carolina complete health™

Welcome to Carolina Complete Health;

North Carolina's First and Only Statewide Provider-Led Entity

HERE FOR YOUR HEALTH

Carolina Complete Health

New Provider Orientation
2026

Agenda

Overview

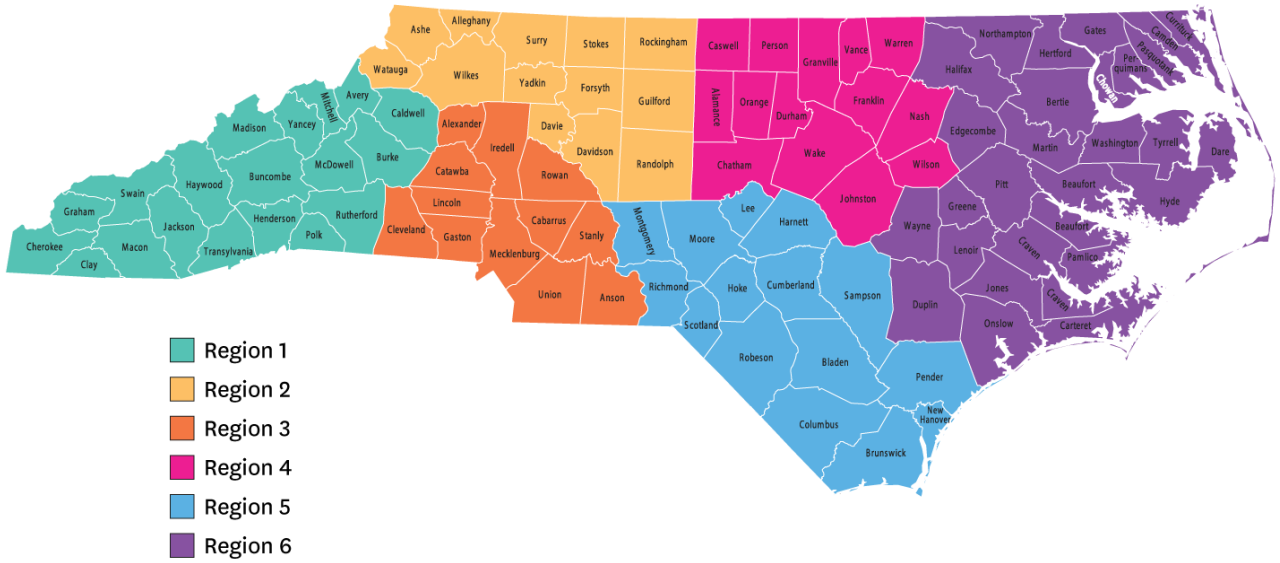
- Who We Are
- Carolina Complete Health and WellCare North Carolina Merger
- Network and Contracting FAQs
- Tailored Plan Partnership

What You Need to Know

- Provider Support
- Provider Manual
- Access Standards
- Public Website and Secure Portal
- Verification Member Eligibility, Benefits and Copays
- Care Management
- Claims, Billing and Payments
- Utilization Management
- Grievances and Appeals
- Clinical policy
- Onboarding Trainings
- Resources

Single Statewide **Provider-Led Entity**

- On April 1, 2026 WellCare of North Carolina and Carolina Complete Health merged into a single statewide PLE.
- **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

Provider-Led Managed Care

Centene Corporation	• Fortune 25 company with over 30 years of Medicaid experience • #1 in Medicaid and #1 in Marketplace in the U.S., operating in 50 states • Insure 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	• 39 health center grantees and look-alike organizations • Serving over 500,000 underinsured and uninsured • 270 clinical sites across 100 counties in North Carolina

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Contracting and Network

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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.

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.

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Tailored Plans

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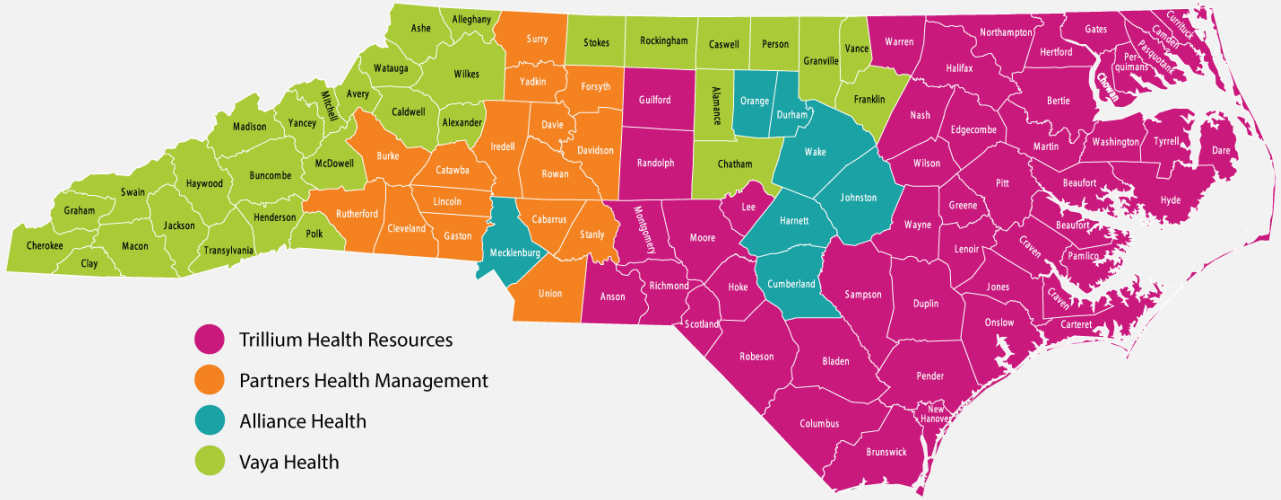
Confidential and

