federal guidelines. This document must be executed and returned to PCOT with the opt in/out letter. Each physician must execute this agreement to participate in this contract. This response and the CMS participation agreement should be mailed to PCOT, 1310 Doctors Dr. Suite B , Tyler, Texas 75701 or faxed to the attention of Credentialing at 903-526-2320. Your prompt attention to this matter will be appreciated. Please return to the PCOT by September 1, 2009.

Sincerely,

Brenda Shepherd

Brenda Shepherd, MBA, CPC, CPCS
Executive Director

_____ Yes, our practice will accept these fees and all physicians in the practice will participate in the Medicare Advantage contract with HealthSpring Life & Health Insurance Company, Inc..

_____ No, our practice does not wish to participate in the Medicare Advantage contract with HealthSpring Life & Health Insurance Company, Inc..

Date:_____ Practice Name:_____

Authorized Signature:_____

Tax I.D. No._____

Printed Physician Name(s):

1310 Doctor's Drive, Ste. B Tyler, Texas 75701
903-526-3268 or 1-888-248-1907 Fax: 903-526-2320
info@pcot.org www.PCOT.org

		PCOT		
		Contract Review Worksheet		
		Date:	5/1/2009	BLS
		Background Information		**Notes**
	1	Payor Name, Organizational Status	**HealthSpring Life & Health Insurance Company**	
	2	Type of Organization	Medicare Advantage FFS Plan	
	3	Type Product (any ERISA Plans?)	PPO	
	4	Background Due Diligence, OIG Exclusion, TDI	no information found	
	5	Number of covered lives, major employers	bidding for lives in this area; per Federal law contracts/network must be developed prior to offering to Medicare population	
	6	Hospital affiliations	ETMC and all affiliate Hospitals; Good Shepherd; TMF Rehab;	
	7	Laboratory affiliations	Quest; see in-Office Lab list	
	8	Benefit plan description (Covered Services defined)	Medicare Advantage	
	9	Provider procedure manual	yes; online healthspring.com	
			See Formulary	
	10	References/ Notes	www.healthspring.com	
		Terms		**Notes**
**	11	PCOT Agency Status defined	yes	
	12	Each party responsible for their own acts	yes	
		Indemnify and hold harmless	yes	
		Arbitration & mediation non binding	yes	
**	13	No assignment without consent (Silent PPO)	marketed to Medicare population only	
	14	No all products clauses	na	
	15	No marketing w/o consent	yes	
		Medical Necessity/Necessary	Follows Federal Law/ CMS	
**	16	Credentialing delegated	yes	
**	17	Members can not be terminated w/o cause	yes; for non compliance of NCQA or Quality of Care Issues	
**	18	Adequate grievance process	yes	
	19	Modifications must be mutually accepted	yes; except for Federal and State Laws	
**	20	Access and confidentiality reasonable	yes	
	21	Members may charge for requested medical records	yes; follow TMB guidelines	
	22	Governed by Texas Law, Smith Co. preferred	**Dallas County, Texas; (would not amend)**	
**	23	Max liability insurance required 200,000/ 600,000	$200,000/$600,000 minimum	
		General Liability	1M/1M minimum	
**	24	Term: 1 year max	yes	
	25	Auto renewal	yes	
**	26	Termination w/o cause not > 90 days	yes	
	27	Termination Tail reasonable	90 days	
	28	HIPAA language--code sets	yes	
		Billing/ Compensation		**Notes**
	29	Claims processor (payor) identified	Follows Federal Law/ CMS	
**	30	Claims paid < 30 days (or comply with SB 418)	Follows Federal Law/ CMS	
	31	Penalty for non timely payment (Predetermined)	**Must file claims within 95 days from date of services**	
	32	Payment to Non-Physician Providers	yes	
	33	Standard filing form (CMS 1500) acceptable; electronic file	yes	
	34	Right to coordination of benefits payments	yes	
	35	Retroactive adjustments within 90 days	Follows Federal Law/ CMS	
	36	Enrollee identification process specified	yes	
**	37	Complete fee schedule	105% of Medicare for Primary Care Physicians; 100% of Medicare for Specialist Physicians; 100% of Medicare for imaging services performed in the office setting; 100% of Medicare for laboratory services included on the in-office lab carve out list; 80% of Medicare for laboratory services performed within their offices not included on the in-office lab carve out list. (patient can be billed for 20% coinsurance for this category); All % of Medicare is based on Rest of Texas	
		Non Specified	40% off Billed Charges	
		Workers Comp	na	
	38	Fee schedule fixed for contract period	yes; updated annually on April 1st	
	39	Fee schedule review & increase at renewal (auto escalate)	per Medicare guidelines; updated annually on April 1st	
	40	New CPT Code Changes/Updates effective January 1st	per Medicare guidelines	
		Notes		

PROVIDER ACCEPTANCE OF CMS REQUIRED PROVISIONS FOR MEDICARE ADVANTAGE DOWNSTREAM PROVIDER AGREEMENTS

1.1 Compliance with CMS Agreement and Federal Medicare Law. Provider shall comply with any and all requirements in the CMS Agreement which are applicable to Provider as a subcontractor of Medicare Advantage Plan as a result of this Agreement. Provider shall comply with Title XVIII of the Social Security Act and the regulations adopted thereunder by CMS for the Medicare program.

1.2 Prompt Payment. For each Clean Claim submitted by Provider, Medicare Advantage Plan shall pay the amount due to Provider within thirty (30) calendar days following receipt of a Clean Claim by Medicare Advantage Plan.

1.3 Confidentiality of Medical Records. Provider shall establish and maintain procedures and controls so that no information contained in its records or obtained from CMS or from others shall be used by or disclosed by it, its agents, officers, or employees except as provided in Section 1106 of the Social Security Act, as amended, and regulations prescribed thereunder.

1.4 Continuing Care Obligations. In the event of termination of Provider participation with Medicare Advantage Plan for any reason, Provider shall continue to provide Covered Services to Members, including any Members who become eligible during the termination notice period, until the Member is transitioned to another Medicare Advantage Plan Participating Provider.

1.5 Managed Care Program Services, Medicare Advantage Plan Accountability and Provider Cooperation. Consistent with the requirements of State and Federal Law, Medicare Advantage Plan shall be accountable for the performance of the following services for all Managed Care Medicare Advantage Plans: (i) quality management and improvement, (ii) medical management, (iii) credentialing, (iv) Member rights and responsibilities, (v) preventive health services, (vi) medical record review and (vii) payment and processing of claims (collectively, "Managed Care Program Services"). Without limiting the foregoing, Medicare Advantage Plan shall remain accountable to CMS for complying with its obligations under the CMS Agreement. Provider shall cooperate with Medicare Advantage Plan in the performance of all Managed Care Program Services.

1.6 Medical Records. Provider shall maintain all patient medical records relating to Covered Services provided to Members, in such form and containing such information as required by State and Federal Law. Medical records shall be maintained in a manner that is current, detailed, organized and permits effective patient care and quality review by Provider and Medicare Advantage Plan pursuant to State and Federal law. Medical records shall be maintained in a form and physical location which is accessible to Provider, Medicare Advantage Plan and Government Agencies. Provider shall maintain the confidentiality of all Member medical records and treatment information in accordance with State and Federal Law and have procedures in place that specify the purpose for which the information shall be used within Provider' organization and to whom and for what purposes Provider may disclose the information outside of Provider. Medical records shall be retained by Provider for at least ten (10) years following the provision of Covered Services and as required by State and Federal Law. The provisions of this Section shall survive termination of this Agreement for the period of time required by State and Federal Law.

1.7 No Billing of Members. Provider hereby agrees that in no event, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against a Medicare Advantage Plan Member or person, for Covered Services provided.

This provision shall not prohibit collection of deductibles, Copayments, co-insurance and/or non-Covered Services.

1.8 Submission of Data. Provider shall cooperate with Medicare Advantage Plan in submitting to the Secretary of Health and Human Services statistical data pertaining to Provider Services provided by Provider, any other reports the Secretary may reasonably require to carry out its functions under the Medicare Advantage program.

1.9 Term. The provisions of this letter are effective as of the date signed below and shall remain in effect until terminated by Provider with ninety (90) days' written notice to Medicare Advantage Plan.

By signing below, Provider accepts of all terms in this letter and states that Provider is a Medicare Participating Provider. Provider must maintain status as a Medicare Participating Provider in order to participate with Medicare Advantage Plan:

