carolina complete health™

Carolina Complete Health and WellCare of North Carolina Merger

Home Health, Personal Care Services, Electronic Visit Verification

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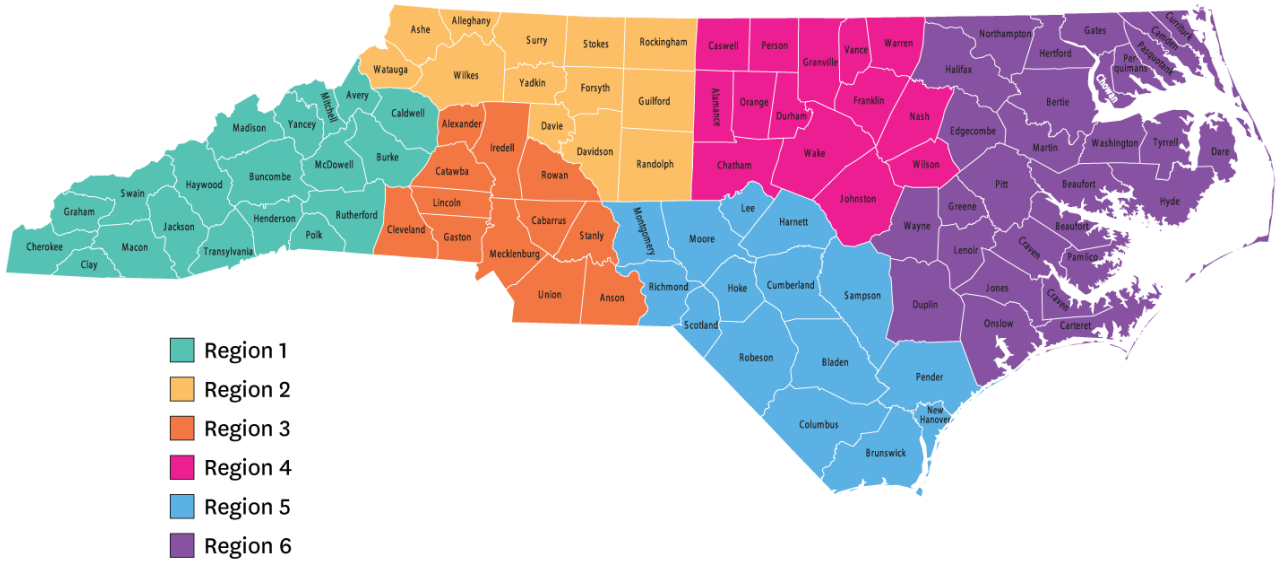
Single Statewide **Provider-Led Entity**

- WellCare of North Carolina operates in all six regions; Carolina Complete Health operates in regions 3, 4, and 5.
- **The combined health plan, named Carolina Complete Health, will be state-wide on April 1, 2026.**
- Post-merger, the combined entity will operate in all six regions, 100 counties.



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Standard Plan members

Provider-Led Entity Governance Structure

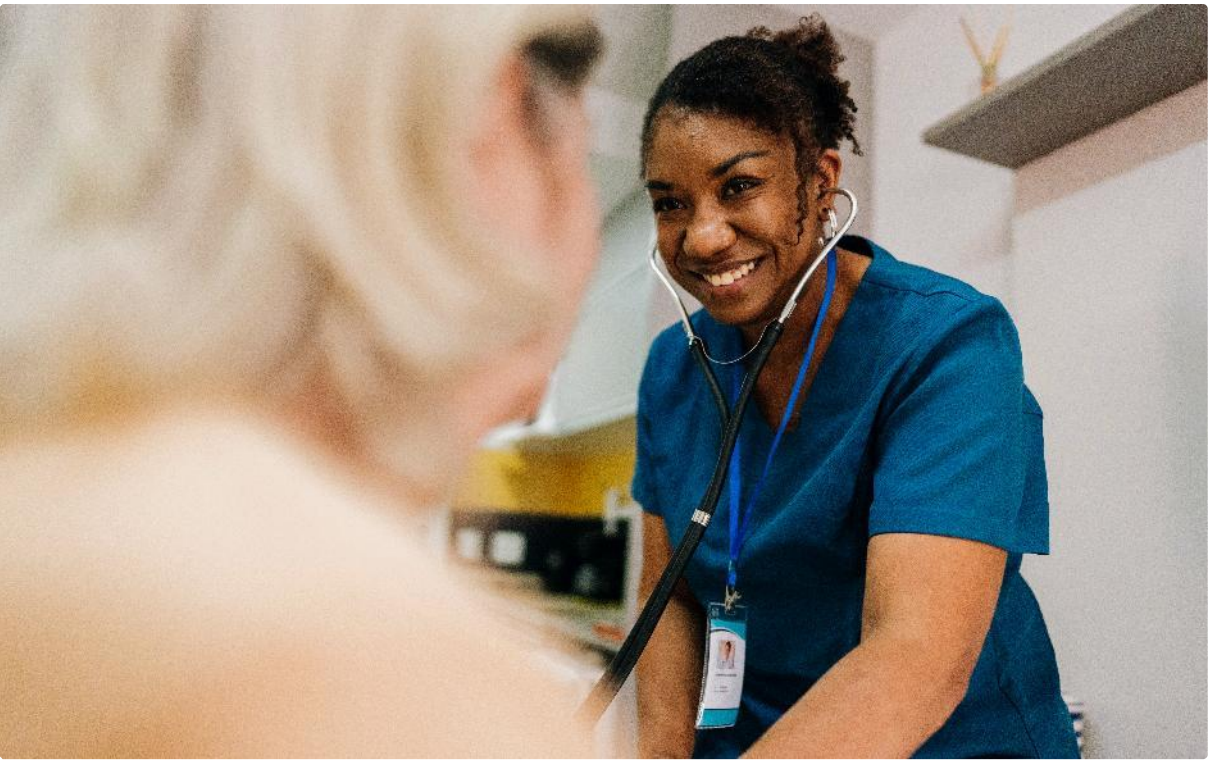
The Provider-Led Entity (PLE) gives physicians, community health centers, and other providers a strong voice in the governance and clinical policy of the Medicaid health plan and the care of its members.

The new Unified Standard Plan will retain Carolina Complete Health's structure as a Provider-Led Entity (PLE) state-wide. The PLE structure was established through a unique joint venture between Centene and the NC Medical Society in conjunction with the NC Community Health Center Association and individual Federally Qualified Health Centers. This provider ownership is operationalized through the Carolina Complete Health Network (CCHN), an organization owned in part by the NC Medical Society, NCCHCA and 27 individual health center clinics that seeks out physician and clinician expertise in medical policy and aims to give providers a voice in how to best care for their patients while reducing administrative burden.

Centene Corporation	• **Fortune 22** company with over 30 years of Medicaid experience • **#1 in Medicaid and #1 in Marketplace** in the U.S., operating in **50** states • Insures over **28 million** members
North Carolina Medical Society	• Representing physicians and PAs dedicated to enhancing the health and lives of people across North Carolina • Leading physician-informed health policy in North Carolina • Supporting practice transformation and provider recruitment strategies • Advocating for access to care in rural and medically underserved communities
NC Community Health Center Association & 27 FQHC's	• Association membership includes **over 40** Federally Qualified Health Center grantees and look-alike organizations. • Serving over **760,000** underinsured and uninsured • **600** clinical sites across 92 counties in North Carolina

carolina complete health WellCare

A Streamlined, Supportive Experience



1

Fewer Payers in Medicaid Managed Care

Combining operations to create a simpler, more efficient experience for Medicaid providers.

2

Administrative Simplification

One set of processes, policies, and systems so providers have less duplicative tasks.

3

Enhance Quality Care

Members will continue to receive the same Medicaid benefits, along with an expanded selection of value-added services.

Network and Contracting

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Important Reminder

Providers:

- No action is required for providers with active Medicaid contracts with either plan. All contracted providers will be considered **in-network** with the unified plan effective April 1, 2026, and therefore your **members will stay assigned to you.**
- Contracts for WellCare Medicare, Ambetter of North Carolina Inc., and Tailored Plan Physical Health with Trillium and Partners remain unaffected by the merger.
- There is no re-credentialing or additional application process required as part of this merger on 4/1/26. Both health plans ingest provider information from NC Tracks. If the data is correct, there will be no need to notify when a new provider comes on board under the Tax ID. If the group NPI is already contracted, new individual NPIs are enrolled automatically.

Members:

- No action is required from members. All WellCare of North Carolina and Carolina Complete Health members will automatically transition to the new statewide plan and keep their Primary Care Provider.

Member Identification

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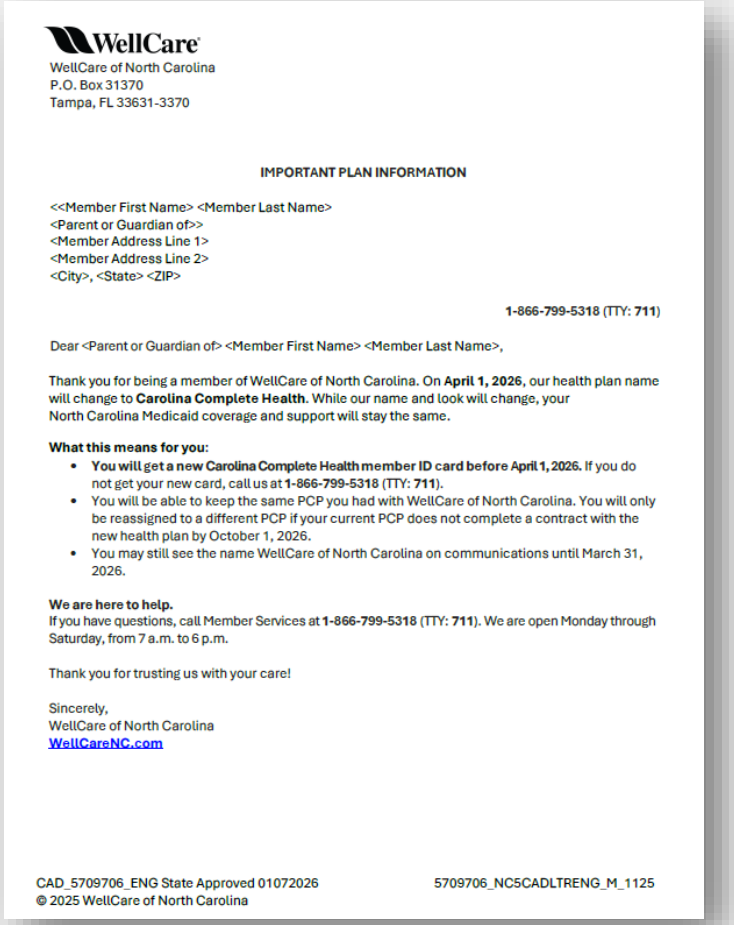
Member Communications and Impact

- WellCare members received an announcement letter in January, followed by a series of informational materials.
- These communications will ensure members understand what is changing, what is staying the same, and how to access their benefits.
- WellCare of North Carolina members will be automatically transitioned to the integrated health plan, retaining the name Carolina Complete Health, on April 1, 2026.
- Members can **continue** seeing their same Primary Care Provider.
- Members **will not** be assigned a new Medicaid ID.
- Members receive the **same benefits** plus **new and updated Value-Added Services.**



WellCare

WellCare of North Carolina
P.O. Box 31370
Tampa, FL 33631-3370

IMPORTANT PLAN INFORMATION

<<Member First Name> <Member Last Name>
<Parent or Guardian of>>
<Member Address Line 1>
<Member Address Line 2>
<City>, <State> <ZIP>

1-866-799-5318 (TTY: **711**)

Dear <Parent or Guardian of> <Member First Name> <Member Last Name>,

Thank you for being a member of WellCare of North Carolina. On **April 1, 2026**, our health plan name will change to **Carolina Complete Health**. While our name and look will change, your North Carolina Medicaid coverage and support will stay the same.

What this means for you:

- **You will get a new Carolina Complete Health member ID card before April 1, 2026.** If you do not get your new card, call us at **1-866-799-5318** (TTY: **711**).
- You will be able to keep the same PCP you had with WellCare of North Carolina. You will only be reassigned to a different PCP if your current PCP does not complete a contract with the new health plan by October 1, 2026.
- You may still see the name WellCare of North Carolina on communications until March 31, 2026.