Tailored Plans

- Beginning April 1, 2026, Carolina Complete Health will be serving **all four Tailored Plains**: Alliance Health, Partners Health Management, Trillium Health Resources, and Vaya Health.
- Tailored Plans cover the same physical health services as Standard Plans plus specialized services for individuals with significant behavioral health conditions, intellectual/developmental disabilities (I/DDs), and traumatic brain injury (TBI), including Innovations and TBI waiver enrollees.
- Alliance and Vaya will continue managing their own provider networks. Carolina Complete Health will continue contracting for physical health providers for Trillium and Partners.
- For Alliance and Vaya, Carolina Complete Health will provide Nurse Advice Line services.
- For Trillium and Partners, Carolina Complete Health will continue to process physical health claims*, provide utilization management functions, serve in a secondary care management role for some members, provide Nurse Advice Line services, and some of the other same services and supports that have historically been provided.

*Trillium intends to pay its own physical health claims as early as 7/1/2026.



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Provider Support

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Provider Experience Team

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 Interactive Voice Response (IVR) system to:

- 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
- Obtain co-payment information when checking beneficiary eligibility
- Connect to care coordinators and referral specialist

Provider and Billing Manuals

- Located https://network.carolinacompletehealth.com/resources/manuals-and-forms.html

- Both manuals includes a wide array of important information relevant to providers including, but not limited to:
  - Network information
  - Billing guidelines
  - Claims information
  - Regulatory information
  - Key contact list
  - Quality initiatives
  - And much more!

Provider and Billing Manuals

Located network.carolinacompletehealth.com/forms

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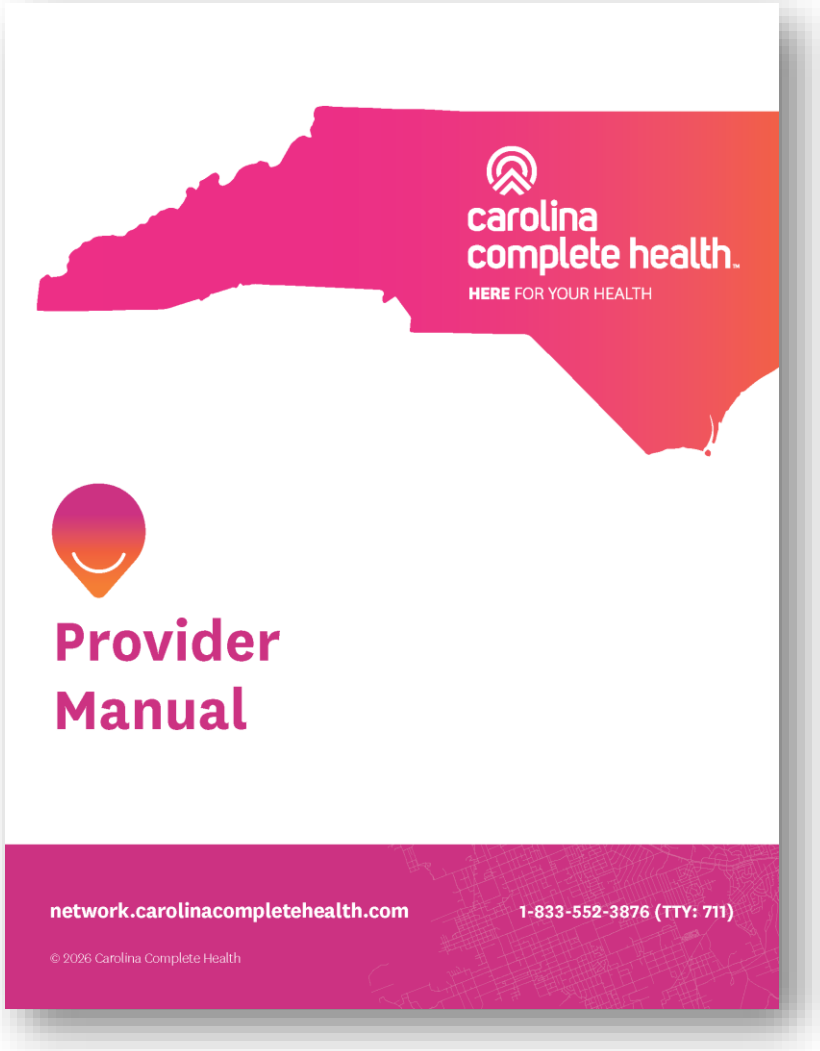

Access and Availability Standards

Visit Type	Standard
Primary Care	
Preventive Care Service – adult, twenty-one (21) years of age and older	Within thirty (30) Calendar days
Preventive Care Services – child, birth through twenty (20) years of age	Within fourteen (14) Calendar days for Beneficiary less than six (6) months of age Within thirty (30) Calendar days for Beneficiary's six (6) months or age and older.
Urgent Care Services	Within twenty-four (24) hours
Routine/Check-up without Symptoms	Within thirty (30) Calendar days
After-Hours Access – Emergent and Urgent	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
Prenatal Care	
Initial Appointment – 1st or 2nd Trimester	Within fourteen (14) Calendar days
Initial Appointment – high risk pregnancy or 3rd Trimester	Within five (5) Calendar days
Specialty Care	
Urgent Care Services	Within twenty-four (24) hours
Routine/Check-up without Symptoms	Within thirty (30) Calendar days
After-Hours Access – Emergent and Urgent Instructions	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
Behavioral Health Care	
Mobile Crisis Management Services	Within two (2) hours
Urgent Care Services for Mental Health	Within twenty-four (24) hours
Urgent Care Services for SUDs	Within twenty-four (24) hours
Routine Services for Mental Health	Within fourteen (14) calendar days
Routine Services for SUDs	Within forty-eight (48) hours
Emergency Services for Mental Health	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}
Emergency Services for SUDs	Immediately {available twenty-four (24) hours a day, three hundred sixty-five (365) days a year}

After Hours 24-Hour Access

After Hours (Passing Standards)
During after-hours, a provider must have arrangements for:

- Access to a covering physician,
- An answering service,
- Triage service, or
- A voice message that provides a second phone number that is answered. Any recorded message must be provided in English and Spanish, if the provider's practice includes a high population of Spanish speaking beneficiaries.