ENTITY NAME: _____

BY: _____

NAME: _____

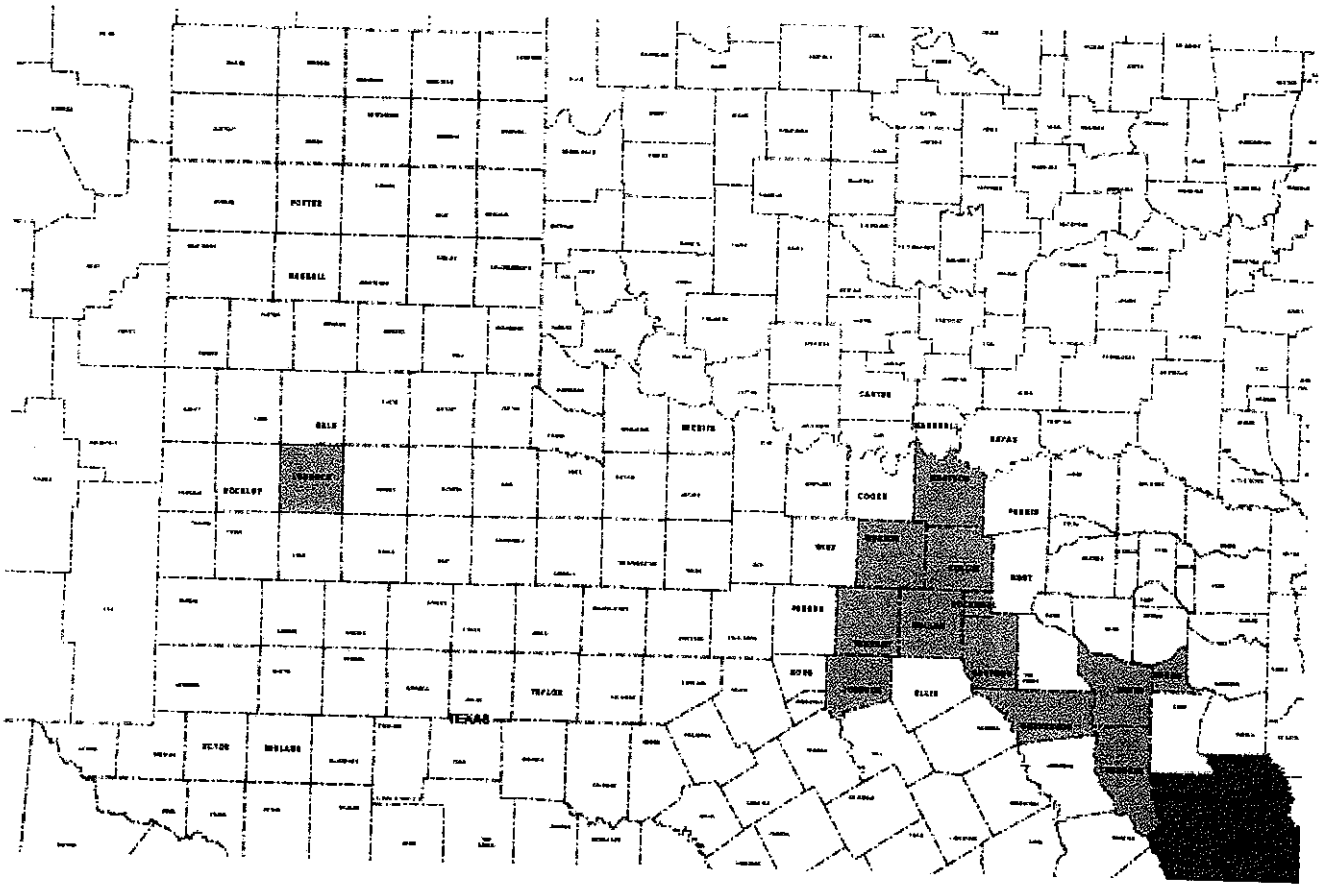
TITLE: _____

ADDRESS: _____

_____

DATE: _____

HEALTHSPRING SERVICE AREA – NORTH TEXAS



13 COUNTIES:

WEST TEXAS – LUBBOCK COUNTY

DFW METROPLEX – COLLIN, DALLAS, DENTON, GRAYSON, JOHNSON, KAUFMAN, ROCKWALL, TARRANT

EAST TEXAS – CHEROKEE, GREGG, HENDERSON, SMITH

In-Office Lab List

Code	Description
36410	Non-routine blood draw > 3 yrs
36415	Routine Venipuncture
81000	urinalysis w/ microscopy
83036 & 83037	Hemoglobin A1C
81001	Urinalysis - automated, with microscopy
81002	Urinalysis W/O microscopy, non-automated
81003	Urinalysis W/O microscopy, automated
81005	Urinalysis, qualitative
81007	Urine screen for bacteria
81025	Urine pregnancy
82009	Acetone or other Ketone bodies
82044	Urine dipstick for micro-albumin
82270	fecal occult
82948	Glucose, blood reagent strip
82962	Glucose blood test
84703	Chorionic gonadotropin assay (pregnancy test)
85007	Blood smear
85013	Spun hematocrit
85014	Other than spun hematocrit
85018	Hemoglobin A1C
85025	CBC
85027	Hemogram and platelet count
85048	WBC
85610	Prothrombin time
85651	Sedimentation rate
86403	Particle agglutination (rapid strep)
86580	TB (Intradermal)
86580	TB (Tine test)
87210	Wet mount-smear, stain and interpretation
87220	KOH-tissue exam for fungi
87804	Influenza
87880	Strep Screen
89320	Semen analysis

Provider will be paid at contracted rate for above codes when performed in office

All other lab can be drawn in office for reimbursement on venipuncture and sent to contracted lab provider, Quest Diagnostics

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Texas HealthSpring Formularies

What is the Texas HealthSpring formulary?

A formulary is a list of drugs selected by Texas HealthSpring in consultation with a team of healthcare providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. To get updated information about the drugs covered by HealthSpring, call Customer Service at 1-800-280-8888, seven days a week, 8 a.m. to 8 p.m. CST. TTY users should call 1-877-893-1504.

If we remove drugs from our formulary, or add prior authorization, quantity limits and/or step therapy restrictions on a drug, or move a drug to a higher cost-sharing tier, we must notify members who take the drug that it will be removed at least 60 days before the date that the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 60-day supply of the drug.

Texas HealthSpring's drug formularies are below. "Abridged" formularies are a partial list of drugs the plans cover. "Comprehensive" formularies are a complete list of approved drugs. You can access either version of our covered list of drugs through the links listed below for each of our plans:

Changes to the HealthSpring Formulary
HealthSpring may add or remove drugs from our formulary during the year. If we remove drugs from our formulary, or add prior authorization, quantity limits and/or step therapy restrictions on a drug and/or move a drug to a higher cost-sharing tier, we will notify you of the change at least 60 days before the date that the change becomes effective. However, if the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary.

View Changes to the HealthSpring Formulary: Click Here

What if my drug is not on the formulary?
For information on how to obtain an exception to the HealthSpring Prescription Drug Plan formulary, contact HealthSpring customer service at 1-866-845-6941 (TTY/TDD users should call 1-866-845-7230, 8 a.m. to 8 p.m., CST, 7 days a week.

2008 Comprehensive formulary for Advantage Plus Rx, Valley Advantage Plus Rx, SpecialCare and TotalCare
2008 Abridged formulary for Advantage Plus Rx, Valley Advantage Plus Rx, SpecialCare and TotalCare
2008 Comprehensive formulary for Healthy Living and OptimaCare
2008 Abridged formulary for Healthy Living and OptimaCare

For more information about the differences between plans, click **here** to view a Summary of Benefits for each plan.

Adobe Acrobat Reader is needed to open PDF files on this page. Download it for free here:
http://www.adobe.com/products/acrobat/readstep2.html

Formulary Exception / Drug Prior Authorization Form: Revised 8.23.06

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RESPONSE TIME:

- Allow up to 3 days for review of prior authorization request.
- If you have questions please call (800) 331-6293.
- If Urgent please see bottom of form.

REMEMBER:
Please consider formulary alternatives before completing this form. Formulary available: **www.myhealthspring.com**

Provider Information		Member (Patient) Information
Provider Name:	Provider Specialty:	**Member Name:**
Office Contact Person:		**HealthSpring ID #:**
Office Phone:	Office Fax:	Date of Birth:

Medication Request

Where will the drug be administered? ☐Patient's home ☐Physician's office ☐Home infusion ☐LTC ☐Assisted living

How will drug be supplied? ☐Retail Pharmacy ☐Specialty Pharmacy ☐Physician's own supply ☐Other: _____

Is the request for an inpatient that is awaiting discharge?

☐Yes ☐No ☐Other, please specify: _____

If this request is for a transplant medication, was the transplant covered by Medicare?

☐Yes ☐No ☐Other, please specify: _____

Requested Medication (please specify drug name, strength, dosing schedule, and duration of therapy):	If the drug is administered intravenously, please check one: ☐Infusion pump ☐Gravity ☐Implanted pump ☐Other, please specify: _____

Diagnosis related to medication request:

Please list all alternatives that have been tried/failed (include drug dose, strength, and trial dates):

Please state medical necessity for requested medication:

Additional information must be submitted to support medical necessity (i.e. office visit notes, relevant lab values, etc.):

X Signature:	**Date:**

Fax Completed Form and ALL Supportive Documentation to:
Fax # (615) 291-7025 or (866) 845-7267

Please Read If Urgent Request: By signing below, I certify that applying the standard 72-hour review time frame **may seriously jeopardize the life or health** of the member or the member's **ability to regain maximum function:**
Signature:

If urgent (see explanation above): Fax completed form and supportive documentation to: (615) 234-6789 or (866) 593-4407.

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2009 Summary of Benefits

All Plans

	NTX Healthy Advantage Plus Rx #001		NTX Healthy Advantage #002		NTX Healthy Advantage Premier #003	
	In-Network	Out-of Network	In-Network	Out-of Network	In-Network	Out-of Network
Medical Monthly Premium	$0	$0	$0	$0	$35.00	$0
Part B Reduction	N/A	N/A	$39.00	N/A	N/A	N/A
Annual Deductible	$0	$500	$0	$500	$0	$500
Max OOP	$3,000 Medicare covered benefits – Including routine eye exams & eye wear	$9,000 out-of-pocket limit for Medicare-covered benefits – Including routine eye exams & eye wear	$3,000 Medicare covered benefits – Including routine eye exams & eye wear	$9,000 out-of-pocket limit for Medicare-covered benefits – Including routine eye exams & eye wear	$3,000 Medicare covered benefits – Including routine eye exams, eye wear, routine hearing exams, & aids	$9,000 out-of-pocket limit for Medicare-covered benefits – Including routine eye exams, eye wear, routine hearing exams, & aids

	NTX Healthy Advantage Plus Rx #001		NTX Healthy Advantage #002		NTX Healthy Advantage Premier #003	
Inpatient Care Services						
	In-Network	**Out-of Network**	**In-Network**	**Out-of Network**	**In-Network**	**Out-of Network**
Inpatient Hospital Facility	$75 each day for day(s) 1-5 $0 each day for days 6-90 for Medicare-covered stay at a network hospital.	Deductible + 20% of Medicare covered hospital stay.	$75 each day for day(s) 1-5 $0 each day for days 6-90 for Medicare-covered stay at a network hospital.	Deductible + 20% of Medicare covered hospital stay.	$75 each day for day(s) 1-5 $0 each day for days 6-90 for Medicare covered stay at a network hospital.	Deductible + 20% of Medicare covered hospital stay.
Inpatient Mental Health Care	20% of the cost for Medicare-covered stay at a network hospital.	Deductible + 20% of the cost for each Medicare-covered stay.	20% of the cost for Medicare-covered stay at a network hospital.	Deductible + 20% of the cost For each hospital stay. Medicare-covered stay.	20% of the cost for each hospital stay20% of the cost for Medicare-covered stay at a network hospital.	Deductible + 20% of the cost for each hospital stay. Medicare-covered stay.
Skilled Nursing Facility (SNF)	$0 each day for day(s) 1-20 $100 each day for days 21-100 for a stay in a Skilled Nursing Facility	Deductible + 20% of the cost for each SNF stay	$0 each day for day(s) 1-20 $100 each day for days 21-100 for a stay in a Skilled Nursing Facility	Deductible + 20% of the cost for each SNF Stay	$0 each day for day(s) 1-20 $100 each day for days 21-100 for a stay in a Skilled Nursing Facility	Deductible + 20% of the cost for each SNF Stay
Long Term Acute Care Facility (LTAC)	$500 Per Admission	Deductible + 20% of the cost for Long Term Acute care	$500 Per Admission	Deductible + 20% of the cost for Long Term Acute care	$500 Per Admission	Deductible + 20% Of the cost for Long Term Acute Care
Outpatient Care Services						
PCP Office Visit	$5 copay	$20 copay +deductible	$5 copay	$20 copay +deductible	$0 copay	$20 copay +deductible
Specialist Office Visit	$25 copay	$40 copay +deductible	$25 copay	$40 copay +deductible	$25 copay	$40 copay +deductible
Lab and X-Rays	$0-20% of the cost Medicare-covered lab Services	Deductible + 20% of the cost for Medicare-Covered Diagnostic procedures and test	$0-20% of the cost Medicare-covered lab Services	Deductible + 20% of the cost for Medicare-covered Diagnostic procedures and test	$0-20% of the cost Medicare-covered lab Services	Deductible + 20% of the cost for Medicare covered Diagnostic procedures and test