We are here to help.
If you have questions, call Member Services at **1-866-799-5318** (TTY: **711**). We are open Monday through Saturday, from 7 a.m. to 6 p.m.

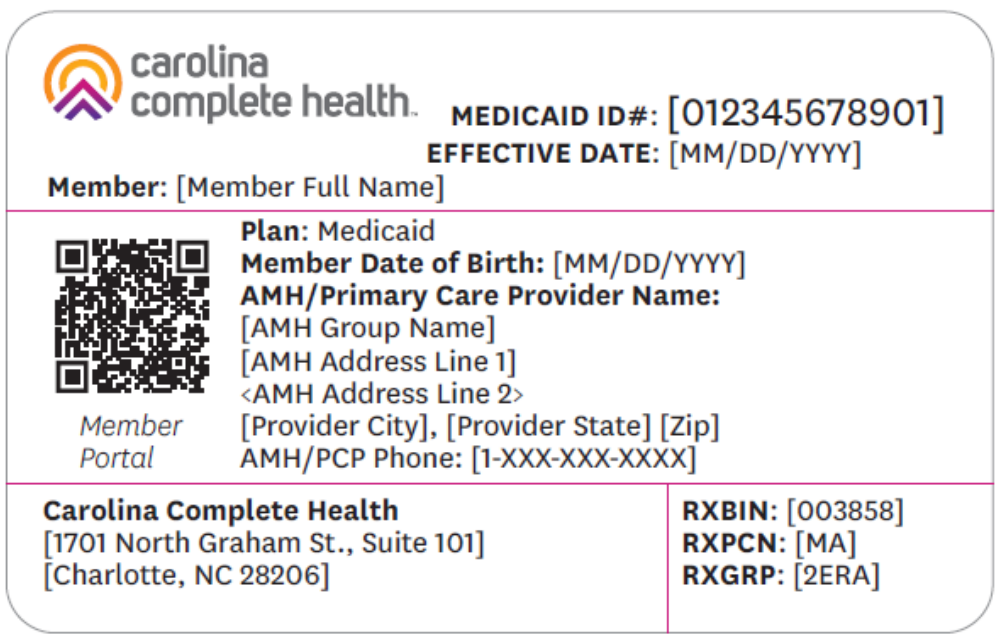
Thank you for trusting us with your care!

Sincerely,
WellCare of North Carolina
WellCareNC.com

CAD_5709706_ENG State Approved 01072026 5709706_NC5CADLTRENG_M_1125

Member Identification

- Members' Medicaid ID numbers will **not change.**
- Members will receive new Carolina Complete Health ID cards


carolina complete health

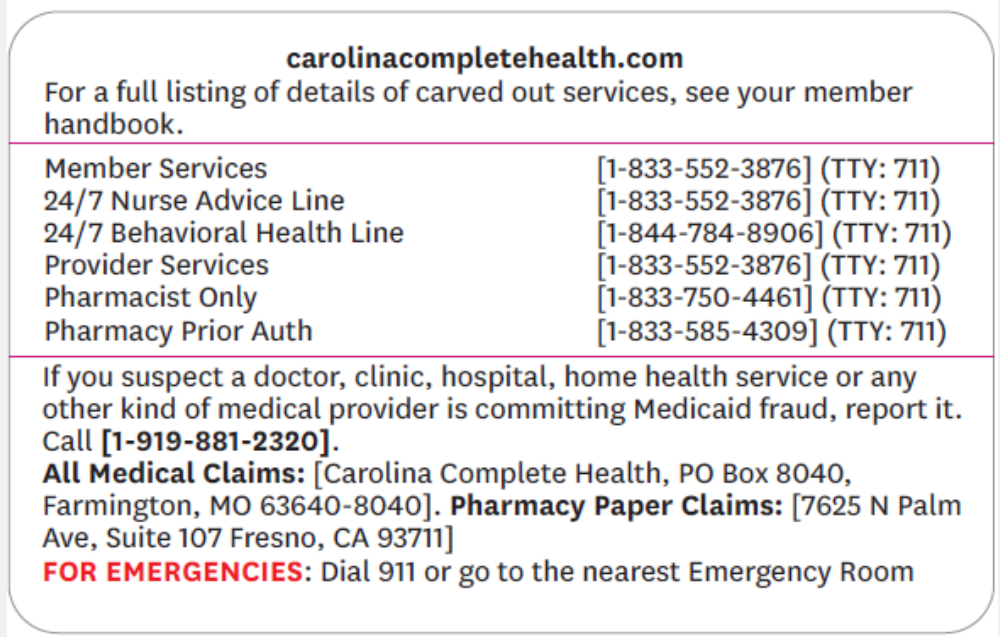
MEDICAID ID#: [012345678901]
EFFECTIVE DATE: [MM/DD/YYYY]
Member: [Member Full Name]

Member Portal

Plan: Medicaid
Member Date of Birth: [MM/DD/YYYY]
AMH/Primary Care Provider Name:
[AMH Group Name]
[AMH Address Line 1]
<AMH Address Line 2>
[Provider City], [Provider State] [Zip]
AMH/PCP Phone: [1-XXX-XXX-XXXX]

Carolina Complete Health
[1701 North Graham St., Suite 101]
[Charlotte, NC 28206]

RXBIN: [003858]
RXPCN: [MA]
RXGRP: [2ERA]


carolinacompletehealth.com
For a full listing of details of carved out services, see your member handbook.

Member Services	[1-833-552-3876] (TTY: 711)
24/7 Nurse Advice Line	[1-833-552-3876] (TTY: 711)
24/7 Behavioral Health Line	[1-844-784-8906] (TTY: 711)
Provider Services	[1-833-552-3876] (TTY: 711)
Pharmacist Only	[1-833-750-4461] (TTY: 711)
Pharmacy Prior Auth	[1-833-585-4309] (TTY: 711)

If you suspect a doctor, clinic, hospital, home health service or any other kind of medical provider is committing Medicaid fraud, report it. Call **[1-919-881-2320]**.
All Medical Claims: [Carolina Complete Health, PO Box 8040, Farmington, MO 63640-8040]. **Pharmacy Paper Claims:** [7625 N Palm Ave, Suite 107 Fresno, CA 93711]
FOR EMERGENCIES: Dial 911 or go to the nearest Emergency Room

Web-based Tools

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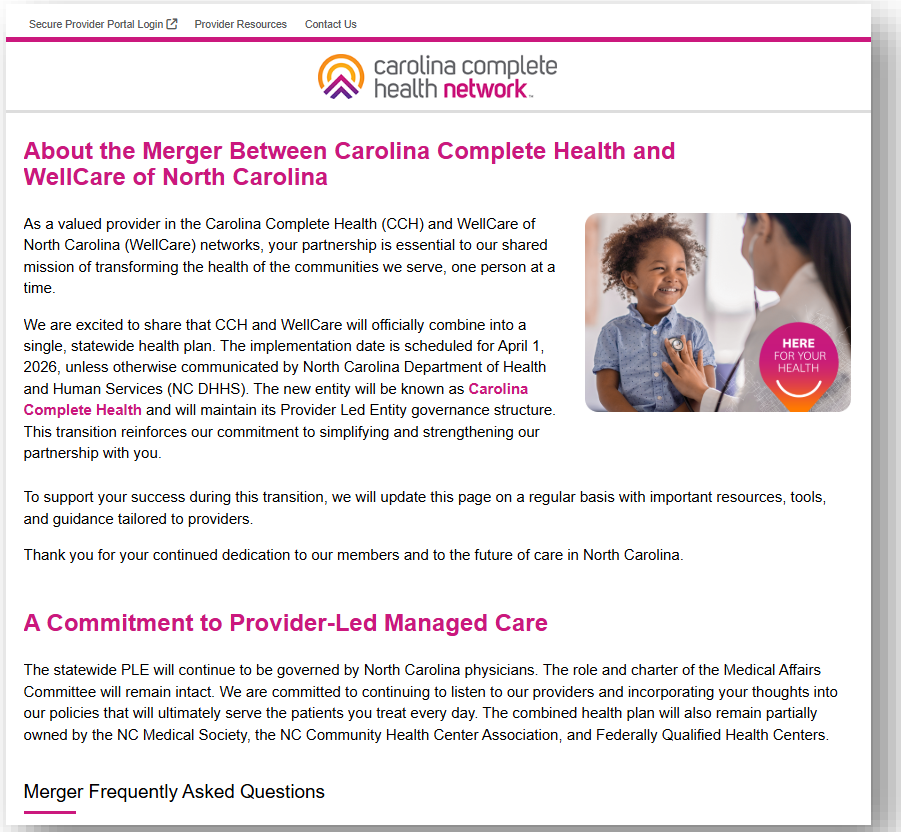
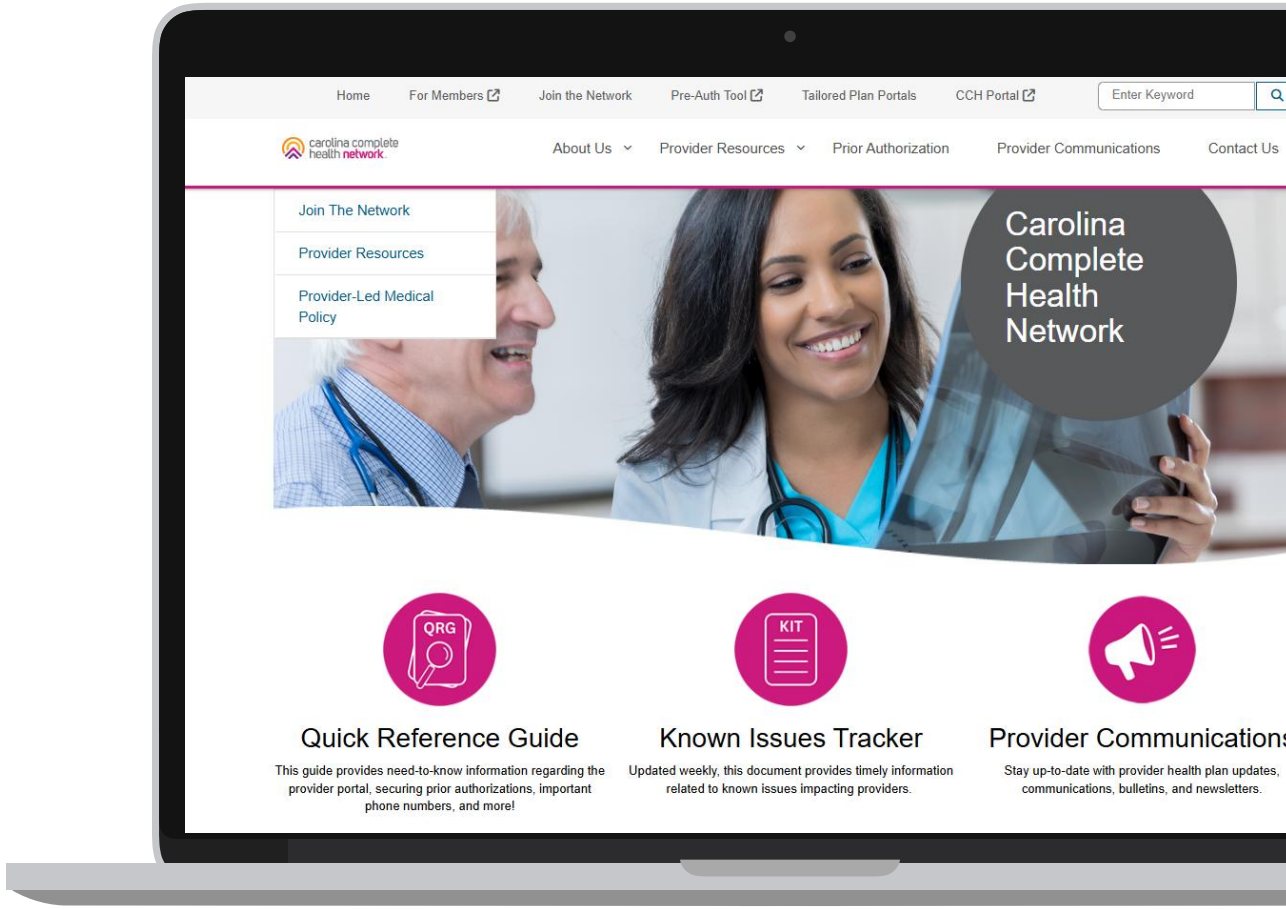
Provider Website and Integration Resources