Web-based Tools

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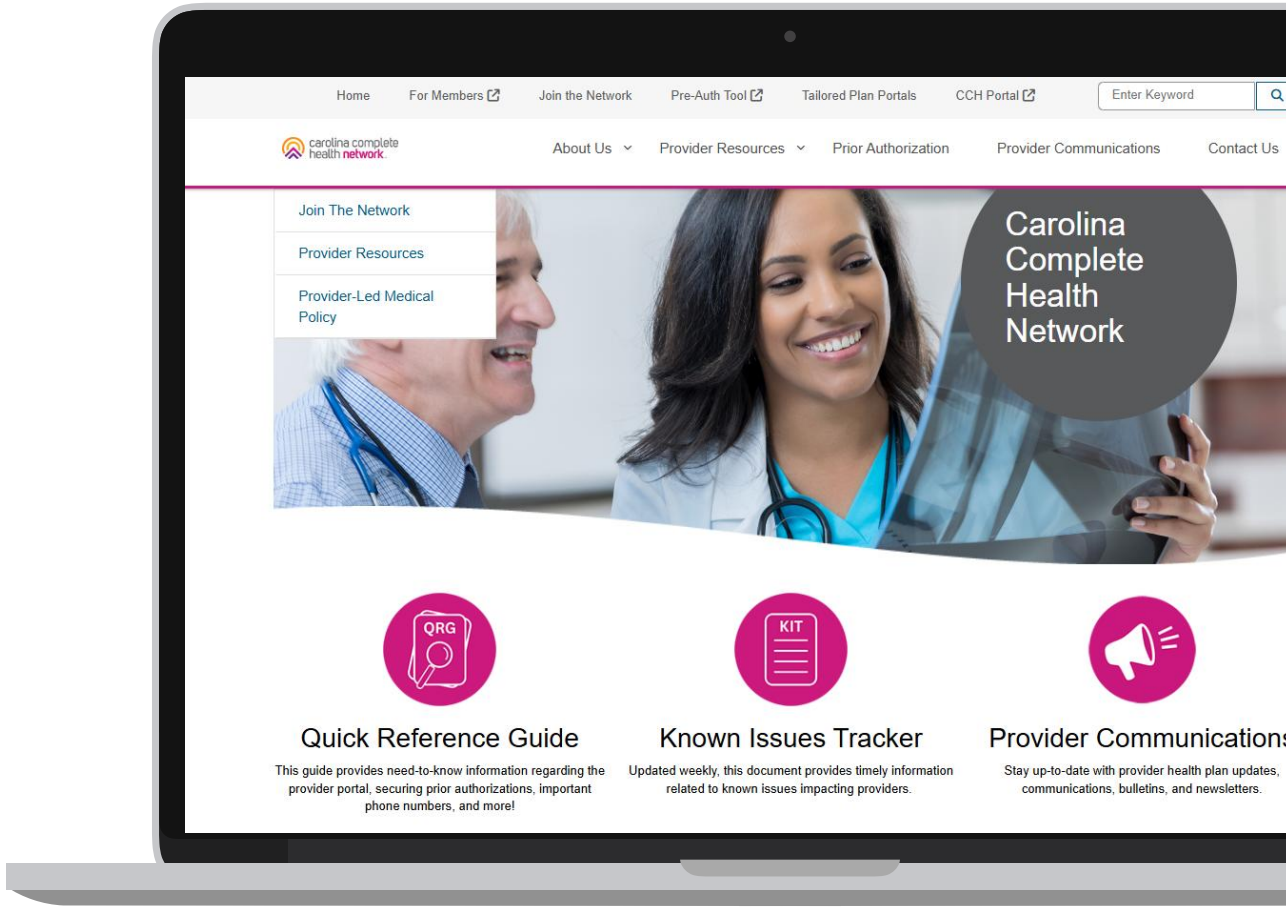
Provider Website

network.carolinacompletehealth.com

- Quick Reference Guide
- Pre-Auth Tool
- Known Issues Tracker
- Provider and Billing Manuals
- Forms and Guides
- Communications
- PE Contact Information
- FAQs, Toolkits, Training, and more!



Tailored Plan Physical Health Portals

- Effective July 1, 2024, providers who are contracted with Partners for Tailored Plan will submit Physical Health claims or authorization inquiries through Partners ProviderCONNECT Portal.
- https://www.partnersbhm.org/tailoredplan/providers/providerconnect/
- Partners ProviderCONNECT set up:
- Designated portal administrators must complete Partners Health Management ProviderCONNECT set-up form.
- For questions about this form please contact credentialingteam@partnersbhm.org.
- View additional information on ProviderConnect through Partners provider website.