	NTX Healthy Advantage Plus Rx #001		NTX Healthy Advantage #002		NTX Healthy Advantage Premier #003	
Outpatient Care Services						
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
CT Scan, MRI,Cardiac/ Nuclear Medicine	20% of the cost Medicare-covered lab Services	Deductible + 20%of the cost for Medicare-covered Diagnostic procedures and test	20% of the cost Medicare-covered lab Services	Deductible + 20%of the cost for Medicare-covered Diagnostic procedures and test	20% of the cost Medicare-covered lab Services	Deductible + 20%of the cost for Medicare-covered Diagnostic procedures and test
PET Scan	20% of the cost Medicare-covered lab Services	Deductible + 20%of the cost for Medicare-covered Diagnostic procedures and test	20% of the cost Medicare-covered lab Services	Deductible + 20%of the cost for Medicare-covered Diagnostic procedures and test	20% of the cost Medicare-covered lab Services	Deductible + 20%of the cost for Medicare-covered Diagnostic procedures and test
Outpatient Services and/or Surgery	$75 copay for each Medicare-Covered ambulatory surgical center visit. $85 copay for each Medicare covered outpatient hospital facility visit.	Deductible + 20% of the cost for Medicare-Covered ambulatory surgical center visit. 20% of the cost for Medicare-Covered outpatient hospital facility visit.	$75 copay for each Medicare-Covered ambulatory surgical center visit or Medicare covered outpatient hospital facility visit.	Deductible + 20% of the cost for Medicare-Covered ambulatory surgical center visit. 20% of the cost for Medicare-Covered outpatient hospital facility visit.	$75 copay for each Medicare-Covered ambulatory surgical center visit or Medicare covered outpatient hospital facility visit.	Deductible + 20% of the cost for Medicare-Covered ambulatory surgical center visit. 20% of the cost for Medicare-Covered outpatient hospital facility visit.
Radiation Therapy	20% of the cost for Medicare-covered Therapeutic radiology Services.	Deductible + 20% of the cost for Medicare-covered Therapeutic Radiology Services.	20% of the cost for Medicare-covered Therapeutic radiology Services.	Deductible + 20% of the cost for Medicare-covered Therapeutic Radiology Services.	20% of the cost for Medicare-covered Therapeutic radiology Services.	Deductible + 20% of the cost for Medicare-covered Therapeutic Radiology Services.
Outpatient Rehabilitation Services (PT, OT, etc)	$25 copay for Medicare Covered Occupational Therapy visits. $25 copay for Medicare Covered Physical and/or Speech/Language Therapy visits.	Deductible + $40 copay for Medicare Covered Occupational Therapy visits. Deductible + $40 copay for Medicare Covered Physical and/or Speech/ Language Therapy visits.	$25 copay for Medicare Covered Occupational Therapy visits. $25 copay for Medicare Covered Physical and/or Speech/Language Therapy visits.	Deductible + $40 copay for Medicare Covered Occupational Therapy visits. Deductible + $40 copay for Medicare Covered Physical and/or Speech/ Language Therapy visits.	$25 copay for Medicare Covered Occupational Therapy visits. $25 copay for Medicare Covered Physical and/or Speech/Language Therapy visits.	Deductible + $40 copay for Medicare Covered Occupational Therapy visits. Deductible + $40 copay for Medicare Covered Physical and/or Speech/ Language Therapy visits.
Medicare-Covered Drugs & Biologicals (chemotherapy drugs, allergy serums, etc.)	20% of the cost for Part B covered drugs $1,000 Maximum Out-of-Pocket for In-Network Part B Drugs	Deductible + 40% of the cost for Part B covered drugs	20% of the cost for Part B covered drugs $1,000 Maximum Out-of-Pocket for In-Network Part B Drugs	Deductible + 40% of the cost for Part B covered drugs	20% of the cost for Part B covered drugs $1,000 Maximum Out-of-Pocket for In-Network Part B Drugs	Deductible + 40% of the cost for Part B covered drugs

	NTX Healthy Advantage Plus Rx #001		NTX Healthy Advantage #002		NTX Healthy Advantage Premier #002	
Outpatient Care Services						
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Home Health Care	$0 copay for Medicare-covered home health visit	Deductible + 20 % for Medicare-covered home health Visits	$0 copay for Medicare-covered home health visit	Deductible + 20 % for Medicare-covered home health Visits	$0 copay for Medicare covered home health visit	Deductible + 20 % for Medicare-covered home health Visits
DME, Prosthetics, and Medical Supplies	20% of the cost for Medicare covered items.	Deductible + 20% of the cost for Medicare-covered prosthetic devices	20% of the cost for Medicare covered items	Deductible + 20% of the cost for Medicare-covered prosthetic devices	20% of the cost for Medicare covered items.	Deductible + 20% of the cost for Medicare-covered prosthetic devices
Renal Dialysis	20% of the cost for renal dialysis $25 copay for Nutrition Therapy for End-Stage Renal Disease.	Deductible + 20% of the cost for renal dialysis Deductible + 20% of the cost for Nutrition Therapy for End-Stage Renal Disease.	20% of the cost for renal dialysis $25 copay for Nutrition Therapy for End-Stage Renal Disease	Deductible + 20% of the cost for renal dialysis 20% of the cost for Nutrition Therapy for End-Stage Renal Disease.	20% of the cost for renal dialysis $25 copay for Nutrition Therapy for End-Stage Renal Disease.	Deductible + 20% of the cost for renal dialysis Deductible + 20% of the cost for Nutrition Therapy for End-Stage Renal Disease.
Diabetic Self Monitoring Training and Supplies	$5 to $25 copay for Diabetes self monitoring training. 0% to 10% of the cost for Diabetes supplies.	Deductible + 20% of the cost for Diabetes self monitoring training. Deductible + 20% of the cost for Diabetes supplies.	$5 to $25 copay for Diabetes self monitoring training. 0% to 10% of the cost for Diabetes supplies	Deductible + 20% of the cost for Diabetes self monitoring training. Deductible + 20% of the cost for Diabetes supplies	$0 to $25 copay for Diabetes self monitoring training. 0% to 10% of the cost for Diabetes supplies.	Deductible + 20% of the cost for Diabetes self monitoring training. Deductible + 20% of the cost for Diabetes supplies.
Nutrition Therapy For Diabetes	$5-$25 copay for Nutrition Therapy For Diabetes	Deductible + 20% of the cost for Nutrition Therapy for Diabetes	$5-$25 copay for Nutrition Therapy For Diabetes	Deductible + 20% of the cost for Nutrition Therapy for Diabetes	$0-$25 copay for Nutrition Therapy For Diabetes	Deductible + 20% of the cost for Nutrition Therapy for Diabetes
Chiropractic Services	$25 copay for Medicare-covered Visit.	Deductible + $40 copay For Medicare-covered Chiropractic benefits.	$25 copay for Medicare-covered Visit.	Deductible + $40 copay For Medicare-covered Chiropractic benefits.	$25 copay for Medicare-covered Visit.	Deductible + $40 co-pay for Medicare-covered Chiropractic Benefits
Podiatry Services	$25 copay for Medicare-covered Visit.	Deductible + $40 copay for Medicare-covered Podiatry Benefits	$25 copay for Medicare-covered Visit	Deductible + $40 copay for Medicare-covered Podiatry Benefits	$25 copay for Medicare-covered Visit	Deductible + $40 copay for Medicare-covered Podiatry Benefits
Substance Abuse Care	$25 copay for Medicare-covered individual or group Visits	Deductible + $40 copay for Medicare-covered substance abuse benefits	$25 copay for Medicare-covered individual or group visits	Deductible + $40 copay for Medicare-covered substance abuse benefits	$25 copay for Medicare-covered individual or group Visits	Deductible + $40 copay for Medicare-covered substance abuse benefits

	NTX Healthy Advantage Plus Rx #001		NTX Healthy Advantage #002		NTX Healthy Advantage Premier #003	
Preventive Health Services						
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Routine Physical Exam Limited to 1 exam every year.	$5 or $25 copay for routine exams.	Deductible + $20 copay for PCP visit Deductible + $40 copay for Specialist	$5 or $25 copay for routine exams.	Deductible + $20 copay for PCP visit Deductible + $40 copay for specialist	$5 or $25 copay for routine exams.	Deductible + $20 copay for PCP visit Deductible + $40 copay for specialist
Bone Mass Mensurement	$0 copay for Medicare-covered bone mass measurement.	Deductible + 20% of the cost for Medicare Covered bone mass measurement.	$0 copay for Medicare-covered bone mass measurement.	Deductible + 20% of the cost for Medicare Covered bone mass measurement.	$0 copay for Medicare-covered bone mass measurement.	Deductible + 20% of the cost for Medicare Covered bone mass measurement
Colorectal Screening Diagnostic Screening or Surgical Procedure (limit one per year)	$75 copay for Medicare-covered colorectal screenings	Deductible + 20% of the cost for Medicare-covered colorectal screenings.	$75 copay for Medicare-covered colorectal screenings	Deductible + 20% of the cost for Medicare-covered colorectal screenings.	$75 copay for Medicare-covered colorectal screenings	Deductible + 20% of the cost for Medicare-covered colorectal screenings
Immunizations (Flu, Pneumonia, and Hepatitis B vaccine)	$0 copay	Deductible + 20% of the cost for immunizations	$0 copay	Deductible + 20% of the cost for immunizations	$0 copay	Deductible + 20% of the cost for immunizations
Mammogram (annual screening)	$0 copay	Deductible + 20% of the cost for screening mammograms.	$0 copay	Deductible + 20% of the cost for screening mammograms	$0 copay	Deductible + 20% of the cost for screening mammograms
Pap Smear and Pelvic Exam (Services may be accessed through the PCP or OBGyn)	$0 copay	Deductible + 20% of the cost for Pap Smears and Pelvic Exams.	$0 copay	Deductible + 20% of the cost for Pap Smears and Pelvic Exams	$0 copay	Deductible + 20% of the cost for Pap Smears and Pelvic Exams

	NTX Healthy Advantage Plus Rx #001		NTX Healthy Advantage #002		NTX Healthy Advantage Premier #003	
Preventive Health Services						
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Prostate Screening Exam	$0 copay for Medicare-covered Prostate cancer screening.	Deductible + 20% of the cost for Medicare-covered Prostate cancer screening.	$0 copay for Medicare-covered Prostate cancer screening	Deductible + 20% of the cost for Medicare-covered Prostate cancer screening.	$0 copay for Medicare-covered Prostate cancer screening	Deductible + 20% of the cost for Medicare-covered Prostate cancer Screening
Vision	$0 copay for one pair of eyeglasses or contact lenses after **Cataract surgery** • Up to 1 pair of glasses every year • Up to 1 pair of contacts every year $25 copay for exams to diagnose and treat disease and condition of the eye. $25 copay for up to 1 routine eye exam every year. **$100 limit on eyewear per 2 years**	$40 copay + deductible for exams to diagnose and treat disease and condition of the eye. $40 copay for up to 1 routine eye exam every year. Deductible + 20% of the cost for eye wear.	$0 copay for one pair of eyeglasses or contact lenses after **Cataract surgery** • Up to 1 pair of glasses every year • Up to 1 pair of contacts every year $25 copay for exams to diagnose and treat disease and condition of the eye. $25 copay for up to 1 routine eye exam every year. **$100 limit on eyewear per year**	$40 copay + Deductible for exams to diagnose and treat disease and condition of the eye. $40 copay for up to 1 routine eye exam every year Deductible + 20% of the cost for eye wear.	$0 copay for one pair of eyeglasses or contact lenses after **Cataract surgery** • Up to 1 pair of glasses every year • Up to 1 pair of contacts every year $25 copay for exams to diagnose and treat disease and condition of the eye. $25 copay for up to 1 routine eye exam every year. **$150 limit on eyewear per year**	$40 copay + deductible for exams to diagnose and treat disease and condition of the eye. $40 copay for up to 1 routine eye exam every year Deductible + 20% of the cost for eye wear.