- network.carolinacompletehealth.com
- network.carolinacompletehealth.com/merger



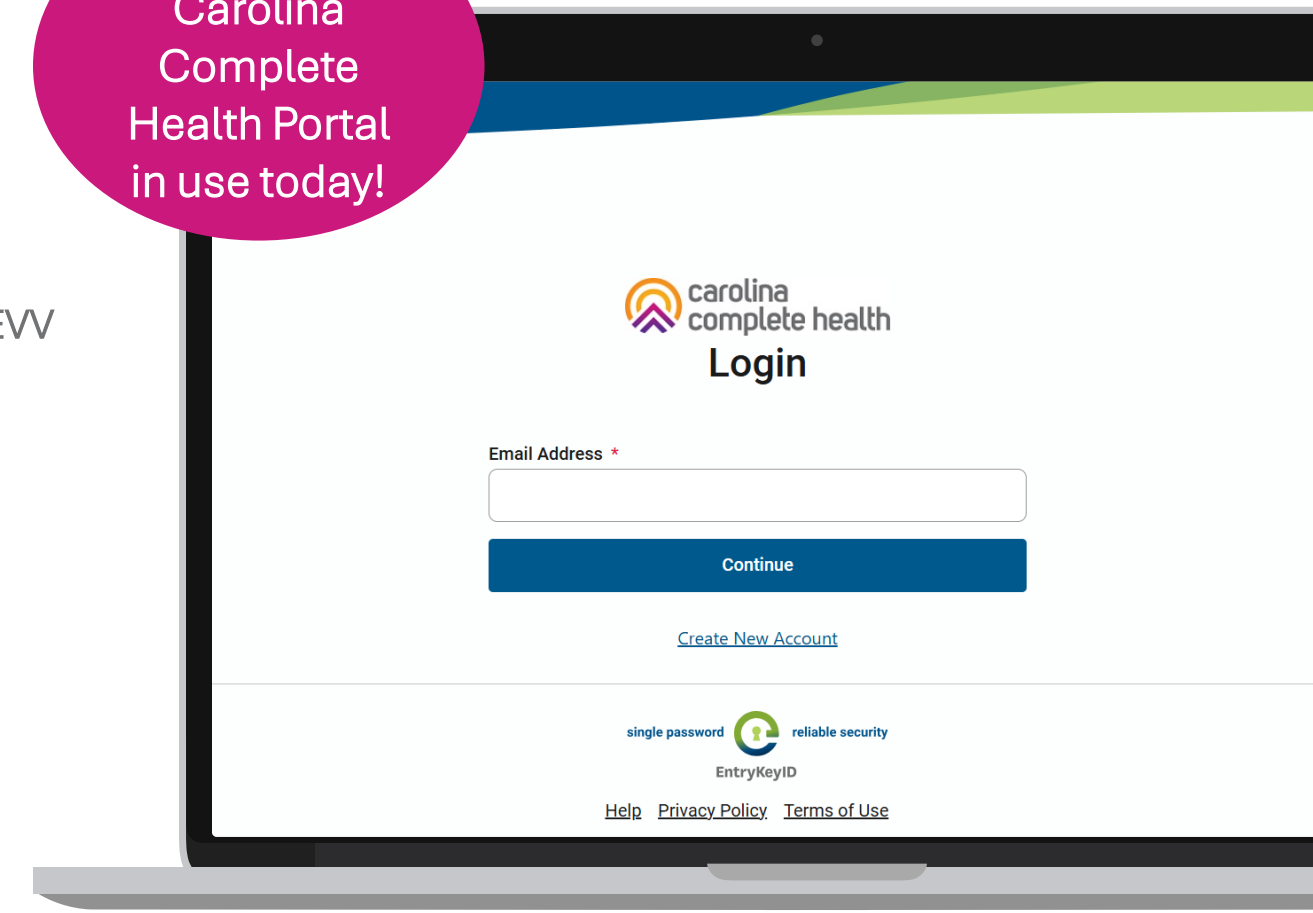


Secure Provider Portal Effective 4/1/26

- New Providers may begin registering on 3/1/26!
- provider.carolinacompletehealth.com/
- Secure Provider Portal Functions:
  - Beneficiary eligibility & patient listings
  - Health records & care gaps
  - Prior Authorization
  - Claims submissions & status (for those not subject to EVV claim submission)
  - Payment history
  - Monthly PCP cost reports
  - ...and more!
- Secure Portal Training:
  - Provider Portal Training

  Guides:
  - Registering and Logging In
  - Submitting a Claim
  - Checking Member Eligibility and Health Record

Same Carolina Complete Health Portal in use today!



Availity Essentials

- Providers can continue using Availity Essentials: Register and Get Started with Availity Essentials
- **Chat features will be available in Availity Essentials**
- Providers Can:
  - Verify Member's Eligibility and Benefits
  - View ID Cards
  - Submit Claims (for those not subject to EVV claim submission i.e. Home Health direct billing or Congregate Care)
  - Check Claim Status
  - Claim Corrections
  - Remittance Viewer
  - Authorization Request/Inquiry
  - Authorization Edits
  - Submit attachments via the Attachments-New dashboard
  - Coming Soon: Claims Disputes and Appeals

Portal Account Manager

A Portal Account Manager is a role assigned to a primary contact within a provider organization. This is up to the discretion of the practice.

The **Portal Account Manage**r will be able to :

- ✓ Verify new portal registrations
- ✓ Disable and/or enable user's portal access
- ✓ Modify portal permissions based on the user's role within the organization

How to Assign an Account Manager:
Once an Account Manager is determined, they should register for the Carolina Complete Health Secure Provider Portal and then email providerengagement@cch-network.com to request Account Manager access. Access will be granted within 2 business days. Once approved, the Account Manager may begin verifying users within the organization.

Claims and Payment

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HHAeXchange

- Carolina Complete Health partners with HHAeXchange as the EVV Vendor.
- **Important Note**: HHAeXchange will link existing WellCare of NC connected agencies to the Carolina Complete Health Secure Provider Portal as part of the transition. A system review has been completed to identify providers who are new to Carolina Complete Health and most links will be established automatically before go-live.
- If you are not yet connected:
  - **Option 1** – Agencies currently without an EVV Solution: use the free EVV tools provided by HHAeXchange & Carolina Complete Health
  - **Option 2** – Agencies currently using another 3rd Party EVV Solution: you must integrate your existing EVV with HHAeXchange – HHA will route visit data to Carolina Complete Health
- The HHAeXchange Provider Info Center outlines necessary requirements to set up access to the HHAeXchange system. Complete Provider Enrollment Form
  - North Carolina PHP Provider Information Center | HHAeXchange
  - North Carolina PHP HHAeXchange Provider Enrollment Form

Provider Managed Diagnosis Codes

- WellCare and Carolina Complete are both configured for provider managed diagnosis codes.
- Providers are responsible for adding and maintaining the member diagnosis codes directly within HHAeXchange
- For providers utilizing EDI, diagnosis codes must be included on the file sent by your 3rd party EVV vendor
- For step-by-step guidance, please refer to the HHAeXchange Knowledge Base

https://knowledge.hhaexchange.com/enterprise/Content/Documentation/Patient/Pat-N-Provider-Billing-Diagnosis-P.htmExternal Link

Rate Management

- Current WellCare and Carolina Complete Health providers can manage their own rates in HHAx. There are not any default rates set, **providers must go into HHAx and set up rates prior to billing for the first time and anytime the fee schedule changes.**
- **Action required:** Any CCH-linked provider must set their rates. If you are NEW to being linked with Carolina Complete Health, then you need to do this prior to billing.
- EDI providers whose vendors *send rates on the visit file* do not need to take action.
- HHAx Knowledge Base: How do I manage my contract rates?

Billing Basics

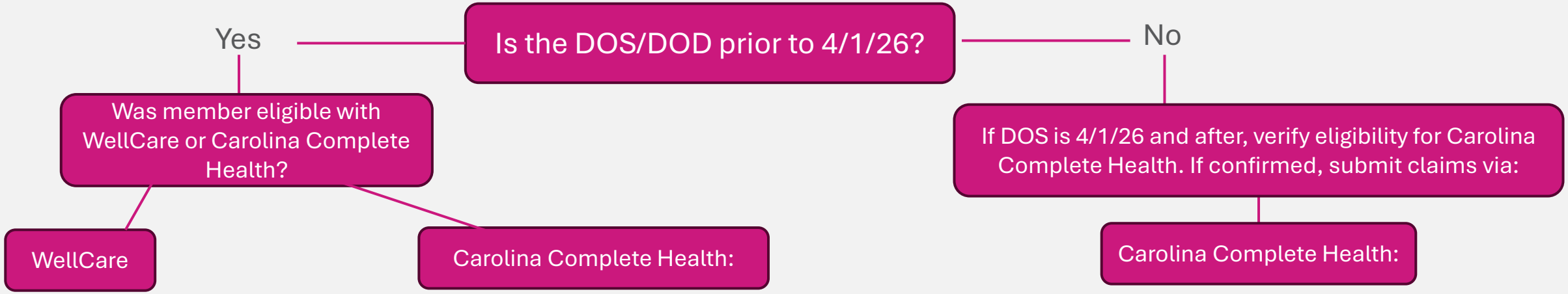
Personal Care Services

- EVV Required:
  - In-Home PCS services (taxonomy 253Z00000X, HA or HB modifier)
  - Claims must be submitted through HHAeXchange.
  - Claims submitted via any other source will be denied for EVV.
- Non-EVV:
  - Other PCS services (i.e Congregate Care settings) can be billed through the CCH Secure Provider Portal.
  - Claims can be submitted through the portal or Availity Essentials

Home Health Services

- Home Health Care Services may be billed directly to the health plan or submitted via EVV.
- For dates of service 4/1/26 and after, if billing directly:
  - Availity Essentials
  - Carolina Complete Health Secure Portal
  - Clearinghouse/EDI: Payer ID 68069
  - Mail: PO Box 8040 Farmington, MO 63640-8040
- **EVV visit data is required for HHCS and must be submitted**

EVV Claim Submission Decision Tree



- The visit and claim will need to be confirmed and billed against the WellCare NC contract
- If using HHAeXchange, select the member record associated with WellCare. Members previously covered by WellCare of North Carolina will show a “discharged” status in the HHAX portal under the WellCare NC record.
- If using third party EVV use HHAX Payer IDs:
  - WellCare PCS Payer ID: 23937
  - WellCare HHCS Payer ID: 57538

- The visit and claim will need to be confirmed and billed against the Carolina Complete Health contract with the Carolina Complete Health member record.
- If using third party EVV use HHAX Payer IDs:
  - Carolina Complete Health PCS Payer ID: 24075
    Carolina Complete Health HHCS Payer ID: 57535

For PCS subject to EVV billing:
- Submit via HHAeXchange with the Carolina Complete Health member record
- Or if using third party EVV, submit to Carolina Complete Health PCS Payer ID 24075

For PCS in congregate care settings:
- Submit per diem claims directly to Carolina Complete Health

For Home Health Care Services
- Submit via HHAexChange with Carolina Complete Health member record or
- If using third party EVV, submit with HHX Payer ID 57535 for Carolina Complete Health HHCS or
- Submit claim to Carolina Complete Health directly

Frequently Asked Question

- If a claim with DOS 4/1/26 and after is submitted to WellCare, will the claim upfront reject or deny?
  - *For HHAx related claims, providers should expect to receive a rejection advising "Patient Not Found or Visits Cannot Be Imported Prior to Patient SOC Date or After Patient Discharge Date" if a claim is submitted with the wrong Payer ID.*

Claim Denials for Lacking EVV

Claims will DENY if they do not have matching EVV visit data.

To ensure your claims are not denied for EVV (EXev), you must :

- Submit billing through HHAX for Carolina Complete Health
- Or for Home Health Care Services, direct bill to CCH **AND** ensure your EVV visit data is successfully imported by HHAX prior to sending your claim to CCH. The CPT/HCPCS + Rev on HHAX visit and claim must match.
  - When the claim is billed directly to Carolina Complete Health without EVV data, it is placed on a 14-day hold to allow time for the EVV visit to be submitted via HHAeXchange and matched with claims data received. If an EVV match is not found within the 14-day hold period, the claim will then be denied "EXev" unless otherwise denied immediately for a reason unrelated to EVV.