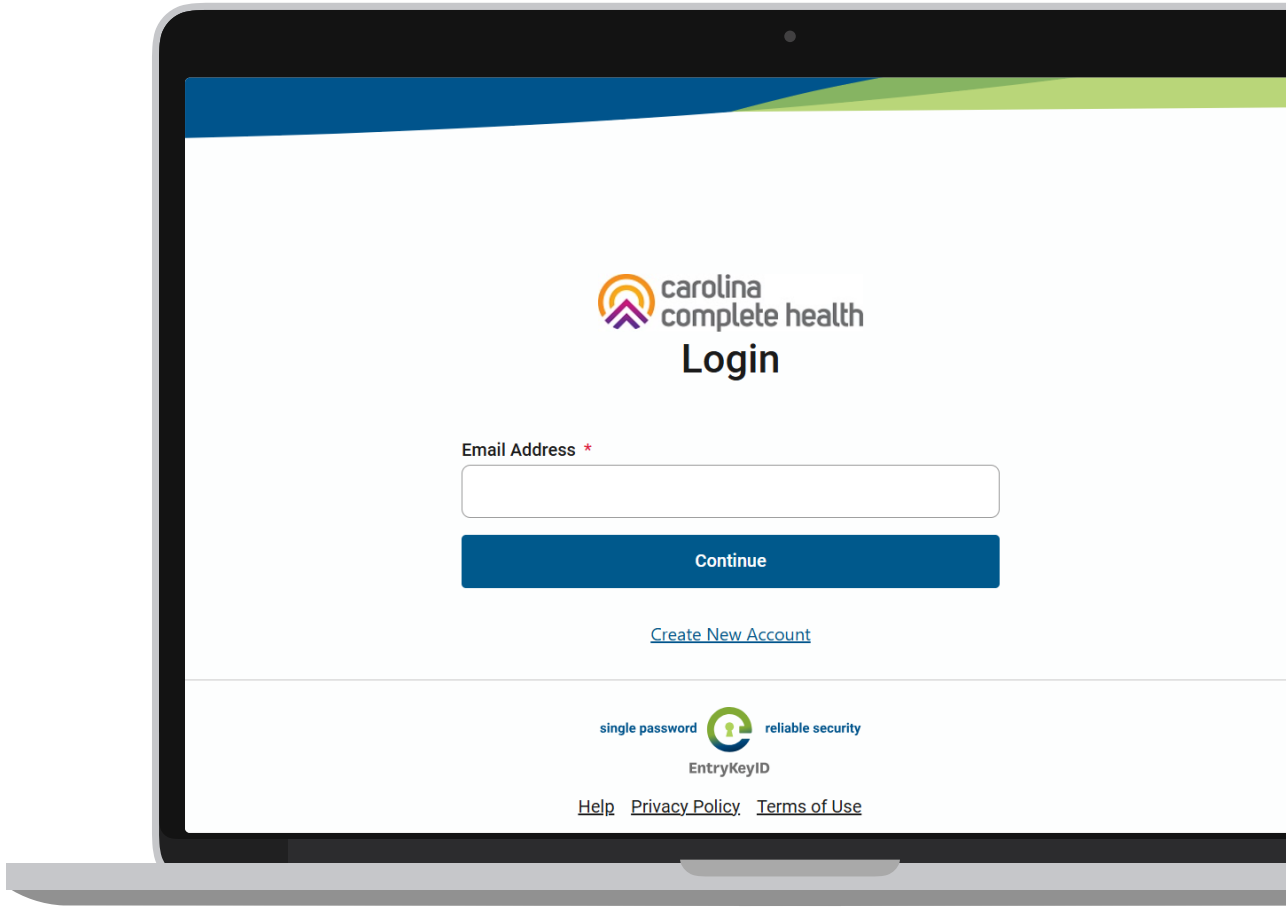
- Effective July 1, 2024, providers who are contracted with Trillium for Tailored Plan will submit Physical Health claims or authorization inquiries through the Trillium Physical Health Portal: https://provider.trilliumhealthresources.org/
- To access the Trillium Physical Health Portal, contracted providers must identify an individual who will serve as the Portal Account Manager.
- The Account Manager should follow the prompts using the portal link to create an account, validate their email, and register the Tax ID Number (TIN)
- After registering, email your assigned Provider Engagement Administrator or ProviderEngagement@cch-network.com to request verification.

Availity Essentials

- Providers can continue using 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
  - 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

Secure Provider Portal

- provider.carolinacompletehealth.com/
- Secure Provider Portal Functions:
  - Beneficiary eligibility & patient listings
  - Health records & care gaps
  - Prior Authorization
  - Claims submissions & status
  - Payment history
  - Monthly PCP cost reports
  - …and more!
- Secure Portal Training:
  - Registering and Logging In
  - Submitting a Claim
  - Checking Member Eligibility and Health Record
  - LINK NEW TRAINING*



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
- ✓ Send password reset email to users whose portal account is locked due to inactivity
- ✓ 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 CCH 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.

Portal Access for Third-Party Billers

Third-party billing entities supporting Carolina Complete Health providers may have access to the Secure Provider Portal when validated by the practice's Portal Account Manager.