	NTX Healthy Advantage Plus Rx #001		NTX Healthy Advantage #002		NTX Healthy Advantage Premier #003	
Emergency / Urgent Care						
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Hearing	$25 copay for Medicare covered diagnostic hearing exams. Routine hearing exams and hear aids NOT COVERED	Deductible + $40 copay for Medicare hearing exams.	$25 copay for Medicare covered diagnostic hearing exams. Routine hearing exams and hear aids NOT COVERED	Deductible + $40 copay for Medicare hearing exams.	$25 copay for Medicare covered diagnostic hearing exams. $0 copay for up to 1 routine hearing exam every year. $500 Allowance limit for hearing aids every two years	Deductible + $40 copay for Medicare hearing exams. $40 copay for up to 1 routine hearing exam every year. $500 Allowance limit for hearing aids every two years
Ambulance Services	$100 copay for Medicare-covered ambulance benefits $0 copay if admitted to the hospital	$100 copay for Medicare-covered ambulance benefits Deductible + 20% of the cost for Medicare-covered ambulance benefits if not an emergency	$100 copay for Medicare-covered ambulance benefits $0 copay if admitted to the hospital	$100 copay for Medicare-covered ambulance benefits Deductible + 20% of the cost for Medicare-covered ambulance benefits if not an emergency	$100 copay for Medicare-covered ambulance benefits $0 copay if admitted to the hospital	$100 copay for Medicare-covered ambulance benefits Deductible + 20% of the cost for Medicare-covered ambulance benefits if not an emergency
Emergency Care Services	$50 copay for Medicare-covered emergency room visit $0 copay if admitted to the hospital with in 3 days for the same condition.	$50 copay for Medicare-covered emergency room visit Not covered outside the U.S. except under limited circumstances. Contact the plan for more details. $0 copay if admitted to the hospital with in 3 days for the same condition	$50 copay for Medicare-covered emergency room visit $0 copay if admitted to the hospital with in 3 days for the same condition.	$50 copay for Medicare-covered emergency room visit Not covered outside the U.S. except under limited circumstances. Contact the plan for more details. $0 copay if admitted to the hospital with in 3 days for the same condition	$50 copay for Medicare-covered emergency room visit $0 copay if admitted to the hospital with in 3 days for the same condition.	$50 copay for Medicare-covered emergency room visit Not covered outside the U.S. except under limited circumstances. Contact the plan for more details. $0 copay if admitted to the hospital with in 3 days for the same condition
Urgent Care Services	$25 copay for Medicare covered urgently needed care visits.	$25 co pay for Medicare covered urgently needed care visits.	$25 copay for Medicare covered urgently needed care visits.	$25 co pay for Medicare covered urgently needed care visits.	$25 copay for Medicare covered urgently needed care visits.	$25 co pay for Medicare covered urgently needed care visits.

	NTX Healthy Advantage Plus Rx #001		NTX Healthy Advantage #002		NTX Healthy Advantage Premier #003	
Additional Benefits						
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Transportation (non-emergent Transportation)	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	$0 copay for up to 15 one way trips to plan-approved location every year.	Reimburse up to $5.00 Max toward Taxi Ride to plan approved location. Must Provide proof of ride.
Silver Sneakers® Program	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	$0 copay	STEPS Program
Smoking Cessation	$5 -25 co pay In PCP or Specialist office	Deductible + $20 non-specialist office or $40 specialist office	$5 -25 co pay In PCP or Specialist office	Deductible + $20 non-specialist office or $40 specialist office	$5 -25 co pay In PCP or Specialist office	Deductible + $20 non-specialist office or $40 specialist office
Dental Services	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	$0 copay up to $1,000 maximum limit for preventive and comprehensive dental benefits every year. First dollar coverage.	50% cost share up to $1,000 maximum limit for preventive and comprehensive dental benefits every year. First dollar coverage.

	NTX Healthy Advantage Plus Rx PPO#001	NTX Healthy Advantage PPO#002	NTX Healthy Advantage Premier PPO#003
Part D - Prescription Drug Benefits Note: People who have limited or low incomes may have different out of pocket drug costs. Contact plan for details.			
Product Type	**Core Plan Formulary 3 (9051)**	**Core Plan without Rx**	**Premier Formulary 6 (9053)**
Premium	**$0**	**$0**	**$0**
Deductible	**$0**	**$0**	**$0**
Initial Coverage Retail Pharmacy & Mail Order	Until you reach **$2700** after your total yearly drug costs per year, you pay:	N/C	Until you reach **$2700** after your total yearly drug costs per year you pay.

	NTX Healthy Advantage Plus Rx PPO#001	NTX Healthy Advantage PPO#002	NTX Healthy Advantage Premier PPO#003
Part D - Prescription Drug Benefits Note: People who have limited or low incomes may have different out of pocket drug costs. Contact plan for details.			
Preferred Generic Tier 1	$0 copay for a one- month (30-day) Supply $0 copay for a three month (90-days)supply and mail order.	N/C	$0 copay for a one- month (30-day) Supply $0 copay for a three month (90-days)supply and mail order.
Preferred Generic Tier 2	$5 copay for one-month (30-days) supply. $15 copay for a three month (90-days)supply and mail order. Generics are covered through the Gap	N/C	$4 copay for one-month (30-days) supply. $12 copay for a three month (90-days)supply and mail order. Generics are covered through the Gap

	NTX Healthy Advantage Plus Rx PPO#001	NTX Healthy Advantage PPO#002	NTX Healthy Advantage Premier PPO#003
Preferred Brand Tier 3	$30 copay for a one-month (30-day) supply $90 copay for a three-month (90-day) supply (Retail & Mail Order	N/C	$30 copay for a one-month (30-day) supply $90 copay for a three-month (90-day) supply (Retail & Mail Order

	NTX Healthy Advantage Plus Rx PPO#001	NTX Healthy Advantage PPO#002	NTX Healthy Advantage Premier PPO#003
Non-Preferred Tier 4	$60 copay for a one-month (30-day) supply $180 copay for a three-month (90-day) supply (Retail & Mail Order)	N/C	$60 copay for a one-month (30-day) supply $180 copay for a three-month (90-day) supply (Retail & Mail Order)
Specialty Drugs Tier 5	33% coinsurance for a one-month (30-day) supply 33% coinsurance For a three-month (90-day) supply (Retail & Mail Order)	N/C	33% coinsurance for a one-month (30-day) supply 33% coinsurance For a three-month (90-day) supply (Retail & Mail Order)

	NTX Healthy Advantage Plus Rx PPO#001	NTX Healthy Advantage PPO#002	NTX Healthy Advantage Premier PPO#003
Coverage Gap *Doughnut Hole (GAP) (*Includes all drugs In Preferred Generic Tier's 1 & 2	The plan covers Generic Tier 1&2 Thru the gap.*	N/C	The plan covers Generic Tier 1&2 Thru the gap.* Generics covered through gap except for brand name drugs at the generic copay
Catastrophic Coverage	After your yearly out-of-pocket drugs costs reach **$4,350,** you pay the greater of: - $2.40 copay for generic (including brand drugs treated as generic) and - $6.00 copay for all other drugs, or - 5% coinsurance	N/C	After your yearly out-of-pocket drugs costs reach **$4,350,** you pay the greater of: - $2.40 copay for generic (including brand drugs treated as generic) and - $6.00 copay for all other drugs, or - 5% coinsurance

URC APPROVAL NEEDED

HEALTHSPRING PRIOR AUTHORIZATION FORM

Utilization Review Committee (URC) approval required.
Services performed by specialist that lack
this approval may be considered as out of network benefits.

Must include authorization number obtained from Health Services to be considered valid:

_____

Patient Information:

Name_____ Date of Birth _____ Phone_____
ID #_____ Effective Date _____
Other Insurance: ❑ Primary ❑ Secondary ❑ Workers' Comp ❑ Other_____
Date of Referral_____ Expiration Date *(60 days after request)*_____

To be Completed by the Primary Care Physician/Referring Provider:

PCP/Referring provider _____ Phone_____
Referred to_____ Phone_____
Date Last Seen for This Dx_____ Provisional Dx_____ Code: _____

PT HX - DURATION, SYMPTOMS, PREVIOUS CONSULTS (ATTACHED ❑) (NA ❑)

DATES & RESULTS OF LAB/X-RAY REPORTS (ATTACHED ❑) (NA ❑)

PREVIOUS TX (MEDS) AND RESPONSE (NA ❑) _____

❑ Physician Request for: ❑2nd. Opinion ❑Consult Only ❑Consult & Tx ❑Follow-up Total Visits Authorized_
❑ Out of Network; Reason for OON_____
❑ Special Procedure/Therapy/Other_____Facility_____
(Specify)

❑ Patient Request for Above

Referring Physician Signature_____ Date_____
❑ Approved ❑ Redirect ❑ Denied Med. Dir. Signature_____Date_____

To Be Completed by the Specialist/Referred to Provider:

Findings_____

Procedures Performed_____
Recommended Tx Plan_____

Request for Additional Visits_____ Specialist Signature_____ Date_____

NOTE: TREATMENT IS AUTHORIZED AS STATED ABOVE. FURTHER SERVICE WILL NOT BE COVERED UNLESS PRIOR AUTHORIZATION IS GIVEN. UNAUTHORIZED CARE IS THE RESPONSIBILITY OF THE MEMBER.