Billing Guidance

- Correcting claims denied for EVV (EXev)
  - If denied due to no EVV visit data in HHAX
    1. First submit data to HHAX and ensure it successfully imports
    2. Then submit a corrected claim to Carolina Complete Health

  - If denied due to mismatched CPT/HCPCS + Rev codes between HHAX visit data and claim
    - If HHAX data contains inaccurate procedure code, submit corrected visit data to HHAX. Then submit a corrected claim to Carolina Complete Health..
    - If claim contains inaccurate procedure code, then submit a corrected claim with the updated procedure code.

- Corrected Claims Submission Guide

Providers Using 3rd Party EVV Vendors

Health Plan EDI Payer ID ≠ HHAX Payer ID

Health Plan EDI Payer ID: used when submitting claims through a clearinghouse for Carolina Complete Health. More claims & billing information on website.

HHAX Payer ID: used when sending visit data to HHAX

- Should align with the member's health plan eligibility for the date of service
- You will receive a "Patient not found" rejection from HHAX if this does not match the member's health plan.

  WellCare PCS Payer ID: 23937

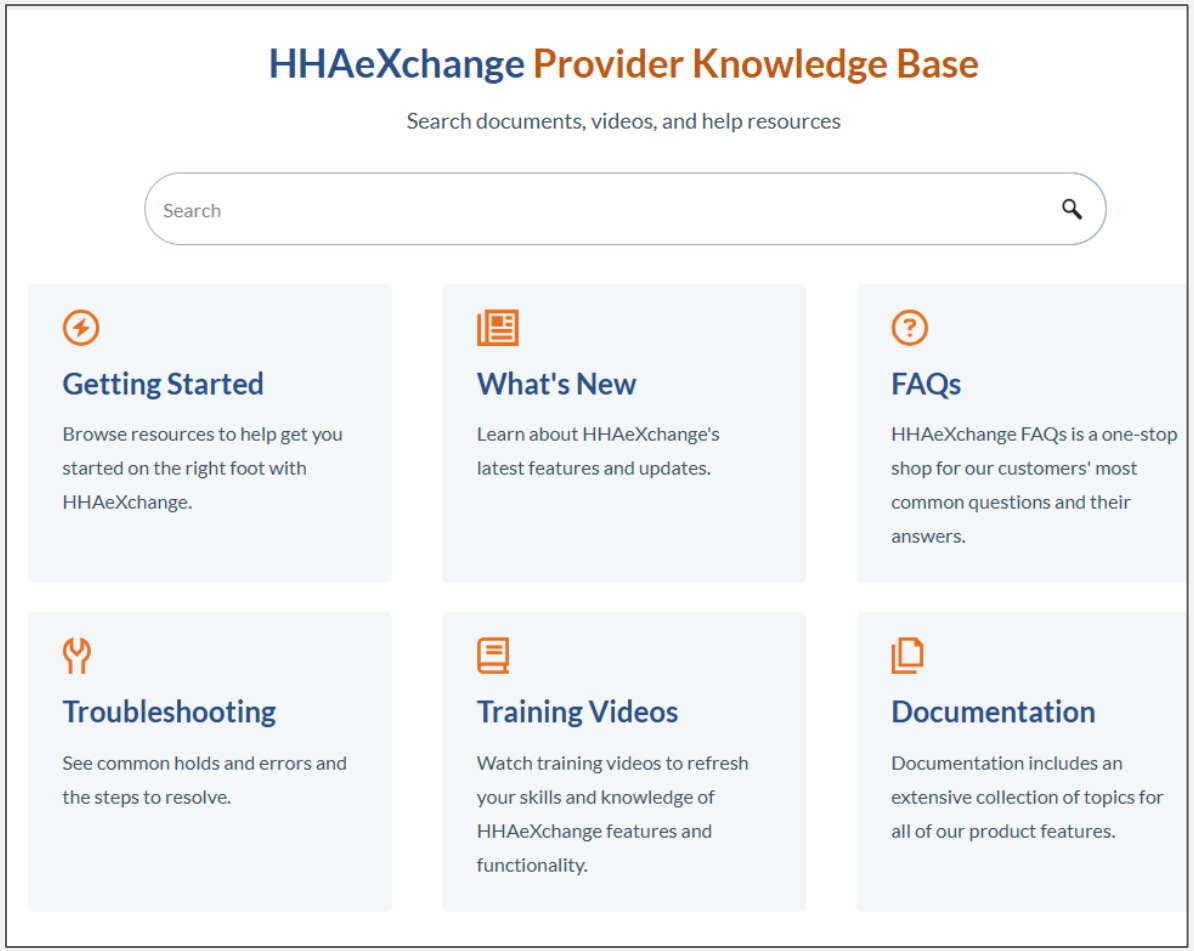
  WellCare Home Health Payer ID: 57538

  Carolina Complete Health Home Health: 57535

  Carolina Complete Health PCS: 24075
- HHAX Standard Plan EDI Code Table

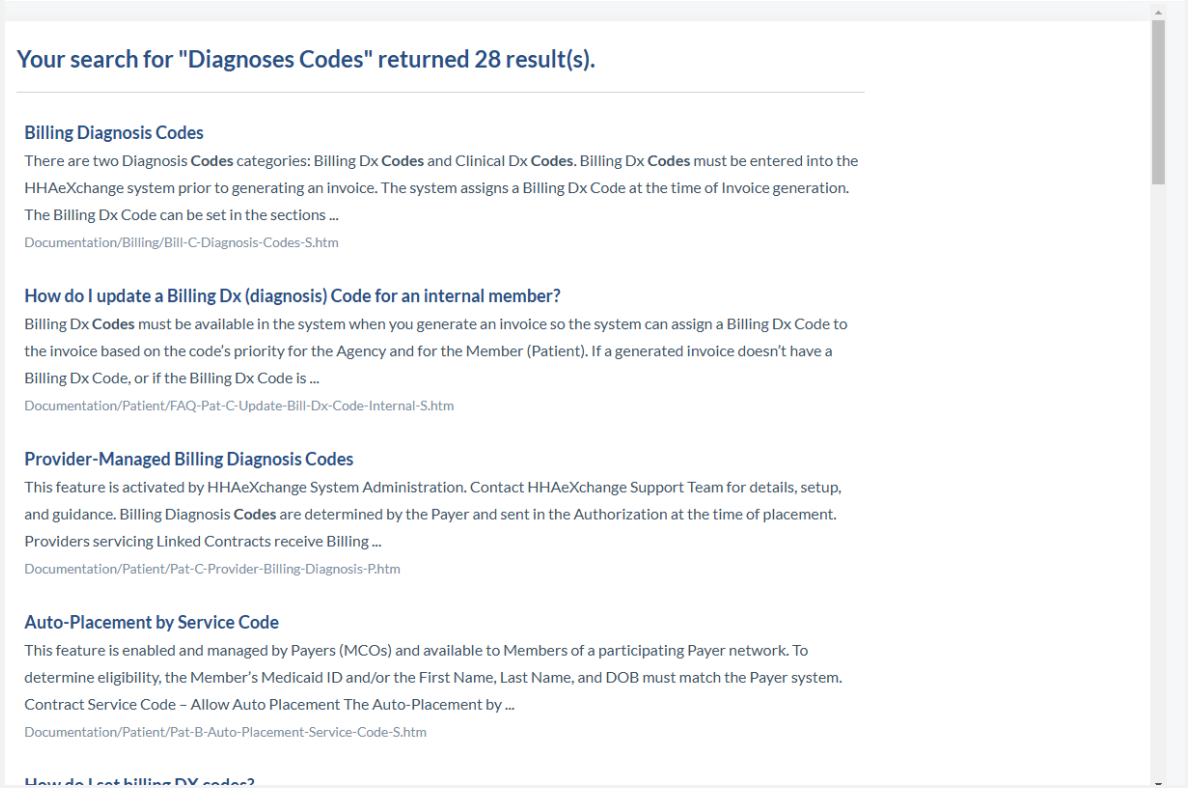
HHAeXchange Billing Resources

- HHAeXchange Customer Support:
  - The Client Support Portal is the fastest method for us to answer and address issues. Through a simple set of questions and selections, we can easily determine assignment and answer questions directly online without waiting.
- Billing Refresher Training
- Job Aids and HHA Provider Knowledge Base
- Knowledge Base for providers with 3rd party EVV provider
- System User Training:
  - Sign Up For HHAeXchange University

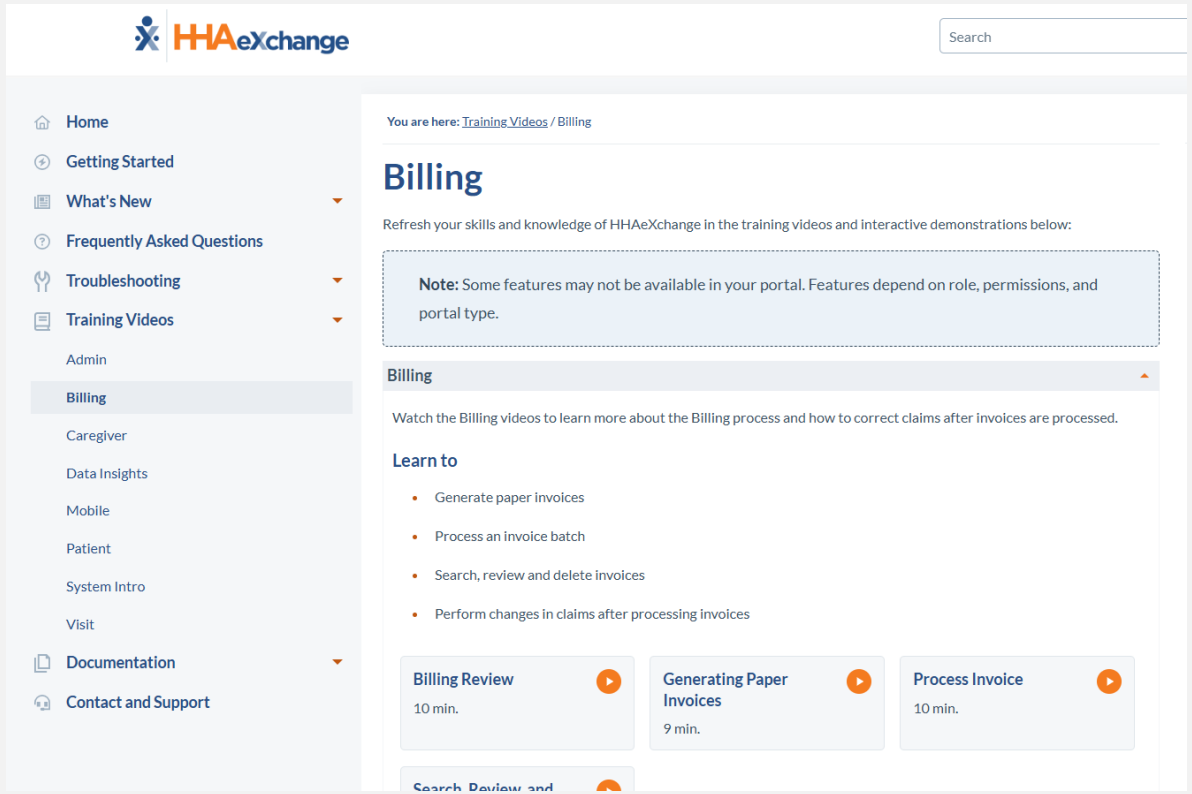


HHAeXchange Knowledge Base

Search for Key Words



Navigate Topics on Left-side Menu



Billing in Congregate Care Settings

- Submit one line per date of service with 1 unit per service.
  - A claim line that spans multiple dates or includes a unit greater than one will deny.
- Providers should bill their usual and customary charge. No calculations are required by providers.
- Claims submitted will hit a pend code for pricing (DF: Pend: Manual Pricing Required)
- For additional details, see the following Provider Bulletin

Check-run Schedule and Electronic Funds Transfer

- The check-run schedule occurs on **Monday, Wednesday and Friday**. Payment is issued to providers the following business day.
- Providers can continue using Payspan, a free solution that provides electronic payment and remittance.
- If providers already use Payspan for WellCare, but not Carolina Complete Health, you can add a line-of-business with a new registration code (provided by Payspan) to set up EFT/ERA with Carolina Complete Health.
  - Contact Payspan via email or phone: PayspanProviderSupport@zelis.com or 1-877-331-7154
  - Confirm 'NC- Medicaid' is listed on your account
- Providers can set up EFT for claim payments, Advanced Medical Home payments, and Tier 3 Care Management payments. Advanced Medical Home and Care Management payments are considered "ALT" payments and require a separate Payspan registration code.