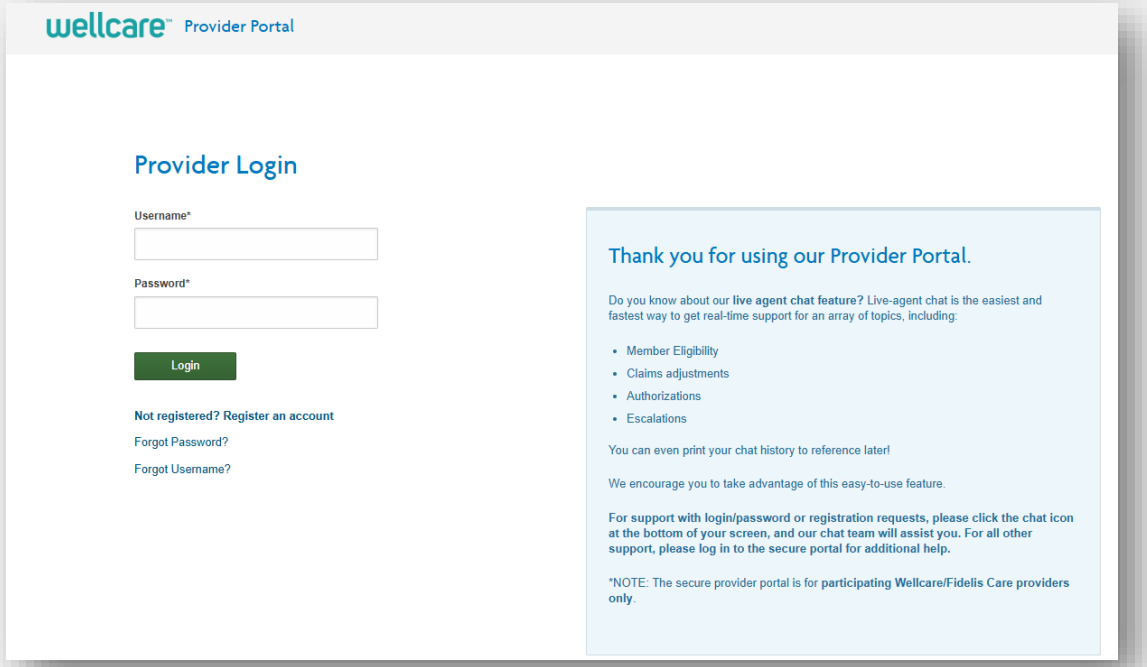
Access Steps:

1. Portal Account Manager sends an invitation to the third-party billers email address.
2. The biller receives an email link to the CCH Secure Provider Portal
3. The biller completes the account set-up by:
    - Creating an account
    - Verifying their email address
    - Entering the TIN, phone number and fax number (enter "0" if not available).
4. The biller contacts the Portal Account Manager to request account verification.
5. Once verified the biller can log in and submit claims and view claims.

For additional information please review the Third-Party Biller Provider Portal Set-up (PDF)

WellCare Portal

- Legacy systems for WellCare of NC will remain operational for historical Medicaid claim access. Historical claim access will be supported for 2 years post 4/1/2026.
- No change for Wellcare Medicare: https://www.wellcare.com/north-carolina
- Secure Provider Portal Functions:
  - Beneficiary eligibility & patient listings
  - Care Gap submission
  - Prior Authorization
  - Claims submissions & status
  - Payment history
  - Active member lists
- Secure Portal Training:
  - New Provider Portal Overview Training | Wellcare
  - Portal Registration Guide
  - Provider Portal Claims | Wellcare
  - Submitting Medical Authorizations | Wellcare



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Serving Carolina Complete Health Members

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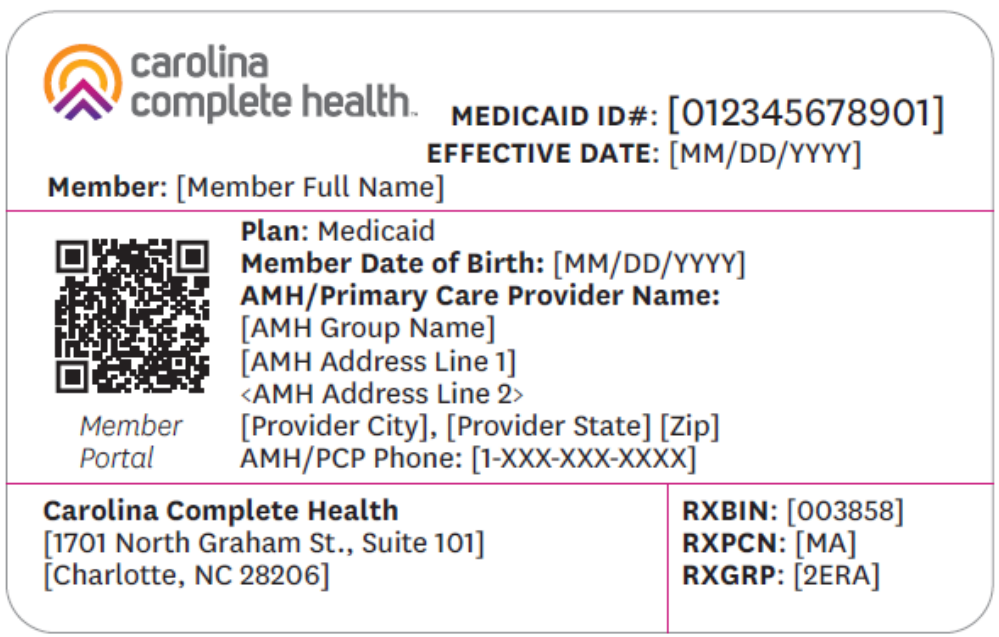
Member ID Card