105 Decker Court, Suite 105 Irving, TX 75062
Toll Free Phone: 866-214-5123 Toll Free Fax: 888-856-3969

White/Referred To Provider – Yellow/Completed Report To Originator – Pink/THS Copy – Goldenrod/Referring Provider

HealthSpring Referral & PRIOR Authorization (PA) Policy
As always, it is the responsibility of each HealthSpring provider to obtain referrals to the Specialist and Prior Authorizations **BEFORE** services are rendered. Primary Care Physicians must refer HealthSpring members to Participating Specialists. It is the responsibility of the provider who renders care to **VERIFY** that a referral and/or Prior Authorization number was granted **BEFORE** treating a HealthSpring member.

It is absolutely essential that members are directed to in-network providers only, when possible. Refer to our online directory www.healthspring.com or contact **Provider Customer Service, toll-free phone: (888) 501-1141 for assistance.**

IMPORTANT:
In accordance with HealthSpring policy, retrospective requests for referrals and authorizations will NOT be accepted

HealthSpring values the PCP's role in directing the care of members to the appropriate, participating Specialist. Participating Specialists are contracted to work closely with our referring PCPs to enhance the quality and continuity of care provided to our members.

To assist you and your staff, always refer to the HealthSpring Prior Authorization List to determine if a procedure or service requires Prior Authorization, or is not a covered benefit by the plan.

HEALTHSPRING'S REFERRAL & PRIOR AUTHORIZATION (PA) LIST:

REQUEST..... Prior Authorization BEFORE services requiring Prior Authorizations are rendered: FAX PA Form to Health Services to FAX (888) 856-3969 or PH (866)214-5123, Mon-Fri, 8am-5pm CST.

VERIFY..... a Prior Authorization number has been granted BEFORE any service is rendered. In accordance with HealthSpring policy, retrospective requests for referrals and authorizations will NOT be accepted.

IMPORTANT..... Prior Authorization and/or Referral Number(s) is/are not a guarantee of benefits or payment at the time of service.

PROCEDURES and SERVICES	No Referral Required	IVR Referral Required	Prior Auth. Required	Not A Covered Benefit	COMMENTS
Admissions			✓		**Hospital** → Yes, Prior Auth required. **LTAC** → Yes, Prior Auth required **Rehabilitation** → Yes, Prior Auth required. **Skilled Nursing Facility** → Yes, Prior Auth required.
Allergy	✓				
Allergy Injections (w/o MD visits)	✓				
Allergy Serum	✓				
Allergy Testing	✓				
Ambulance: Air or Ground	**SEE COMMENT →**				**NON-emergent transports** → Yes, Prior Auth requi **Emergent transports** → Prior Auth not require
Angioplasty / Cardiac Catheterization / Stents (cardiac and renal)	**SEE COMMENT →**				**Inpatient** required → **Yes**, Prior Auth **Outpatient** required → Yes, Prior Auth
Arteriogram/Angiogram			✓		Facility Authorization is required
Audiogram	✓				
Behavioral Health			✓		
Biopsy	**SEE COMMENT →**				**In- office** → **Prior Auth not required** Outpatient Hospital or Freestanding Facility → **Yes, Prior Auth required**
Bone Density Studies	✓				
Bronchoscopy			✓		

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IMPORTANT..... Prior Authorization and/or Referral Number(s) is/are not a guarantee of benefits or payment at the time of service.

PROCEDURES and SERVICES	No Referral Required	IVR Referral Required	Prior Auth. Required	Not A Covered Benefit	COMMENTS
Cardiac Rehabilitation	✓	See Comment →			First five (5) Visits → **Prior Auth not required** **Additional Visits** → **Yes, Prior Auth required**
Cardiac Monitoring	SEE COMMENT →				**Cardiac Event Monitors** → Yes, Prior Auth required. **24-hour Holter Monitor** → Prior Auth not required. **Pacemaker Checks (including telephonic)** → Prior Auth not required.
Cardiac Surgery		✓			
Cardiology		✓			
Cardioversion			✓		
Chemotherapy Agents & Biologicals			✓	SEE COMMENT →	**For chemotherapy → Only a Referral to the Specialist is required. Prior Authorization is required for the Course of Treatment.** **IMPORTANT → "Off-label" use of drugs requires Prior Authorization.** HealthSpring follows Medicare diagnosis guidelines for indications **utilizing chemotherapy. Clinical trials that are sponsored by the National Institutes of Health (NIH) or other federal agencies, and recognized by Medicare (CMS) must be billed directly to Medicare.** Therapies that are NOT registered with Medicare are not covered benefits.
Chiropractic Services		✓			
Compression Hosiery			✓		DME Service
CT Scan: Fast (EBCT)	SEE COMMENT →				All medically necessary CTs are covered and require Prior Authorization. **IMPORTANT: Fast CTs (EBCT)** is NOT a covered benefit by Medicare when screening for CAD in asymptomatic patients.
CT Scans: 64-slice	SEE COMMENT →				All medically necessary CTs are covered and require Prior Authorization. **IMPORTANT: 64-slice CTs** are NOT a covered benefit by Medicare when screening for CAD in asymptomatic patients.
CT / CTA Scans: All modalities	SEE COMMENT →				All medically necessary CTs are covered and require Prior Authorization. **IMPORTANT: CT / CTAs** are NOT covered benefits by Medicare when screening for CAD in asymptomatic patients.
Dermatology	✓				
Diabetic Education	✓				NO Prior Authorization required.
Diabetic Supplies	✓				Must be provided through the Pharmacy or Mail Order
Dialysis	SEE COMMENT →				**In-home** → **Yes**, Prior Auth required. **Outpatient or Free-standing Facility** → Notification is required (phone call to precert line)

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PROCEDURES and SERVICES	No Referral Required	IVR Referral Required	Prior Auth. Required	Not A Covered Benefit	COMMENTS
Discogram	✓				
Doppler / Duplex Studies	✓				
Durable Medical Equipment: Includes wheelchairs and scooters	SEE COMMENT →				**In Office DME:** ▪ **DME provided in office setting with billed charges, per DME line, of less than $150 does NOT require authorization.** **Prior Authorization is Required For:** • All rental DME • All orthotics and prosthetics • All repairs to DME, orthotics and prosthetics • Any DME greater than $150 billed charges
Echocardiogram	✓				
Electrocardiogram (EKG)	✓				
Electrocephalgram (EEG)	✓				
Endocrinology		✓			
EP (Electrophysiology)			✓		
Endoscopy	SEE COMMENT →				**Capsule Endoscopy** → **Yes**, Prior Auth required. **Cystometry** → Prior Auth not required. **Cystoscopy** → Prior Auth not required. **Colonoscopy** → Prior Auth not required.
EMG (Electromyography)	✓				
Emergency Room Visit	✓				PCP must notify HealthSpring of referral to ER.
Epidural Injections	✓				Must have referral to Specialist.
Flex Sigmoidoscopy	✓				
Gastroenterology		✓			
General Surgeon		✓			
Hemodialysis	✓				
Holter Monitors (24-Hour)	✓				
Home Health Care			✓		All services **PROVIDED IN THE HOME** → REQUIRE Prior Authorization.
Home Infusion			✓		
Hospice				✓	Member reverts back to Medicare for Hospice Services HealthSpring would be responsible for value added services.
Hyperbaric Oxygen Treatments			✓		
Imaging (X-ray, Ultrasound, Bone Density, Doppler)	✓				
Immunizations (Pneumonic Flu)	✓				
Infectious Disease		✓			
Infusion Therapy			✓		

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VERIFY..... a Prior Authorization number has been granted BEFORE any service is rendered. In accordance with HealthSpring policy, retrospective requests for referrals and authorizations will NOT be accepted.

IMPORTANT..... Prior Authorization and/or Referral Number(s) is/are not a guarantee of benefits or payment at the time of service.

PROCEDURES and SERVICES	No Referral Required	IVR Referral Required	Prior Auth. Required	Not A Covered Benefit	COMMENTS
Inpatient Admissions			✓		**Prior Authorization is required for all elective, pre-arranged and DIRECT inpatient admissions:** The hospital must contact HealthSpring within 48 hours of a regular business day of the patient's admission to provide updates and status of the patient. HealthSpring may require updates of the patient's medical information weekly or more frequently, dependent upon the patient's condition. ★ **REMINDER** - HealthSpring **DOES NOT REQUIRE the 3-day qualifying hospital stay** in order to for a member to be admitted into a nursing home/skilled nursing facility.
Labs	**SEE COMMENT →**				**In-Home Labs** → Yes, Prior Auth required. **In-Office / Facility Labs** → Prior Auth not required. **PCPS & SPECIALISTS→ IN-OFFICE LABS:** **All Medicare Advantage labs MUST BE SENT TO QUEST DIAGNOSTICS.** Except for those labs listed on the "In Office Lab Exception List." Claims will be subject to OON benefit if they are sent to a NON-Quest provider or hospital.
LEEP (Loop Electrocautery Excision Procedure)	✓				
Lithotripsy			✓		
Mammogram, Screening	**SEE COMMENT →**				Members may Self-Refer
Mental Health/Substance Abuse			✓		Refer all authorization requests for mental health to **HealthSpring Behavioral Health, toll-free: 866-780-8546 (TTY 866-851-1252).**
MRA: All modalities			✓		Prior Authorization required for both PCP & Specialists
MRI: All modalities			✓		Prior Authorization required for both PCP & Specialists.
Myelogram	✓				
Neurodiagnostic Testing	**SEE COMMENTS →**				In-Office Testing → Prior Auth not required Outpatient Testing → Yes, Prior Auth required
Nephrology		✓			
Neurology		✓			
Nuclear Cardiac Studies (including Stress Cardiolyte)	**PCPS: SEE COMMENT →** **SPECIALISTS: No Auth Required.**				PCPs may order/perform nuclear cardiac studies **WITH A PRIOR AUTHORIZATION.** These tests include, *but are not limited to:* Cardio-lite, Sestamibi, Thallium, Persantine Thallium, Adenosine, Adenosine-Thallium.
Nuclear Medicine			✓		
Nutritional Counseling	✓				
OB/Gyn	✓				

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IMPORTANT..... Prior Authorization and/or Referral Number(s) is/are not a guarantee of benefits or payment at the time of service.