Authorizations and Requests for Services

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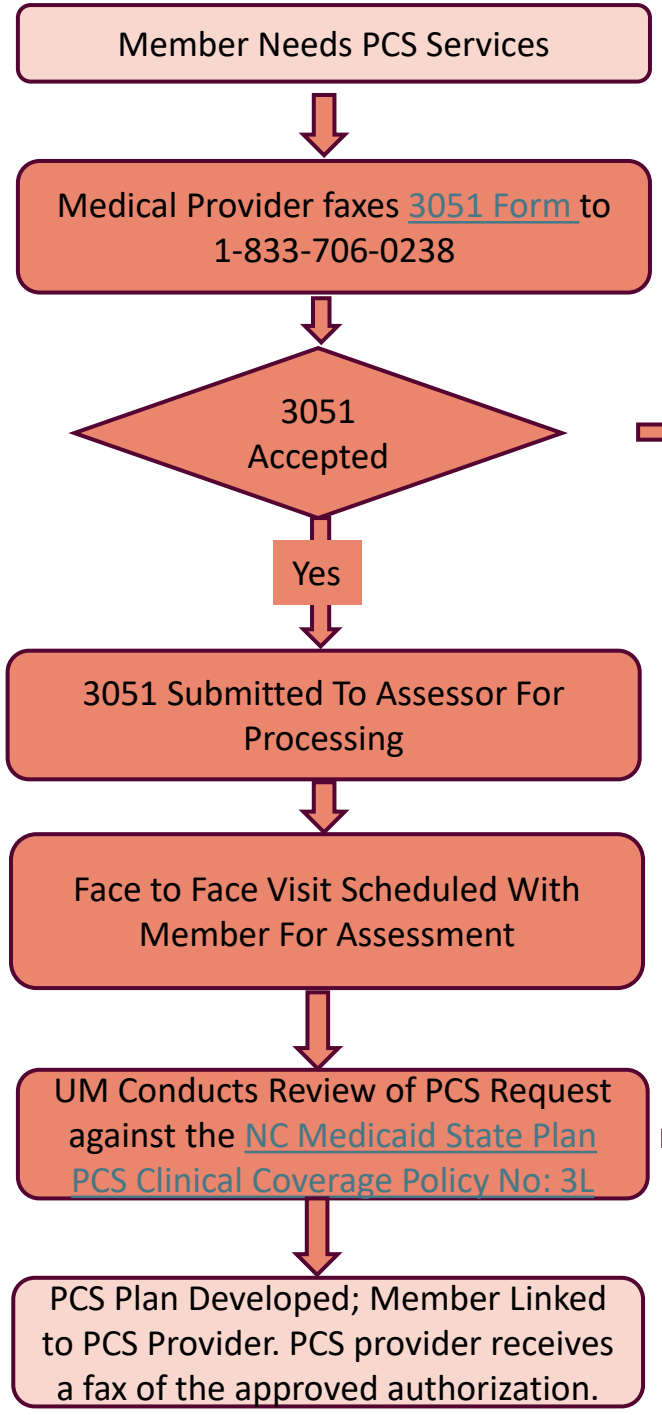
Prior Authorizations (PA)

Transition of Care:

- For services provided to WellCare of NC members before April 1, 2026, continue submitting authorization requests through WellCare or the appropriate WellCare vendor using the WellCare NC Provider Portal, the vendor portal, fax, or phone.
- For services that will be provided *on **4/1/26 or after***, submit authorization requests to Carolina Complete Health or the integrated plan vendor (via the Carolina Complete Health provider portal, vendor portal, via fax or phone to Carolina Complete Health, or through Availity).
- Existing WellCare Prior Authorizations: Authorizations entered and approved before 4/1/2026 will be transferred to Carolina Complete Health. If a service was approved before 4/1/26 but is performed on or after 4/1/26, the claim will process correctly *when filed with Carolina Complete Health*.
  - Example – an authorization is requested and approved for a 60-day period from 3/15/26 - 6/15/26. The authorization will be valid for services provided after 4/1/26, even though it was approved while the member was covered under WCNC prior to the integration date.
  - Exception: All inpatient authorizations (Medical and Behavioral) with admit dates of 3/31/2026 or earlier and no discharge date, will remain in the WellCare systems until date of discharge.

Requesting Initial PCS

- To request an independent assessment for a member, the MD caring for the member should complete Carolina Complete Health's 3051 Form. The completed form should be submitted via fax to 1-833-706-0238:
  - *The form must have the referring practitioner's signature. Signature stamps are not acceptable. The signature must be handwritten to be acceptable.*
- The member's medical provider should re-submit the 3051 form on an annual basis and as needed for a change in medical/functional condition which often occurs during a hospitalization or changes in support.
  - *All new referrals and medical change of status requests will require the referring entity to provide both the medical diagnosis description and diagnosis codes.*
- PCS Providers do not need to request re-authorization of PCS services. This is supported by LTSS Care Managers and the Utilization Management team directly.
  - *Medical Providers may receive a request to submit an updated 3051. Please respond promptly if requested to continue services.*

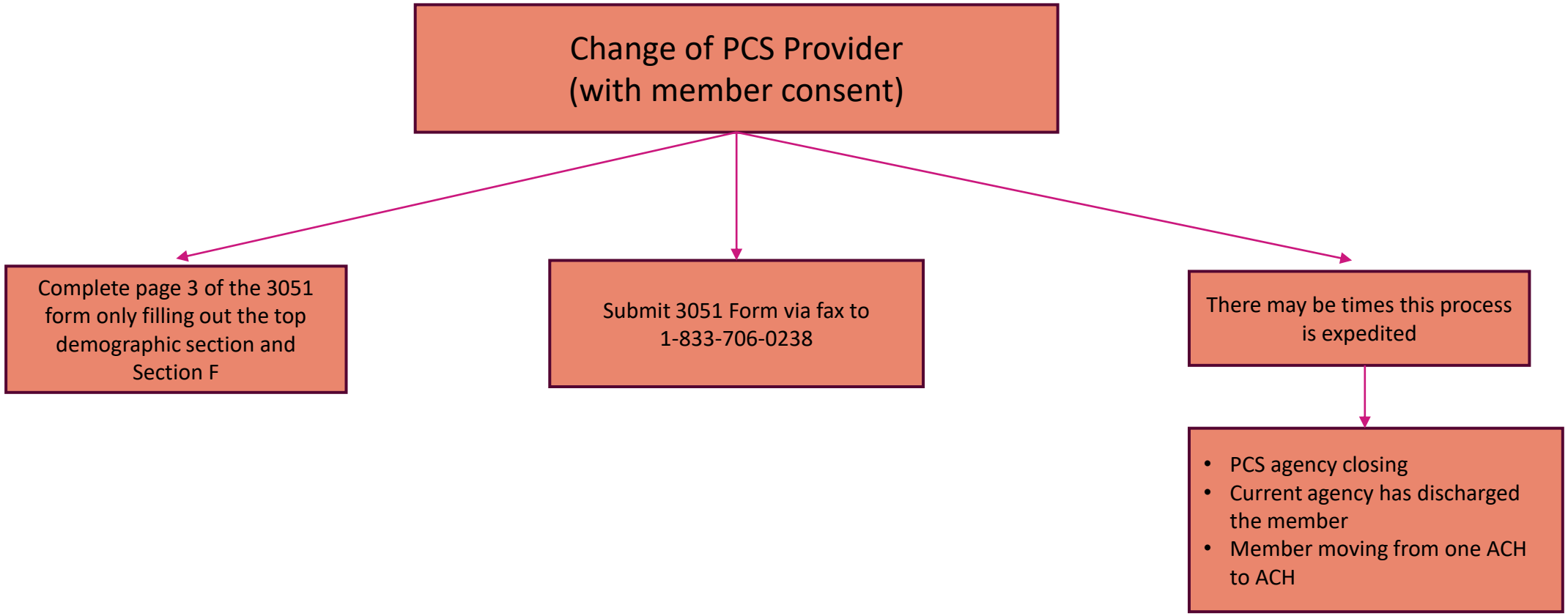


- If form is not complete (missing information, etc.) the 3051 is faxed back to the physician with an explanation of the missing information.
- Unable to Process – a request is considered "Unable to Process" when missing two or more of the identifying pieces of information

- The provider may request a P2P. Instructions will be found on the denial letter.
- If the provider wants to appeal the decision, the provider can call Carolina Complete Health
- A member can also request a State Fair Hearing

Reminder: To update your fax number, please update NCTracks

Changing PCS Providers

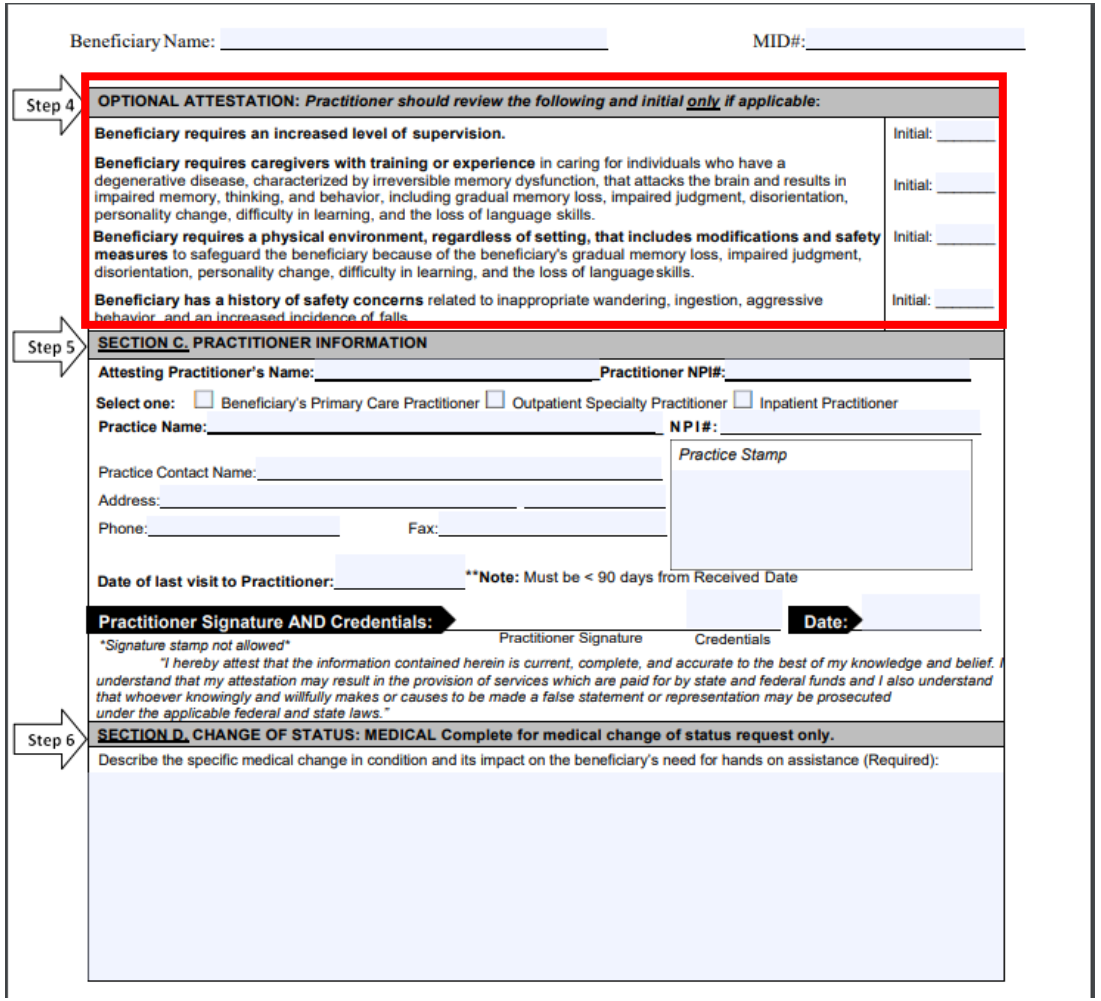


Requesting Additional PCS Hours

If the beneficiary is eligible for additional hours under Session Law 2013-306, the physician must complete the "optional attestation" section of the form to be considered for additional hours of PCS. Submit to via fax to Carolina Complete Health Care Management: 1-833-706-0238

1. Requires an increased level of supervision (observation resulting in an intervention) as assessed during an independent assessment conducted by NC Medicaid or a DHHS designated contractor;
2. Requires caregivers with training or experience in caring for individuals who have a degenerative disease characterized by irreversible memory dysfunction, that attacks the brain and results in impaired memory, thinking, and behavior, including gradual memory loss, impaired judgment, disorientation, personality change, difficulty learning, and the loss of language skills;

3. Regardless of setting, requires a physical environment that addresses safety and safeguards the beneficiary because of the beneficiary's gradual memory loss, impaired judgment, disorientation, personality change, difficulty learning, and loss of language skill; and
4. Health record documentation or verifiable information provided by a caregiver obtained during the independent assessment reflects a history of escalating safety concerns related to inappropriate wandering, ingestion, aggressive behavior, and an increased incidence of falls.