- Possession of an ID card does not guarantee eligibility. Verify eligibility through the secure provider portal, Availity Essentials, or calling 1-833-552-3876.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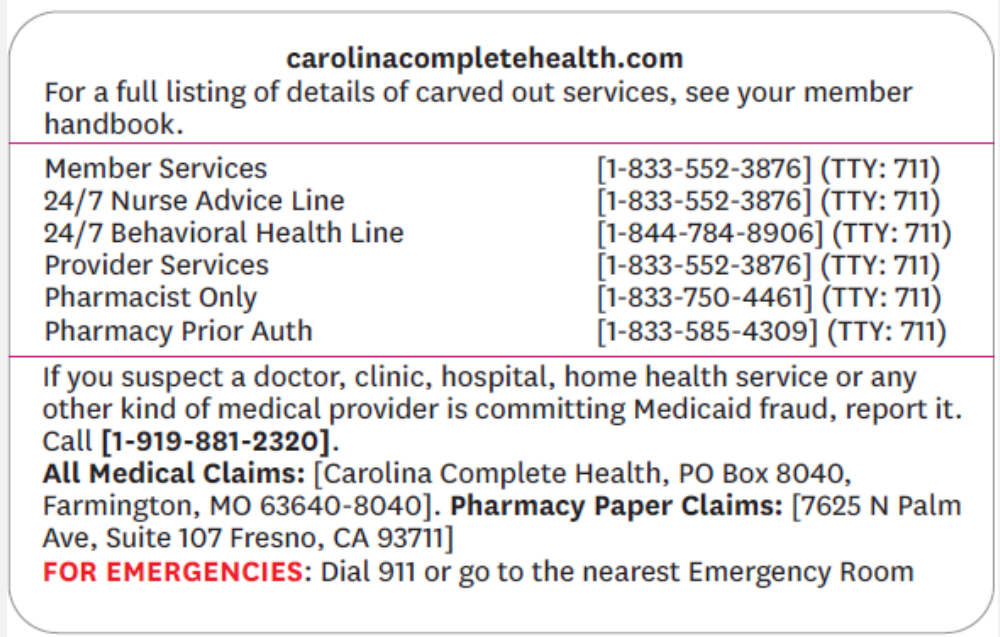
MEDICAID ID#: [012345678901]
EFFECTIVE DATE: [MM/DD/YYYY]
Member: [Member Full Name]

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

Update: Enhanced PCP Member Move Process

Submitting Requests to Assign Members **INTO** Your Practice

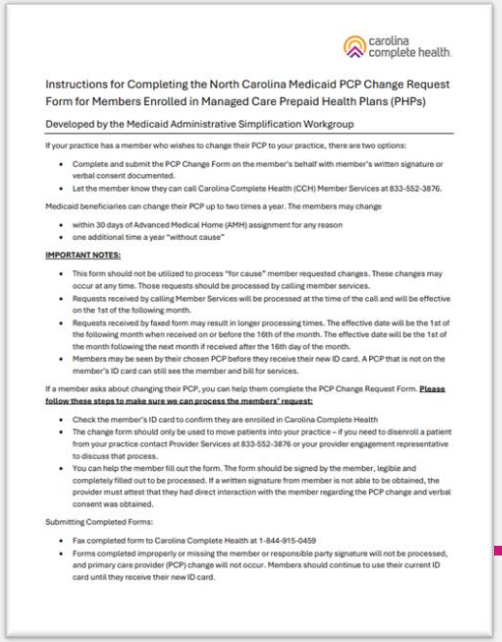
- **Complete the provided spreadsheet.**
- Include the reason for assignment (e.g., date of last visit).
- Complete the attestation to confirm that your practice has been communicated with each member listed.
- Send via secured email to providerengagement@cch-network.com
- For more information refer to Enhanced PCP Member Move Process (PDF)

Submitting Requests to Assign Members **OUT OF** Your Practice **use the same spreadsheet** to request removal of members who:

- Have been discharged
- Have moved care to another PCP Incorrect assignment due to geographical location or has moved out of service area .
- Do not fall into the gender or age limit of your practice.
- Send via secured email to providerengagement@cch-network.com with supporting documentation.

Primary Care Provider Change Form: Alternative Option

- A member can see any in-network PCP even if they are not listed on their CCH Medicaid ID card.
- To update the PCP on a member's card, submit the PCP Change Form.
- A member can also call Member Services at 1-833-552-3876.
- Changes are effective the 1st of the following month.



Instructions for Completing the North Carolina Medicaid PCP Change Request Form for Members Enrolled in Managed Care Prepaid Health Plans (PHPs)

Developed by the Medicaid Administrative Simplification Workgroup

If your practice has a member who wishes to change their PCP to your practice, there are two options:

- Complete and submit the PCP Change Form on the member's behalf with member's written signature or verbal consent documented.
- Let the member know they can call Carolina Complete Health (CCH) Member Services at 833-552-3876.

Medicaid beneficiaries can change their PCP up to two times a year. The members may change

- within 30 days of Advanced Medical Home (AMH) assignment for any reason
- one additional time a year "without cause"

IMPORTANT NOTES:

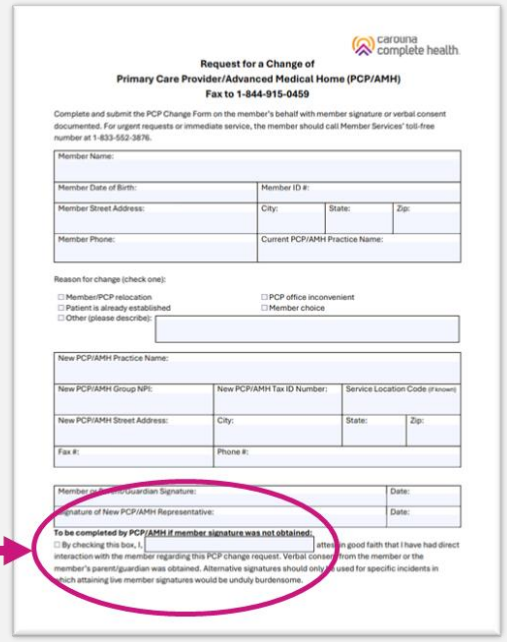
- This form should not be utilized to process "for cause" member requested changes. These changes may occur at any time. Those requests should be processed by calling member services.
- Requests received by calling Member Services will be processed at the time of the call and will be effective on the 1st of the following month.
- Requests received by faxed form may result in longer processing times. The effective date will be the 1st of the following month when received on or before the 16th of the month. The effective date will be the 1st of the month following the next month if received after the 16th day of the month.
- Members may be seen by their chosen PCP before they receive their new ID card. A PCP that is not on the member's ID card can still see the member and bill for services.