PROCEDURES and SERVICES	No Referral Required	IVR Referral Required	Prior Auth. Required	Not A Covered Benefit	COMMENTS
Observation: 23-48 hour	SEE COMMENT →				**OBSERVATION:** 23-48 hour observation Requires Prior Authorization. **If surgery is performed during an observation period:** Prior Authorization is required for the outpatient surgery. **If admitted** → Must pre-certify admission.
Occupational Therapy		✓	SEE COMMENT →		**Outpatient OT → Visits 1-6 require IVR Referral Number.** Treatment **beyond the sixth (6th)** **therapy session** requires Prior Authorization. **In-Home OT** → Requires Prior Authorization before treatment can begin.
Oncology		✓			
Ophthalmology		✓			
Ophthalmology – Diabetic Eye Exam	✓				Diabetic Glaucoma Screeings performed in an ophthalmology office does not require a referral.
Orthognathic / Oral Surgery			✓		In-Office Procedures → Prior Auth not required
Orthopedics		✓			
Orthotics / Prothetics			✓		**Prior Authorization is Required For:** • All rental DME requires Prior Authorization. • All orthotics and prosthetics require Prior Authorization. • All repairs to DME, orthotics and prosthetics require Prior Authorization.
Ostomy Supplies (Disposable)	SEE COMMENT →				All supplies **with billed charges, per line item, greater than $150** require Prior Authorization. See DME Guidelines
Out of Network Services (Non-participating)	✓				Subject to OON Benefits
Out of Network Services (providers with Auth in Service Area) (Non-participating providers)			✓		For Service Area Only – Paid @ In-network Rate
Outpatient Surgery			✓		
Pain Management			✓		
Plasmapherisis: Out-Patient	✓				
(Administration of...) Platelets / Blood / Blood Products	✓				
Photopherisis: Out-patient	✓				
Physical Therapy		✓	SEE COMMENT →		**Outpatient PT → Visits 1-6 REQUIRE IVR REFERRAL NUMBER.** Treatment **beyond the sixth (6th) therapy session REQUIRES** Prior Authorization. **In-Home PT** → Requires Prior Authorization **BEFORE** treatment can begin.

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PROCEDURES and SERVICES	No Referral Required	IVR Referral Required	Prior Auth. Required	Not A Covered Benefit	COMMENTS
Physical Medicine/Rehab	✓				
Plastic Surgeon		✓			
Podiatry		✓			
Positron Emission Tomography (PET)			✓		Prior Authorization required for both PCPs & Specialists.
Prosthetics / Orthotics			✓		**Prior Authorization is Required For:** • All rental DME requires Prior Authorization. • Purchased DME **with billed charges, per DME line item, greater than $150** requires Prior Authorization. • All orthotics and prosthetics require Prior Authorization. • All repairs to DME, orthotics and prosthetics require Prior Authorization.
Pulmonary Function Test PFT	✓				
Pulmonary Rehabilitation	✓				**First five (5) visits → No Auth is Required** **All Additional visits → Yes, Prior Auth required**
Pulmonology		✓			
Radiation Therapy			✓		
RAST Testing	✓				
Renal Ultra Sound	✓				
Retinopathy		✓			
Rheumatology		✓			
Routine Vision → All routine vision must be referred to **BLOCK VISION**	**SEE COMMENT →**				**IMPORTANT:** For HealthSpring members with routine vision benefits - ALL routine vision must be referred to **participating BLOCK VISION providers.** **MEDICARE ADVANTAGE Members & Vision Benefits:**. To find a Block Vision provider and verify routine vision benefits, Medicare Advantage members may call Block Vision, **toll-free: 800-428-8789**
Respiratory Therapy	**SEE COMMENT →**				**If respiratory therapy is provided in the home → Yes, Prior Auth required.** If respiratory therapy is Provided in the office → No Auth is Required
Seed Implant			✓		
Skilled Nursing Facility Care: SNF / Subacute			✓		**IMPORTANT:** HealthSpring recognizes that many conditions, while difficult to treat in the home, can be appropriately managed in the nursing home/skilled nursing facility. Therefore... ★ HealthSpring **DOES NOT REQUIRE the 3-day qualifying hospital stay** in order to for a member to be admitted into a nursing home/skilled nursing facility.
Sleep Studies			✓		
Speech Therapy			✓		All Speech Therapy requires Prior Authorization before treatment can begin.
Supplies	**SEE COMMENT →**				All supplies **with billed charges, per line item, greater than $150** require Prior Authorization.

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IMPORTANT..... Prior Authorization and/or Referral Number(s) is/are not a guarantee of benefits or payment at the time of service.

PROCEDURES and SERVICES	No Referral Required	IVR Referral Required	Prior Auth. Required	Not A Covered Benefit	COMMENTS
Surgery: Out-Patient / In-Office	SEE COMMENT →				**OUT-PATIENT SURGICAL PROCEDURES:** **All outpatient surgeries require Prior Authorization** - unless otherwise indicated within this list. **Outpatient surgery resulting in observation status** -MUST have the surgery prior-authorized. **IN-OFFICE SURGICAL PROCEDURES:** **In-office surgeries do not require Prior Authorization** - unless otherwise indicated within this list.
TEE (Transesophageal Echo)			✓		
Thallium Studies		PCPS: SEE COMMENT →			PCPs may order/perform nuclear cardiac studies **WITH A PRIOR AUTHORIZATION**.
		SPECIALISTS: No Auth Required.			These tests include, *but are not limited to:* Cardio-lite, Sestamibi, Thallium, Persantine Thallium, Adenosine, Adenosine-Thallium.
Thoracentesis	SEE COMMENTS →				**Outpatient or Free-standing Facility** → **Yes**, Prior Auth required. **In-office** → Prior Auth not required.
Thyroid Studies	✓				
TMJ Diagnosis and therapy			✓		
Transfers: Facility to Facility	SEE COMMENTS →				Requires Prior Notification (phone call to precert line)
Transplant Evaluations / Transplants			✓		
Ultrasounds	✓				
Urgent Care Center	✓				
Urology		✓			
Uvulopalatoplasty: Laser-assisted			✓		
Vaccination	SEE COMMENT →				**Vaccination not covered for travel.** No authorization required for routine vaccination.
VAP Test (Vaginal Acid Phosphatase Test)		✓			
VQ (Ventilation Perfusion) Lung Scan	✓				
Well Woman Exam	✓				Self Direct
Wheelchairs / Scooters (Standard & Custom)			✓		See DME Guidelines
Wound Care	SEE COMMENT →				**Outpatient or Free-standing Facility** → **Yes**, Prior Auth required. **In-office** → Prior Auth not required.
X-rays	✓				
Yag Laser	SEE COMMENT →				**Outpatient or Free-standing Facility** → **Yes**, Prior Auth required. **In-office** → Prior Auth not required for CPT 66821

HEALTHSPRING NETWORK PARTICIPATING HOSPITALS

The Network Participating Hospital Grid has been designed for use as a quick reference tool. If you are interested in searching for a particular participating provider or would like to view one of our Provider Directories, log onto www.healthspring.com.

County	HOSPITAL (S)
Cherokee	East Texas Medical Center Athens
Collin	Centennial Medical Center (Tenet) Presbyterian Hospital of Allen Presbyterian Hospital of Plano
Dallas	Richardson Regional Medical Center RHD (HPA facility) Trinity Medical Center (HPA facility) Doctors Hospital (Tenet) Presbyterian Hospital of Dallas
Denton	Presbyterian Hospital of Denton
Grayson	Wilson N. Jones Medical Center Texoma Medical Center
Gregg	Good Shepherd Medical Center
Henderson	East Texas Medical Center of Athens
Johnson	Walls Regional Hospital
Kaufman	Presbyterian Hospital of Kaufman
Lubbock	Covenant Medical Center Lakeside Covenant Medical Center Hospital
Rockwall	Lake Pointe Medical Center (Tenet) Presbyterian Hospital of Rockwall
Smith	East Texas Medical Center Tyler East Texas Specialty Hospital
Tarrant	Huguley Memorial Medical Center Arlington Memorial Hospital Harris Methodist Northwest Hospital Harris Methodist HEB Harris Methodist Springwood Harris Methodist Fort Worth Harris Methodist Southwest

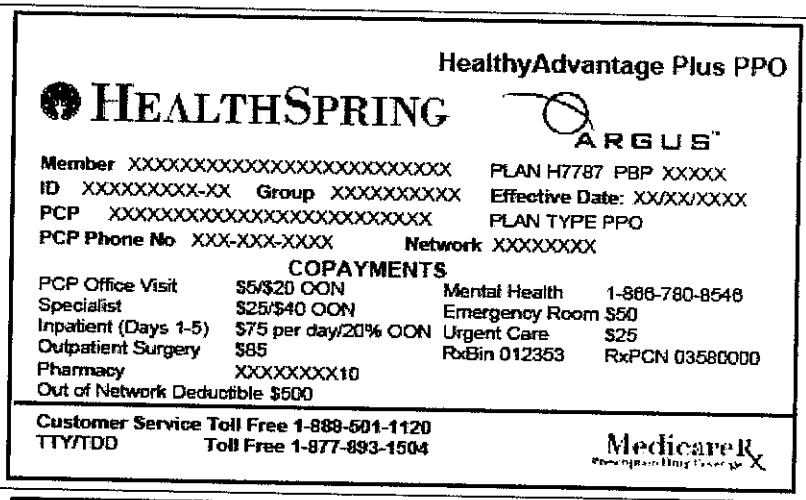
HEALTHSPRING IDENTIFICATION CARD SAMPLES: North Texas

HealthSpring
A COMMUNITY HEALTH PLAN

How To Verify Eligibility & Benefits: Please call Provider Services: phone (888) 501-1141, to verify eligibility and benefits.

Where To Send Claims: Please refer to the back of the ID card for the claims mailing address.

Need Additional Assistance? Please contact Provider Services: phone (888) 501-1141 or Provider Relations at (972) 281-2280.