Beneficiary Name: _____ MID#: _____

Step 4

OPTIONAL ATTESTATION: ***Practitioner should review the following and initial only if applicable:***

Beneficiary requires an increased level of supervision.	Initial: _____
Beneficiary requires caregivers with training or experience in caring for individuals who have a degenerative disease, characterized by irreversible memory dysfunction, that attacks the brain and results in impaired memory, thinking, and behavior, including gradual memory loss, impaired judgment, disorientation, personality change, difficulty in learning, and the loss of language skills.	Initial: _____
Beneficiary requires a physical environment, regardless of setting, that includes modifications and safety measures to safeguard the beneficiary because of the beneficiary's gradual memory loss, impaired judgment, disorientation, personality change, difficulty in learning, and the loss of language skills.	Initial: _____
Beneficiary has a history of safety concerns related to inappropriate wandering, ingestion, aggressive behavior, and an increased incidence of falls.	Initial: _____

Step 5

SECTION C. PRACTITIONER INFORMATION

Attesting Practitioner's Name: _____ **Practitioner NPI#:** _____

Select one: ☐ Beneficiary's Primary Care Practitioner ☐ Outpatient Specialty Practitioner ☐ Inpatient Practitioner

Practice Name: _____ **NPI#:** _____

Practice Contact Name: _____

Address: _____

Phone: _____ Fax: _____

Practice Stamp

Date of last visit to Practitioner: _____ ****Note:** Must be < 90 days from Received Date

Practitioner Signature AND Credentials: _____ Practitioner Signature _____ Credentials **Date:** _____

Signature stamp not allowed

"I hereby attest that the information contained herein is current, complete, and accurate to the best of my knowledge and belief. I understand that my attestation may result in the provision of services which are paid for by state and federal funds and I also understand that whoever knowingly and willfully makes or causes to be made a false statement or representation may be prosecuted under the applicable federal and state laws."

Step 6

SECTION D. CHANGE OF STATUS: MEDICAL Complete for medical change of status request only.

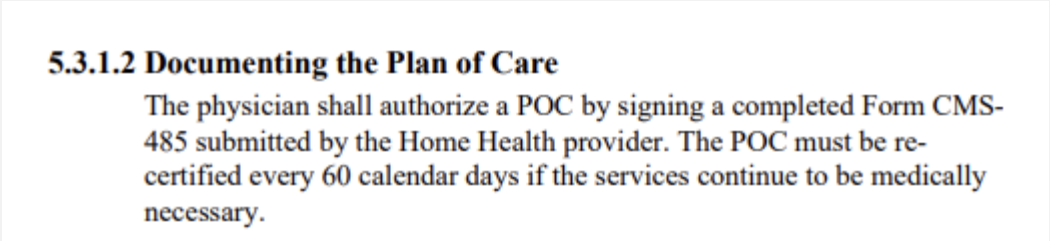
Describe the specific medical change in condition and its impact on the beneficiary's need for hands on assistance (Required):

Continuing PCS

- Providers do not need to request reauthorization of PCS.
- CCH LTSS Care Managers are responsible for reauthorizing personal care services through comprehensive face-to-face visits and assessments.
- Providers can access member health records, assessments and authorization status through the Secure Provider Portal. For support in navigating the Secure Provider Portal, reach out to your Provider Engagement Administrator.

Home Health Care Services

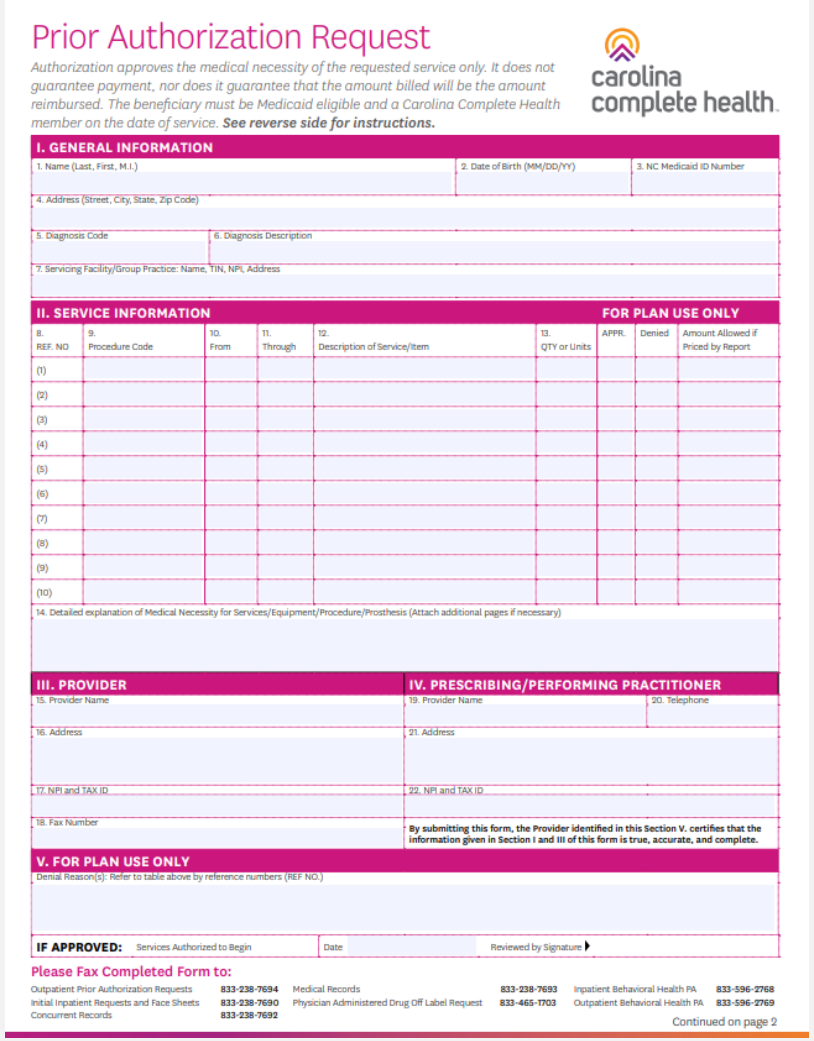
- All Home Health Care Services require a pre-authorization
- When submitting the PA, please attach the Plan of Care (POC) using the CMS-485 Form
- To reduce authorization denials and expedite review and approval, **please submit with the CMS-485 signed by the MD.**
- Clinical Policy: Home Health Services, 3A (PDF)



5.3.1.2 Documenting the Plan of Care

The physician shall authorize a POC by signing a completed Form CMS-485 submitted by the Home Health provider. The POC must be re-certified every 60 calendar days if the services continue to be medically necessary.

PA Submission Methods



Prior Authorization Request

Authorization approves the medical necessity of the requested service only. It does not guarantee payment, nor does it guarantee that the amount billed will be the amount reimbursed. The beneficiary must be Medicaid eligible and a Carolina Complete Health member on the date of service. ***See reverse side for instructions.***

carolina complete health

I. GENERAL INFORMATION

1. Name (Last, First, M.I.) | 2. Date of Birth (MM/DD/YY) | 3. NC Medicaid ID Number

4. Address (Street, City, State, Zip Code)

5. Diagnosis Code | 6. Diagnosis Description

7. Servicing Facility/Group Practice: Name, TIN, NPI, Address

II. SERVICE INFORMATION — **FOR PLAN USE ONLY**

8. REF. NO	9. Procedure Code	10. From	11. Through	12. Description of Service/Item	13. QTY or Units	APPR.	Denied	Amount Allowed if Priced by Report
(1)								
(2)								
(3)								
(4)								
(5)								
(6)								
(7)								
(8)								
(9)								
(10)								

14. Detailed explanation of Medical Necessity for Services/Equipment/Procedure/Prosthesis (Attach additional pages if necessary)

III. PROVIDER

15. Provider Name

16. Address

17. NPI and TAX ID

18. Fax Number

IV. PRESCRIBING/PERFORMING PRACTITIONER

19. Provider Name | 20. Telephone

21. Address

22. NPI and TAX ID

By submitting this form, the Provider identified in this Section V. certifies that the information given in Section I and III of this form is true, accurate, and complete.

V. FOR PLAN USE ONLY

Denial Reason(s): Refer to table above by reference numbers (REF NO.)

IF APPROVED: Services Authorized to Begin | Date | Reviewed by Signature

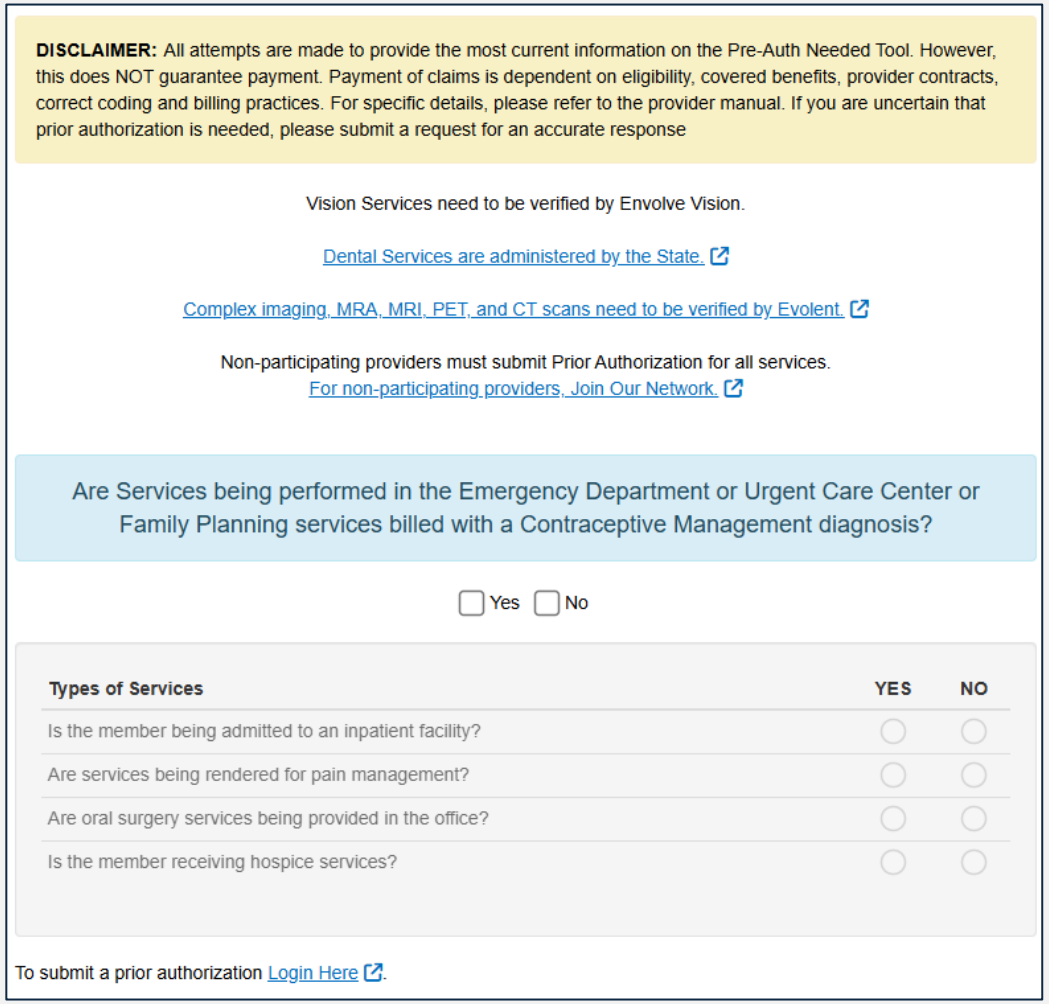
Please Fax Completed Form to:

Outpatient Prior Authorization Requests	833-238-7694	Medical Records	833-238-7693	Inpatient Behavioral Health PA	833-596-2768
Initial Inpatient Requests and Face Sheets	833-238-7690	Physician Administered Drug Off Label Request	833-465-1703	Outpatient Behavioral Health PA	833-596-2769
Concurrent Records	833-238-7692				

Continued on page 2

- Prior Authorization Requests can be submitted via the Secure Provider Portal, Availity Essentials, by phone or via fax.
- Provider portal: https://provider.carolinacompletehealth.com/
- Availity Essentials: https://essentials.availity.com/login
- Prior Authorizations Fax Form can be found on the Carolina Complete Health website under the Prior Authorization tab to submit via phone and fax.
- Phone: 1-833-552-3876
- Fax: Outpatient PA Requests: 833-238-7694
  Initial Inpatient Requests: 833-238-7690
  Concurrent Records: 833-238-7692
  Inpatient Behavioral Health PA: 833-596-2768.
  Outpatient Behavioral Health PA: 833-596-2769

Prior Authorizations (PA) Check Tool



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

Vision Services need to be verified by Envolve Vision.