If a member asks about changing their PCP, you can help them complete the PCP Change Request Form. **Please follow these steps to make sure we can process the members' request:**

- Check the member's ID card to confirm they are enrolled in Carolina Complete Health
- The change form should only be used to move patients into your practice – if you need to disenroll a patient from your practice contact Provider Services at 833-552-3876 or your provider engagement representative to discuss that process.
- You can help the member fill out the form. The form should be signed by the member, legible and completely filled out to be processed. If a written signature from member is not able to be obtained, the provider must attest that they had direct interaction with the member regarding the PCP change and verbal consent was obtained.

Submitting Completed Forms:

- Fax completed form to Carolina Complete Health at 1-844-915-0459
- Forms completed improperly or missing the member or responsible party signature will not be processed, and primary care provider (PCP) change will not occur. Members should continue to use their current ID card until they receive their new ID card.



Request for a Change of
Primary Care Provider/Advanced Medical Home (PCP/AMH)
Fax to 1-844-915-0459

Complete and submit the PCP Change Form on the member's behalf with member signature or verbal consent documented. For urgent requests or immediate service, the member should call Member Services' toll-free number at 1-833-552-3876.

Member Name:
Member Date of Birth: | Member ID #:
Member Street Address: | City: | State: | Zip:
Member Phone: | Current PCP/AMH Practice Name:

Reason for change (check one):

☐ Member/PCP relocation ☐ PCP office inconvenient
☐ Patient is already established ☐ Member choice
☐ Other (please describe):

New PCP/AMH Practice Name:
New PCP/AMH Group NPI: | New PCP/AMH Tax ID Number: | Service Location Code (If known)
New PCP/AMH Street Address: | City: | State: | Zip:
Fax #: | Phone #:

Member or Parent/Guardian Signature: | Date:
Signature of New PCP/AMH Representative: | Date:

To be completed by PCP/AMH if member signature was not obtained:

☐ By checking this box, I, _____ attest in good faith that I have had direct interaction with the member regarding this PCP change request. Verbal consent from the member or the member's parent/guardian was obtained. Alternative signatures should only be used for specific incidents in which attaining live member signatures would be unduly burdensome.

Value-Added Services

- In this merger, WellCare of North Carolina and Carolina Complete Health combined its value-added services (VAS)
- VAS details can be found at carolinacompletehealth.com/vas.

- $75 My Heath Pays Visa® Rewards Card)
- $150 Annual Household Food Allowance
- Active & Fit Gym Membership (Aged 18+)
- Doula and Breastfeeding Support Including Breast Pump
- $150 New Parent's Package (Choice of car seat, portable crib, or stroller)
- 12 Hours of Tutoring for Members (Pre-K-12)
- $50 Backpack with School Supplies (K-12)
- GED Prep and Exam Voucher
- $175 Youth Program Voucher (Age 4-18)
- Up to $150 Room to Breathe Asthma Supplies
- $250 Housing/Utilities Allowance (per household)
- $120 CVS® Over the Counter Allowance
- $125 Vision Allowance for Members (Aged 21+)
- Weight Watchers Program (Aged 18+)
- Mental Health App through Teladoc
- Hearing Aids as an Extra Benefit (Aged 21+)
- $175 Annual Expungement Certification Fee
- Transportation to VAS Service Locations
- $100 on a Rewards Card for two (2) Tribal Talking Circles
- Cell Phone with Free Talk & Text
- Baby Bottles at Welcome Rooms
- Community Baby Showers for New or Expecting Parents
- Sensory and Alzheimer's/Dementia Kits
- Post-Hospitalization Home Delivered Meals

Non-Emergency Medical Transportation

Beginning April 1, 2026, Carolina Complete Health will use Medical Transportation Management (MTM) as our transportation provider. (Please note: this is a vendor change for CCH members)

- Members may arrange transportation up to **30 days ahead**, with a minimum of **48 business hours' notice**.
- Urgent trips can be requested less than two business days.
- MTM reservation hours are Monday through Saturday, 7 a.m. to 6 p.m. EST. MTM is closed Sundays and national holidays (New Year's Day, Memorial Day, 4th of July, Labor Day). Scheduled trips are subject to member eligibility.

New Reservation Number:

MTM Member Reservation Number: 1-844-784-8931 (TTY: 711)

Language Assistance

Carolina Complete Health provides free language assistance to all members in person and telephonically/virtually

Telephonically/virtually

- Language Line: Toll Free 1-866-998-0338
- Account Number 13982
- Medicaid PIN #6329

In-person via Language Services Associates (LSA)

- Contact vendor by phone: 866-827-7028
- Enter Account Number #47716855
- Speak with representative on the details of language needed for appointment or home visit.

Medicaid Co-Pay Information

Service	Member Copay
Physicians	$4 per visit
Outpatient services	$4 per visit
Podiatrists	$4 per visit
Generic and brand prescriptions	$4 for each prescription
Chiropractic	$4 per visit
Optical services/supplies	$4 per visit
Optometrists	$4 per visit
Non-emergency Emergency Department visits	$4 per visit

Pregnant women enrolled in NC Medicaid (regardless of Medicaid eligibility category) **may not be charged co-pays** for any Medicaid-covered services. This includes all pregnant beneficiaries, regardless of Medicaid eligibility category, including but not limited to:

- MAD – Medicaid Aged, Blind, and Disabled
- MAF – Medicaid Family and Children
- MIC – Medicaid for Infants and Children
- MXP – Medicaid Expansion (Parent/Caretaker, Childless Adult groups)

This policy is not limited to individuals enrolled under the Medicaid for Pregnant Women (MPW) coverage group.