HealthyAdvantage Plus PPO

HEALTHSPRING

ARGUS

Member XXXXXXXXXXXXXXXXXXXXXXXX PLAN H7787 PBP XXXXX
ID XXXXXXXXX-XX Group XXXXXXXXX Effective Date: XX/XX/XXXX
PCP XXXXXXXXXXXXXXXXXXXXXXXX PLAN TYPE PPO
PCP Phone No XXX-XXX-XXXX Network XXXXXXXX

COPAYMENTS

PCP Office Visit	$5/$20 OON	Mental Health	1-866-780-8546
Specialist	$25/$40 OON	Emergency Room	$50
Inpatient (Days 1-5)	$75 per day/20% OON	Urgent Care	$25
Outpatient Surgery	$85	RxBin 012353	RxPCN 03580000
Pharmacy	XXXXXXXX10		

Out of Network Deductible $500

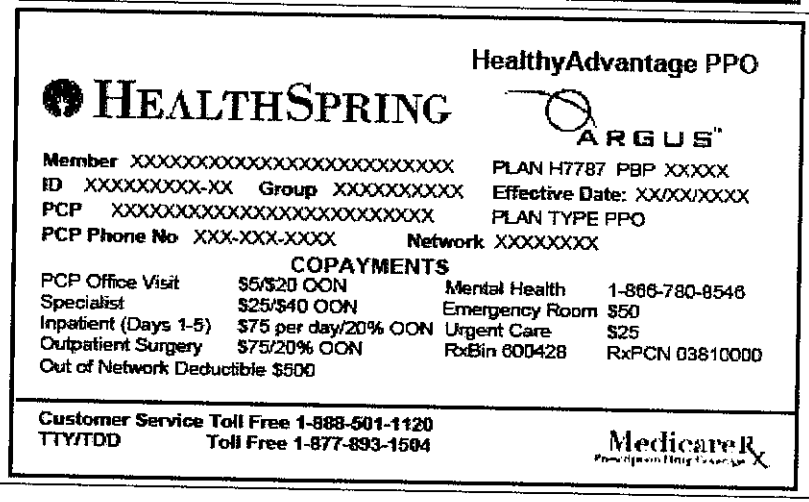
Customer Service Toll Free 1-888-501-1120
TTY/TDD Toll Free 1-877-893-1504

MedicareRx

← North Texas Healthy Advantage Plus Rx

$0 Premium; $0 deductible; Drug Coverage; $5 PCP Copay; $25 Specialist Copay; $75 copay (days 1-5) Inpatient stay; vision benefit

PCP is Required


HealthyAdvantage PPO

HEALTHSPRING

ARGUS

Member XXXXXXXXXXXXXXXXXXXXXXXX PLAN H7787 PBP XXXXX
ID XXXXXXXXX-XX Group XXXXXXXXX Effective Date: XX/XX/XXXX
PCP XXXXXXXXXXXXXXXXXXXXXXXX PLAN TYPE PPO
PCP Phone No XXX-XXX-XXXX Network XXXXXXXX

COPAYMENTS

PCP Office Visit	$5/$20 OON	Mental Health	1-866-780-8546
Specialist	$25/$40 OON	Emergency Room	$50
Inpatient (Days 1-5)	$75 per day/20% OON	Urgent Care	$25
Outpatient Surgery	$75/20% OON	RxBin 600428	RxPCN 03810000

Out of Network Deductible $500

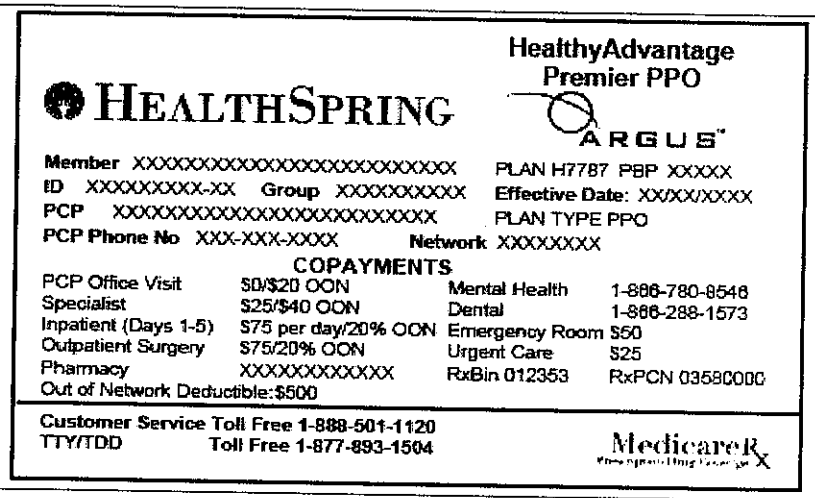
Customer Service Toll Free 1-888-501-1120
TTY/TDD Toll Free 1-877-893-1504

MedicareRx

← North Texas Healthy Advantage

No drug coverage; $39 Part B Premium Reduction; $5 PCP Copay; $25 Specialist Copay; $75 Copay (days 1-5) Inpatient stay; vision benefit

PCP is Required



HEALTHSPRING

HealthyAdvantage Premier PPO

ARGUS

Member XXXXXXXXXXXXXXXXXXXXXXXX PLAN H7787 PBP XXXXX
ID XXXXXXXXX-XX **Group** XXXXXXXXXX **Effective Date:** XX/XX/XXXX
PCP XXXXXXXXXXXXXXXXXXXXXXXX PLAN TYPE PPO
PCP Phone No XXX-XXX-XXXX **Network** XXXXXXXX

COPAYMENTS

PCP Office Visit	$0/$20 OON	Mental Health	1-866-780-8546
Specialist	$25/$40 OON	Dental	1-866-288-1573
Inpatient (Days 1-5)	$75 per day/20% OON	Emergency Room	$50
Outpatient Surgery	$75/20% OON	Urgent Care	$25
Pharmacy	XXXXXXXXXXXX	RxBin 012353	RxPCN 03580000

Out of Network Deductible:$500

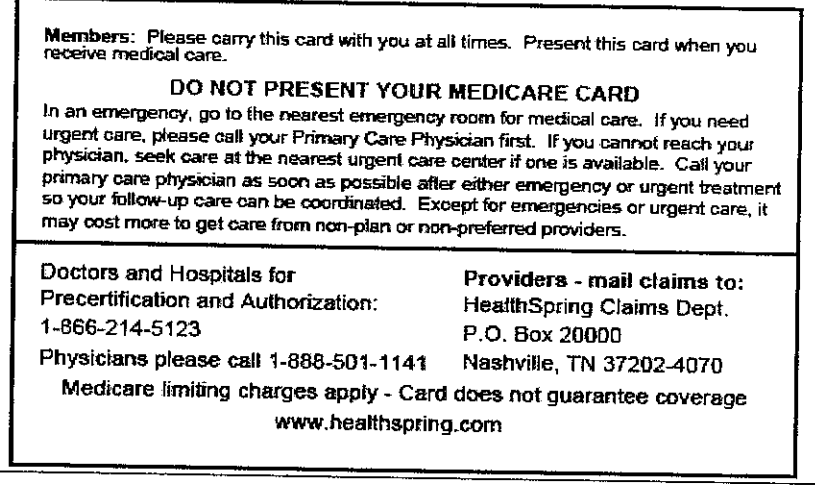
Customer Service Toll Free 1-888-501-1120
TTY/TDD Toll Free 1-877-893-1504

MedicareRx

← **North Texas Healthy Advantage Premier**

$35 Monthly Premium; $0 PCP Copay; $25 Specialist Copay; $75 Copay (days 1-5) Inpatient stay; Dental Benefit, Hearing Aid Allowance, Transportation benefit, Silver Sneakers Benefit

PCP is Required



Members: Please carry this card with you at all times. Present this card when you receive medical care.

DO NOT PRESENT YOUR MEDICARE CARD

In an emergency, go to the nearest emergency room for medical care. If you need urgent care, please call your Primary Care Physician first. If you cannot reach your physician, seek care at the nearest urgent care center if one is available. Call your primary care physician as soon as possible after either emergency or urgent treatment so your follow-up care can be coordinated. Except for emergencies or urgent care, it may cost more to get care from non-plan or non-preferred providers.

Doctors and Hospitals for Precertification and Authorization:
1-866-214-5123
Physicians please call 1-888-501-1141

Providers - mail claims to:
HealthSpring Claims Dept.
P.O. Box 20000
Nashville, TN 37202-4070

Medicare limiting charges apply - Card does not guarantee coverage

www.healthspring.com

← **Back of Card**

Shows where to mail claims and how to contact HealthSpring for member benefits, eligibility, authorizations and referrals.

ELECTRONIC SUBMISSION APPLICATION: North Texas

Complete the accompanying EDI Form and submit to HealthSpring at fax number located below.
Our EDI Coordinator will contact individual identified on the EDI Form to begin the testing process.

DATE: _____

OFFICE INFORMATION

GROUP/PROVIDER Name: _____

Group/Provider Federal Tax I.D. #: _____

Contact Name: _____

Contact's E-Mail Address: _____

Phone Number: _____ Fax Number: _____

BUSINESS Address: _____

City: _____ State: _____ Zip code: _____

MAILING Address: _____

City: _____ State: _____ Zip code: _____

BILLING INFORMATION

BILLING AGENT Name: _____

Billing Agent Contact Name: _____

Billing Agent Address: _____

City: _____ State: _____ Zip code: _____

Phone Number: _____ Fax Number: _____

Software Vendor: _____

EDI Clearinghouse: _____

PROVIDER INFORMATION: Please list ALL providers, use back of form if necessary.

Provider Name:	UPIN:	Medicare Number:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