Dental Services are administered by the State.

Complex imaging, MRA, MRI, PET, and CT scans need to be verified by Evolent.

Non-participating providers must submit Prior Authorization for all services.
For non-participating providers, Join Our Network.

Are Services being performed in the Emergency Department or Urgent Care Center or Family Planning services billed with a Contraceptive Management diagnosis?

☐ Yes ☐ No

Types of Services	YES	NO
Is the member being admitted to an inpatient facility?	○	○
Are services being rendered for pain management?	○	○
Are oral surgery services being provided in the office?	○	○
Is the member receiving hospice services?	○	○

To submit a prior authorization Login Here.

- Use the Carolina Complete Health Standard Plan Pre-Auth Tool, which can be found on the Carolina Complete Health website, to check if a service or procedure requires prior authorization.
- Carolina Complete Health Standard Plan Pre-Auth Tool

Prior Authorization Reminders and Resources

- Emergency / Urgent services do not require prior authorization
- All out-of-network services and providers require prior authorization
- Failure to complete the required authorization or notification may result in denied claim
- Please include Contact Information on Authorization Requests

Provider Resources:

- How to Secure a Prior Authorization
- Carolina Complete Health Standard Plan Prior Authorization Fax Form (Also reference the PA Form Tip Sheet)
- Documentation Tips for Prior Authorization Submission
- How to View Authorizations and Assessments in the Secure Portal

Non-Covered Services and Beyond Benefit Limits

- Prior Authorization is required when:
  - A provider determines a member needs services not included in NC Medicaid covered services/procedures or products
  - A provider determines a member needs services, procedures, or products beyond the identified benefit limits.
- Prior Authorization requirements:
  - When submitting an authorization for the above, providers should fax the request and note the reason for the request:
    - “PA request due to a need beyond the benefit limit”
    - “PA review needed due to code not being found on the NC Medicaid Managed Care Covered Code list”

EXAMPLES:

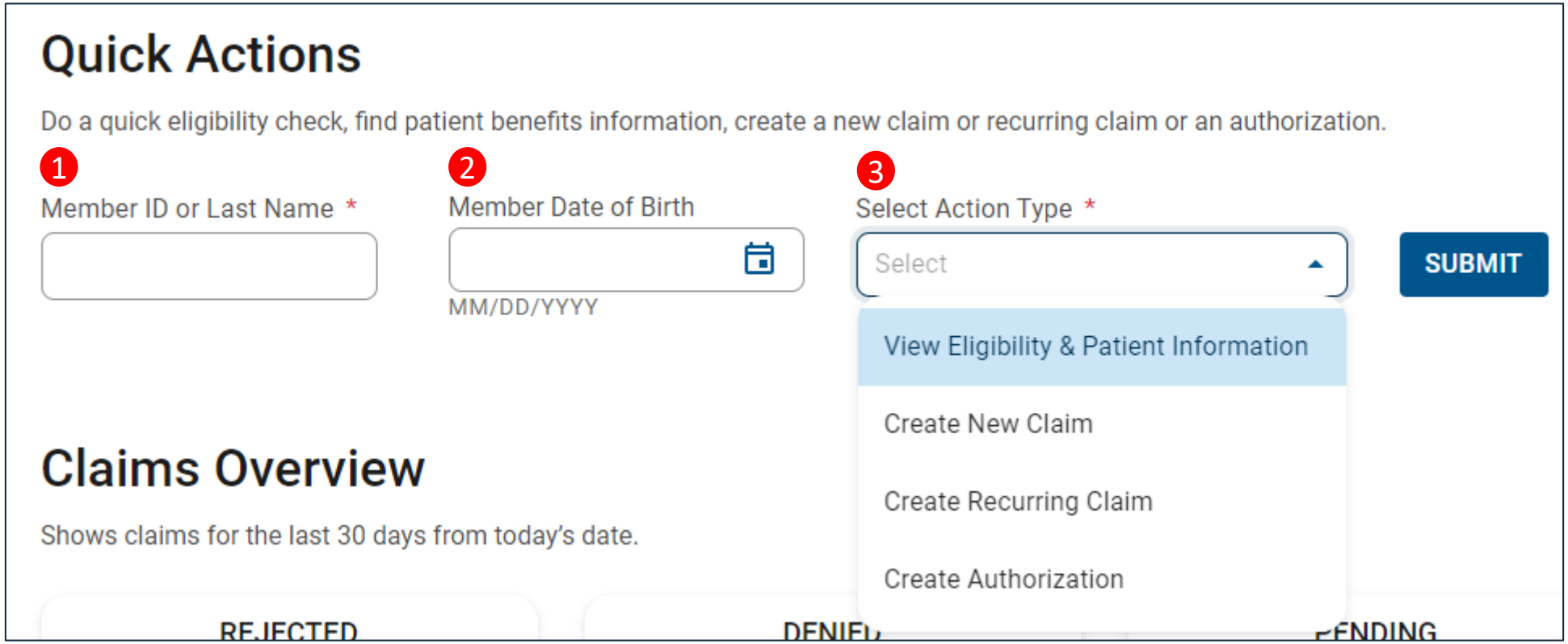
Code/Description	Pre-Auth Check Tool	Benefit Limit per Policy	PA Requirement Beyond Limit/Not Covered
A6258 – Transparent film, sterile, >16 sq. in. but ≤48 sq. in., each dressing	No PA required for all providers	16 per month	PA required if member needs >16/month
T4544 – Adult-sized disposable incontinence product, protective underwear/pull-on, above extra large, each	No PA required for all providers	200 per month	PA required if member needs >200/month
A7035 – Headgear used with positive airway pressure device	No PA required for all providers	2 per year	PA required if member needs >2/year