HEALTHSPRING EDI DEPARTMENT USE ONLY

Date Rec'd by HealthSpring: _____ HealthSpring Vendor #: _____

Approved ☐ -or- Denied ☐ Date: _____

Comments: _____

_____

▶ FAX COMPLETED FORM TO EDI COORDINATOR – ATTN: TO BE DETERMINED◀
FAX # (XXX) XXX-XXXX

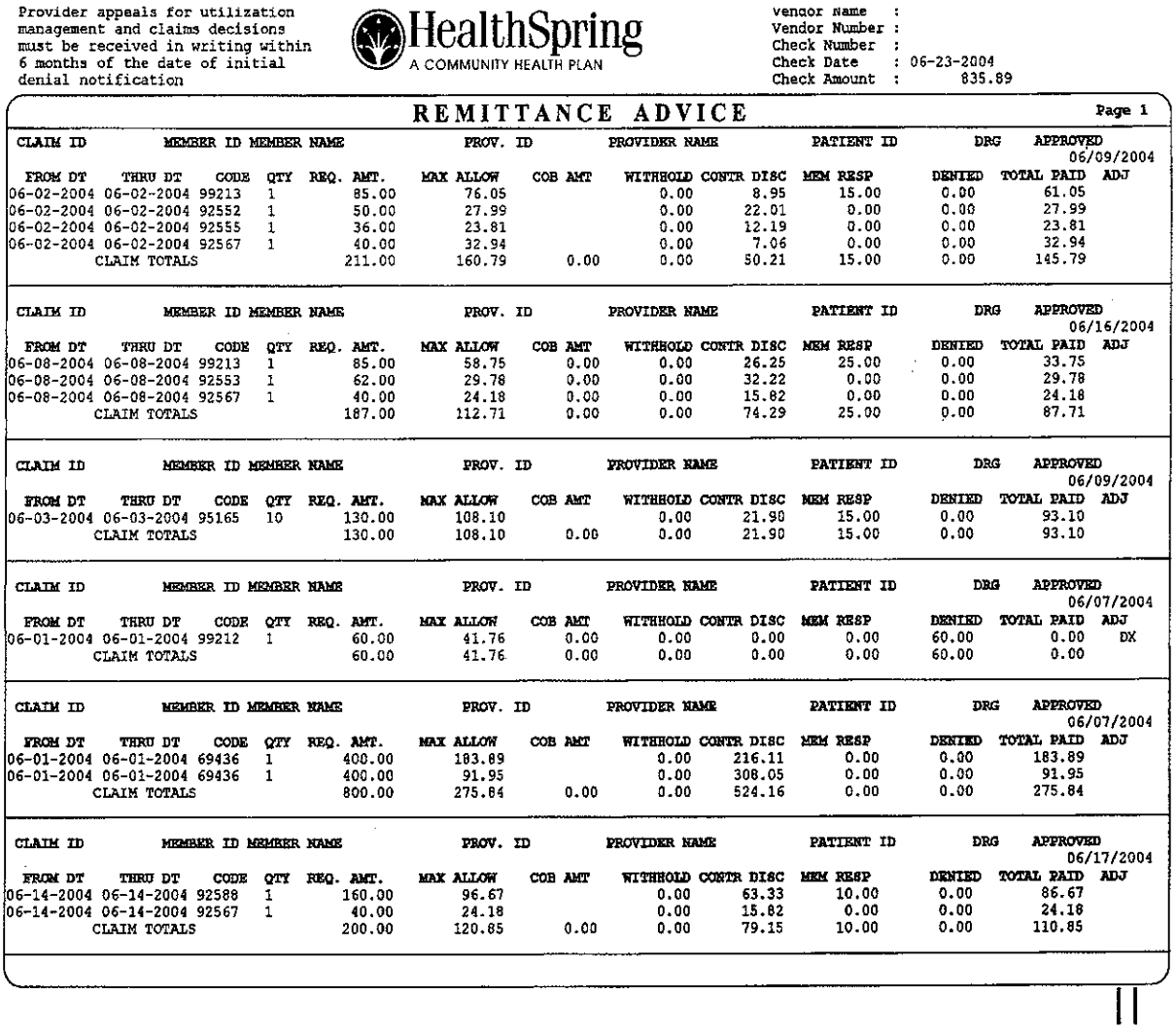
REMITTANCE ADVICE

Description/Purpose

The Remittance Advice (RA) statement is sent to the member and/or hospital after coverage and payment have been determined by HealthSpring. The statement provides a detailed description of how the claim was processed.

Remittance Advice

We have added a new column to reflect the contractual discount on the Remittance Advice. If the maximum allowable (MAX ALLOW) column is subtracted from the requested amount (REQ. AMT.) column, the difference is then displayed in the contractual discount (CONTR DISC) column to the right.



Provider appeals for utilization management and claims decisions must be received in writing within 6 months of the date of initial denial notification

HealthSpring
A COMMUNITY HEALTH PLAN

Vendor Name :
Vendor Number :
Check Number :
Check Date : 06-23-2004
Check Amount : 835.89

REMITTANCE ADVICE — Page 1

CLAIM ID	MEMBER ID	MEMBER NAME	PROV. ID	PROVIDER NAME	PATIENT ID	DRG	APPROVED 06/09/2004

FROM DT	THRU DT	CODE	QTY	REQ. AMT.	MAX ALLOW	COB AMT	WITHHOLD	CONTR DISC	MEM RESP	DENIED	TOTAL PAID	ADJ
06-02-2004	06-02-2004	99213	1	85.00	76.05		0.00	8.95	15.00	0.00	61.05	
06-02-2004	06-02-2004	92552	1	50.00	27.99		0.00	22.01	0.00	0.00	27.99	
06-02-2004	06-02-2004	92555	1	36.00	23.81		0.00	12.19	0.00	0.00	23.81	
06-02-2004	06-02-2004	92567	1	40.00	32.94		0.00	7.06	0.00	0.00	32.94	
	CLAIM TOTALS			211.00	160.79	0.00	0.00	50.21	15.00	0.00	145.79	

CLAIM ID	MEMBER ID	MEMBER NAME	PROV. ID	PROVIDER NAME	PATIENT ID	DRG	APPROVED 06/16/2004

FROM DT	THRU DT	CODE	QTY	REQ. AMT.	MAX ALLOW	COB AMT	WITHHOLD	CONTR DISC	MEM RESP	DENIED	TOTAL PAID	ADJ
06-08-2004	06-08-2004	99213	1	85.00	58.75	0.00	0.00	26.25	25.00	0.00	33.75	
06-08-2004	06-08-2004	92553	1	62.00	29.78	0.00	0.00	32.22	0.00	0.00	29.78	
06-08-2004	06-08-2004	92567	1	40.00	24.18	0.00	0.00	15.82	0.00	0.00	24.18	
	CLAIM TOTALS			187.00	112.71	0.00	0.00	74.29	25.00	0.00	87.71	

CLAIM ID	MEMBER ID	MEMBER NAME	PROV. ID	PROVIDER NAME	PATIENT ID	DRG	APPROVED 06/09/2004

FROM DT	THRU DT	CODE	QTY	REQ. AMT.	MAX ALLOW	COB AMT	WITHHOLD	CONTR DISC	MEM RESP	DENIED	TOTAL PAID	ADJ
06-03-2004	06-03-2004	95165	10	130.00	108.10		0.00	21.90	15.00	0.00	93.10	
	CLAIM TOTALS			130.00	108.10	0.00	0.00	21.90	15.00	0.00	93.10	

CLAIM ID	MEMBER ID	MEMBER NAME	PROV. ID	PROVIDER NAME	PATIENT ID	DRG	APPROVED 06/07/2004

FROM DT	THRU DT	CODE	QTY	REQ. AMT.	MAX ALLOW	COB AMT	WITHHOLD	CONTR DISC	MEM RESP	DENIED	TOTAL PAID	ADJ
06-01-2004	06-01-2004	99212	1	60.00	41.76	0.00	0.00	0.00	0.00	60.00	0.00	DX
	CLAIM TOTALS			60.00	41.76	0.00	0.00	0.00	0.00	60.00	0.00	

CLAIM ID	MEMBER ID	MEMBER NAME	PROV. ID	PROVIDER NAME	PATIENT ID	DRG	APPROVED 06/07/2004

FROM DT	THRU DT	CODE	QTY	REQ. AMT.	MAX ALLOW	COB AMT	WITHHOLD	CONTR DISC	MEM RESP	DENIED	TOTAL PAID	ADJ
06-01-2004	06-01-2004	69436	1	400.00	183.89		0.00	216.11	0.00	0.00	183.89	
06-01-2004	06-01-2004	69436	1	400.00	91.95		0.00	308.05	0.00	0.00	91.95	
	CLAIM TOTALS			800.00	275.84	0.00	0.00	524.16	0.00	0.00	275.84	

CLAIM ID	MEMBER ID	MEMBER NAME	PROV. ID	PROVIDER NAME	PATIENT ID	DRG	APPROVED 06/17/2004

FROM DT	THRU DT	CODE	QTY	REQ. AMT.	MAX ALLOW	COB AMT	WITHHOLD	CONTR DISC	MEM RESP	DENIED	TOTAL PAID	ADJ
06-14-2004	06-14-2004	92588	1	160.00	96.67		0.00	63.33	10.00	0.00	86.67	
06-14-2004	06-14-2004	92567	1	40.00	24.18		0.00	15.82	0.00	0.00	24.18	
	CLAIM TOTALS			200.00	120.85	0.00	0.00	79.15	10.00	0.00	110.85	

SECTION 8: PROVIDER APPEAL PROCESS

SOLUTIONS UNIT

Provider Appeal Process
As a provider you have ninety days (90 days) from the date on the Remittance Advice to appeal a claim decision. To properly submit an appeal the following items will be required:

- Letter outlining the reason for the appeal (to include member name, Identification Number, Date of Service, Provider Name)
- Supporting medical records

The information should be sent to:

HealthSpring Life & Health Insurance Company

ATTN: Solutions Unit
2900 North Loop West, Ste 1300
Houston, TX 77092

To inquire about an appeal that has been submitted, call 1-888-501-1141 and ask to speak with a representative in the Solutions Unit.

Option 1: Will connect you to an individual in the Solutions Unit that can answer your questions about a grievance/appeal that has already been filed; and...

Option 2: Will connect you to a Provider Relations Representative should you need information on how to file a grievance/appeal.

*Please allow at least 60 days for the processing of the appeal.

Inpatient Appeal
Should a facility or provider disagree with an adverse determination while the HealthSpring member is still classified as inpatient, the provider may request an expedited appeal. This request may be in written or verbal form to HealthSpring. The case will then be reviewed by one of HealthSpring's Medical Directors (the physician that originally reviewed the case for service determination will not review the case on appeal). This could take up to 72 hours for resolution.

If the provider still does not agree with the peer to peer review, notification must be made to the health plan and the case will be sent out to a third party to be determined by HealthSpring for review.

Outpatient/Post Discharge
Should a facility or provider disagree with an adverse determination, claim reimbursement or specific claim denial they should provide written notification to HealthSpring within ninety days from the date on the remittance advice. The written notification needs to contain all information necessary to investigate the appeal. If upon appeal, the decision is upheld there is no other level of appeal and HealthSpring will not review the case again.

RESPONSE TIME:

- Allow up to 72 hours for review of prior authorization request.
- If you have questions please call (800) 331-6293
- If Urgent please see bottom of form.

REMEMBER:
Please consider formulary alternatives before completing this form. Formulary available: **www.healthspring.com**

Provider Information		**Member (Patient) Information**	
Provider Name:	Provider Specialty:	**Member Name:**	
Office Phone:		**HealthSpring ID #:**	**Date of Birth:**
Office Fax:		**Member Phone Number:** (H) (C)	
Office Contact Person:		**Member Address, City, State, Zip:**	

Medication Request

Where will the drug be administered? ☐Patient's home ☐Physician's office ☐Home infusion ☐LTC ☐Assisted living

How will drug be supplied? ☐Retail Pharmacy ☐Specialty Pharmacy ☐Physician's own supply

☐Other: _____

Is the request for an inpatient that is awaiting discharge?

☐Yes ☐No ☐Other, please specify: _____

If this request is for a transplant medication, was the transplant covered by Medicare?

☐Yes ☐No ☐Other, please specify: _____

Requested Medication (please specify drug name, strength, dosing schedule, and duration of therapy):	If the drug is administered intravenously, please check one: ☐Infusion pump ☐Gravity ☐Implanted pump ☐Other, please specify: _____
Diagnosis related to medication request:	
Please list all alternatives that have been tried/failed (include drug dose and strength):	
Please state medical necessity for requested medication:	
Additional information must be submitted to support medical necessity (i.e. office visit notes, relevant lab values, etc.):	
X Signature:	**Date:**

Fax Completed Form and ALL Supportive Documentation to:
Fax # (615) 291-7025 or (866) 845-7267

Please Read If Urgent Request: By signing below, I certify that applying the standard 72-hour review time frame **may seriously jeopardize the life or health** of the member or the member's **ability to regain maximum function:**

Physician Signature: _____

If urgent (see explanation above): Fax completed form and supportive documentation to: (615) 234-6789 or (866) 593-4407 and the request will be processed within 24 hours.