Viewing Authorizations and Assessments

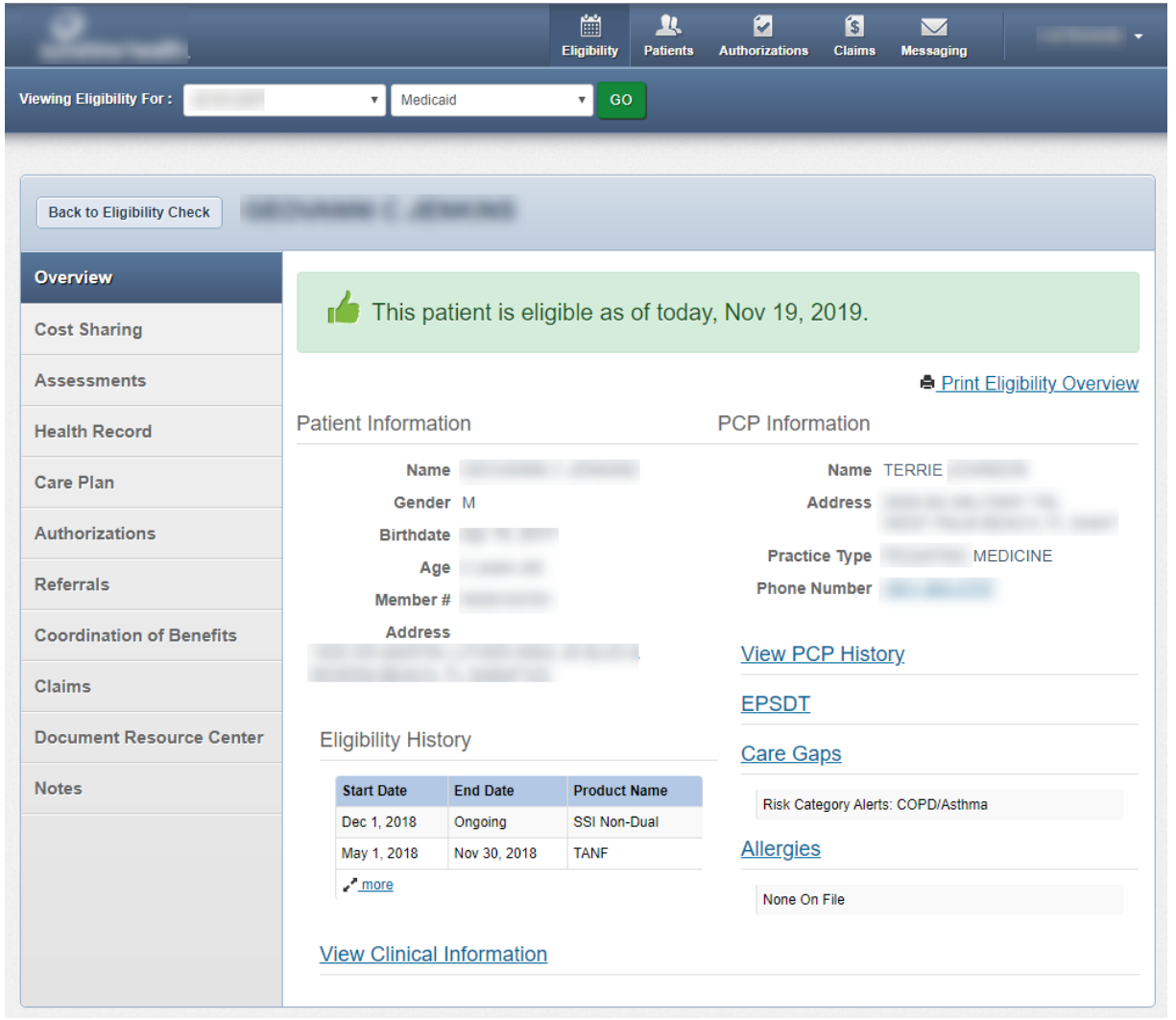
HERE FOR YOUR HEALTH

View Assessments and Auths

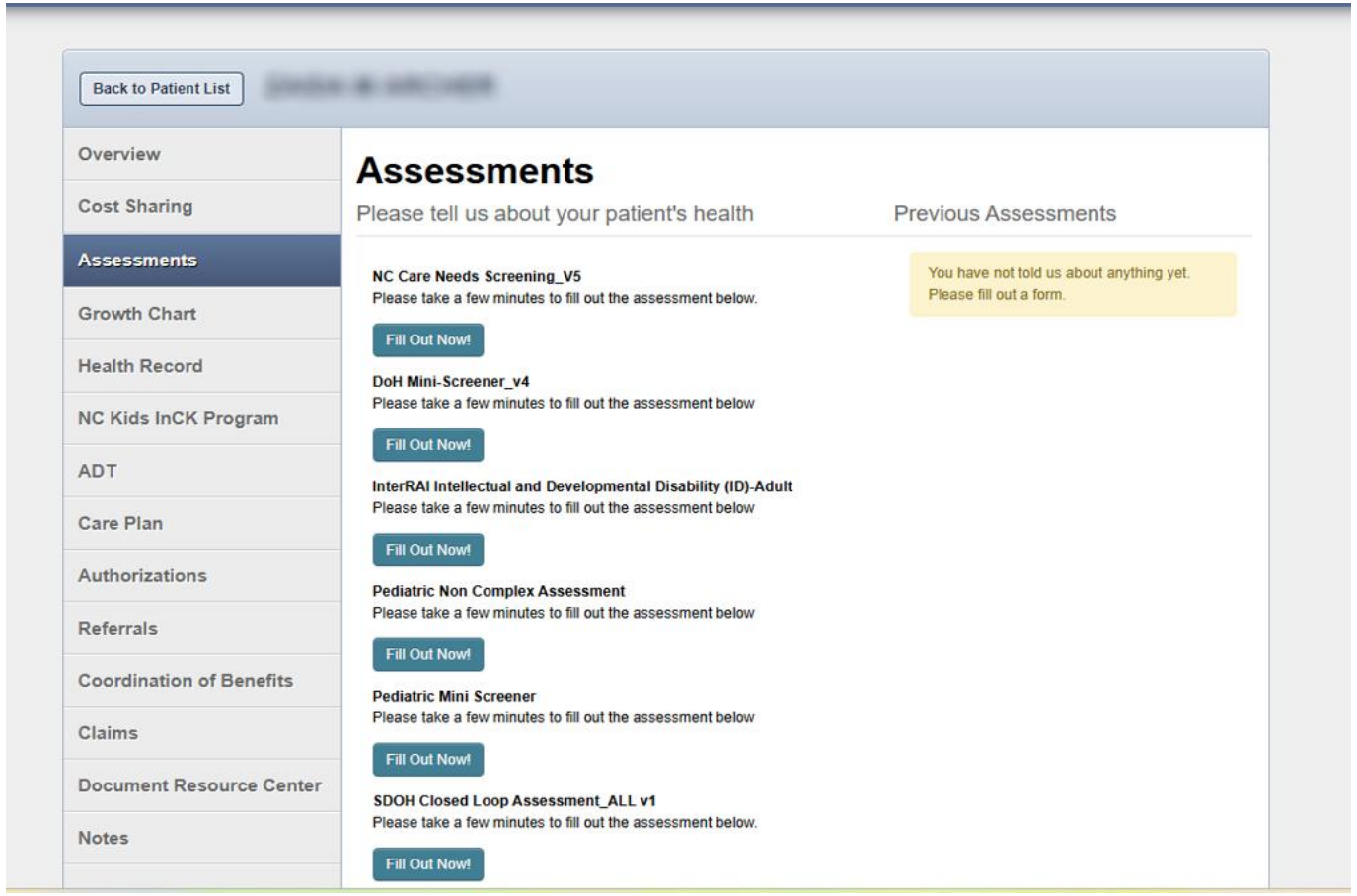
Step 1: View Member Health Record



Patient Overview

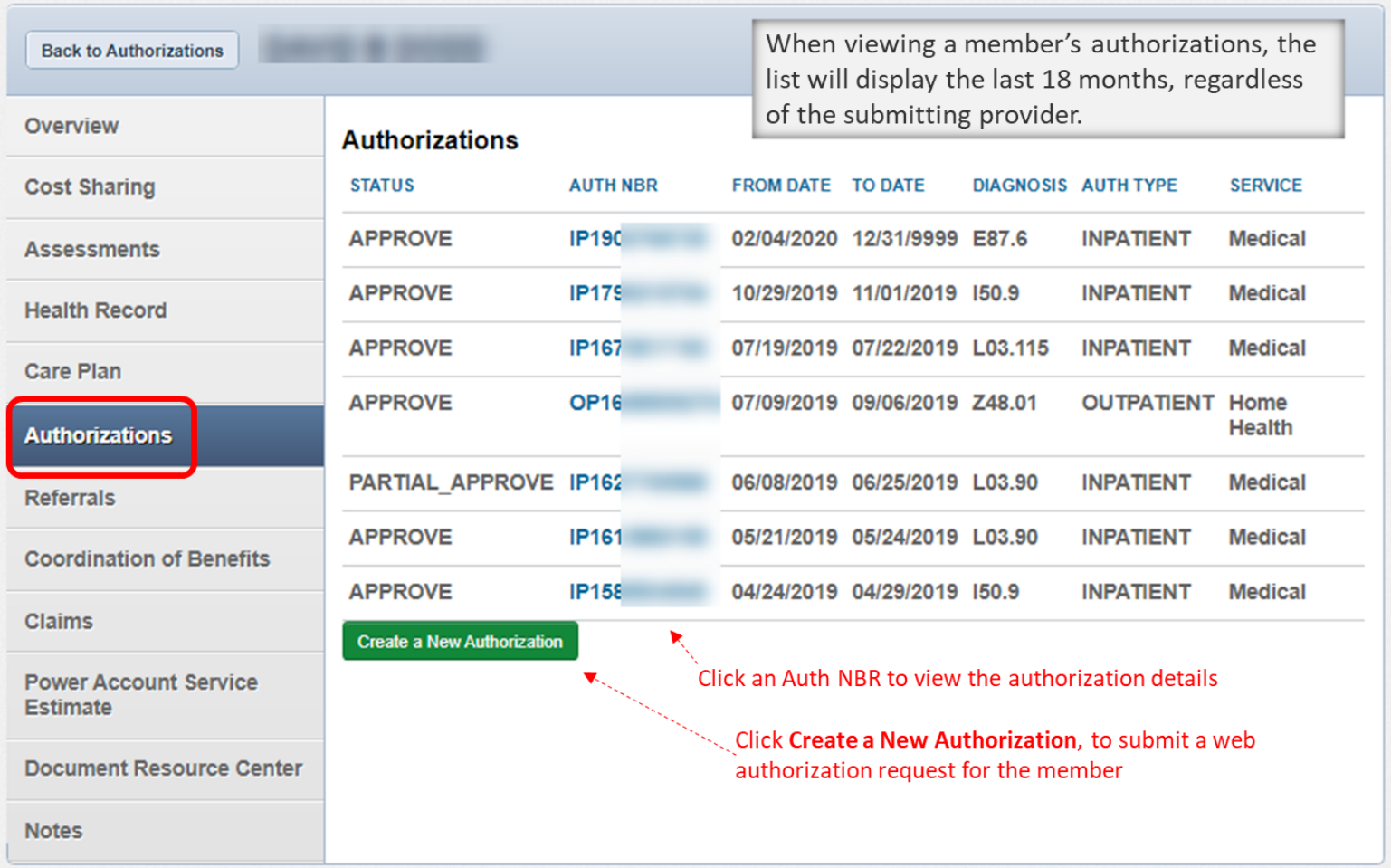


Viewing Assessments



LTSS Assessments will be housed under Previous Assessments

View Authorizations



PCS Provider Tip: When the authorization is winding down, as you meet with the member let them know care management will be reaching out to them to complete their annual assessment. It is very important for the member to stay engaged with care management to complete necessary assessments.

Provider Resources

HERE
FOR YOUR
HEALTH

Provider Resources and Additional Training

- Home Health, PCS Provider Page
- Home Health Provider Office Hours (Monthly on Third Thursday)
- Home Health Care Services Billing, Claims, and Authorizations Guide
- Home Health Care Service Code Crosswalk
- Personal Care Service Provider Guide
- CCH PCS Information Session FAQ and Guide (12/03/25)
- Merger Landing Page
- Provider Communications

Contact Information

Provider Relations:

NetworkRelations@cch-network.com

- Standard contracting requests
- Credentialing/network status
- Claims and payment questions
- Inquiries related to administrative policies, procedures, and operational issues
- ...and more!

Provider Engagement

ProviderEngagement@cch-network.com

- Provider education and orientation
- Provider portal technical assistance
- Payspan support for EFT/ERA
- HEDIS/Care gap reviews
- Financial analysis on P4P and CoC programs
- ...and more!

Provider Services

Dial 1-833-552-3876 to speak with a representative or use the IVR System:

- Verify beneficiary demographic information
- Check claim status
- Obtain benefit information such as office, emergency room, inpatient and outpatient coverage, long-term care, and community services
- Connect to care coordinators and referral specialist

Upcoming Sessions

Provider Info Sessions

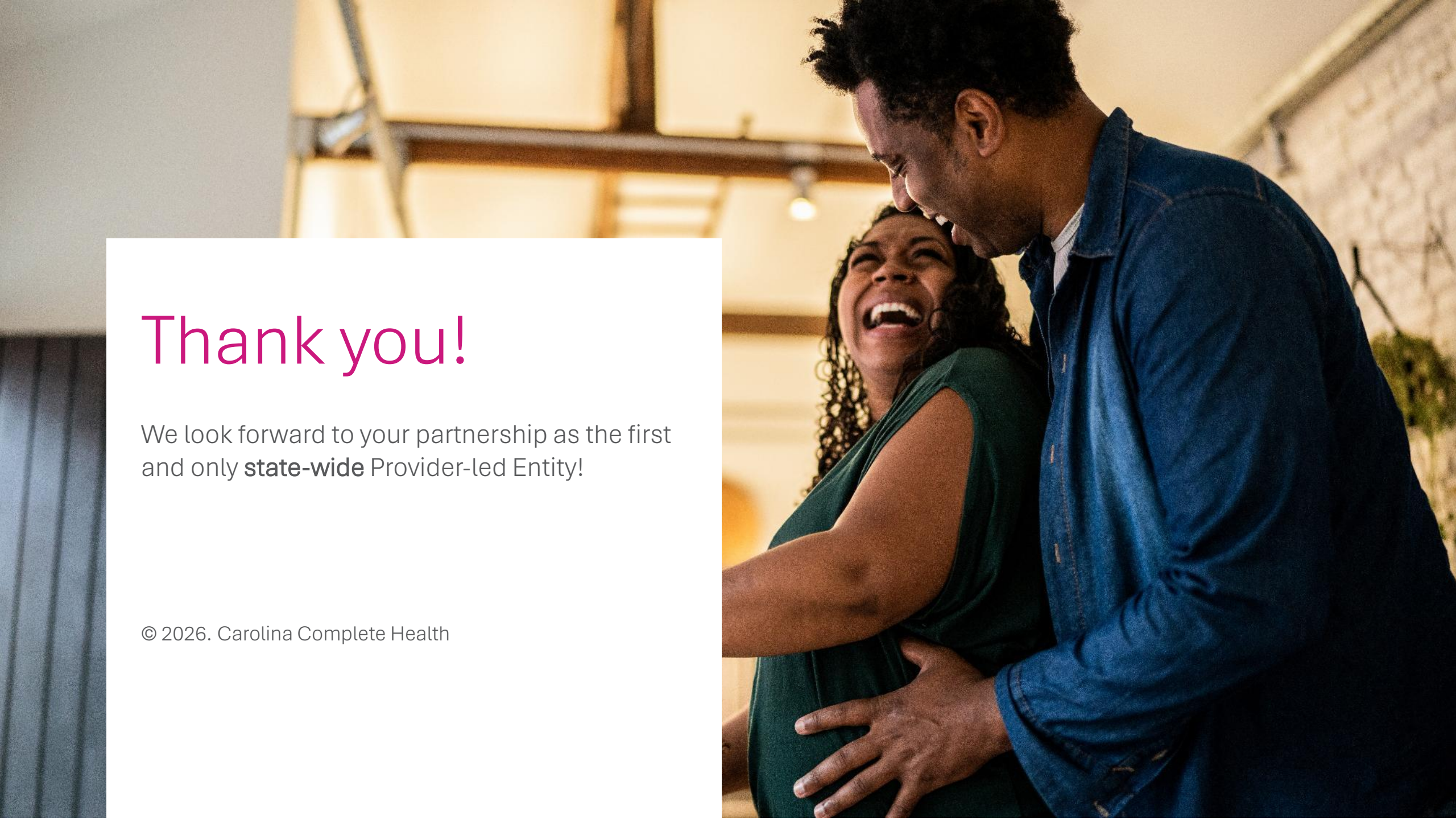
(All sessions begin at 12PM)

- ~~February 19~~
  Slides (PDF), Recording
- ~~March 5th BH/DME/PT/OT/ST~~
  Slides (PDF), Recording
- ~~March 19~~ Slides (PDF)
- April 2
- April 16
- Register Here

Carolina Complete Health
Secure Portal Training

(All sessions begin at 12PM)

- ~~February 26~~
  View slides (PDF), Recording
- ~~March 12~~
- March 26
- April 9
- April 23
- Register Here



Thank you!

We look forward to your partnership as the first and only **state-wide** Provider-led Entity!