For a full list of populations that are not subject to copays view NC Medicaid Copays

Care Management

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Care Management

Carolina Complete Health is committed to supporting the success of the local care management model


Carolina Complete Health
Care Management Department
1-833-552-3876

Care Management

How Care Management Helps:

- Identifies eligible members early through risk stratification & assessments
- Develops & implements care plans
- Coordinates covered & non-covered services
- Addresses medical, functional, behavioral, & social needs
- Assist with access to:
  - Behavioral health
  - Dental & pharmacy
  - Transportation
  - Specialty care & follow-up services

Care Management Programs Available:

- High-Risk Pregnancy Program
- Complex & Pediatric Care Management
- Transplant Coordination
- Members Connections Program
- Chronic Care/ Disease Management

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Claims

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Claims Definition

Clean Claim:

A claim that is received for adjudication in a nationally accepted format in compliance with standard coding guidelines and does not have any defect, impropriety, lack of any required documentation or particular circumstance requiring special treatment that prevents timely payment

Exceptions:

If a claim meets the definition above, but either of the following circumstances apply, it will not be considered a clean claim.

- A claim for which fraud is suspected
- A claim for which a third-party resources should be responsible

Claim Submission

- **For dates of service 4/1/26 and after**, submit Medicaid claims using one of the following methods:
  1. Availity Essentials
  2. Carolina Complete Health Secure Provider Portal
  3. Clearinghouse/EDI: Carolina Complete Health **Payer ID 68069**
  4. Mail: PO Box 8040 Farmington, MO 63640-8040
- **Timely filing for first time claims is 365 calendar days from the date of service (DOS) for Professional claims and from the date of discharge for Facility claims.**

Claim Correction Process Effective 4/1/26

- Claim correction: when a provider needs to make a correction to the initial submission. For example, to correct invalid or incorrect information in the initial submission.
- Contracted providers have 365 calendar days from the date of service to file a timely claim correction.
- Claim corrections can be submitted through the Availity Essentials, Secure Portal, EDI, or paper claim form.

To correct a claim in the Carolina Complete Health Secure Provider Portal, view the claim details and click the DISPUTE button, then select Option 1: Correct the Claim. When correcting a claim please include all fields related to the original claim, this can include authorization numbers, CLIA numbers, taxonomy codes, and services lines with a paid status.

Claim Dispute

Claim Dispute

- Effective for claims with Dates of Service 4/1/26 and after, contracted providers have **90 calendar days** from the date of the Explanation of Payment (EOP) or Electronic Remittance Advice (ERA) to submit a claim dispute, unless otherwise designated by contract.

Examples:

- Claim was paid the incorrect amount (include the calculation of expected payment and supporting information)
- Claims was denied for Member not eligible, but member was eligible on DOS (attach eligibility information).
- Claims denied for other insurance (attach primary Payer Explanation of Payment)
- Claim denied based on Carolina Complete Health's payment policy (attach medical records to support services)

Claim disputes can be submitted through portal, fax, or mail:

- Portal: provider.carolinacompletehealth.com
- Fax: Select "Provider Claim Dispute" on the *Claim Appeal/ Disputes Form* and faxing the completed form to 833-641-0206. Please only submit one claim per form submission, with a maximum of 400 pages.
- Mail: Select "Provider Claim Dispute" on the *Claim Appeal/ Disputes Form* and mail the completed form to
  Carolina Complete Health
  Attn: Medicaid Claim Disputes/Appeals Department
  PO Box 8040
  Farmington, MO 63640-8040

Claim Appeal

- Providers may submit a Provider Claim Appeal in response to an initial adverse authorization determination made by the health plan. Provider Claim Appeals must be submitted within sixty (60) days of the original authorization notice date. After sixty (60) calendar days, the original authorization determination becomes final. Requests for Provider Claim Appeals may be submitted via:
- Claim appeals can be submitted through portal, fax, or mail:
  - Portal: provider.carolinacompletehealth.com
  - Fax: Select "Provider Claim Appeal" on the *Claim Appeal/ Disputes Form* and faxing the completed form to 833-641-0206. Please only submit one claim per form submission, with a maximum of 400 pages.
  - Mail: Select "Provider Claim Dispute" on the *Claim Appeal/ Disputes Form* and mail the completed form to
    Carolina Complete Health
    Attn: Medicaid Claim Disputes/Appeals Department
    PO Box 8040
    Farmington, MO 63640-8040

Electronic Visit Verification

The 21st Century Cures Act requires NC Medicaid to begin using an Electronic Visit Verification (EVV) system for Home Health Care Services (HHCS) and Personal Care Services (PCS).

- To ensure that the provider community complies with the Cures Act mandate requirements, Carolina Complete Health partners with HHAeXchange as its EVV solution.
- **Claims for PCS services billed with CPT 99509 with HA and HB modifier must be submitted through HHAeXchange.**
- **Home Health Care Services can be billed using HHAeXchange or direct billing to CCH.**
- For additional PCS and HH information visit: network.carolinacompletehealth.com/resources/home-health-and-personal-care-services.html
- Please visit CCH Education & Training page to view our PCS and Home Health Care Trainings.

Home Health Services that require to use the EVV solution include:

- Home Health Aide Services
- Skilled Nursing Visits
- Physical Therapy (PT)
- Occupational Therapy (OT)
- Speech-Language Pathology (SLP)

Important EVV Registration Notice from NC DHHS

New PCS & Home Health providers using any EVV vendor other than Sandata, including HHAeXchange or CareBridge must compete the NC DHHS Alternate EVV Registration form.

Important Notes:

- Agencies using multiple NPI Numbers will need to enroll separately for each NPI.
- Please complete all fields on both pages accurately. Any incorrect information will delay credentialing.
- **The registration link can be found here.**
- More information can be found here https://medicaid.ncdhhs.gov/EVV#heading-2

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. View our 2026 Holiday Check Run Schedule
- Providers can continue using Payspan, a free solution that provides electronic payment and remittance.
- If providers already use Payspan for WCNC, but not CCH, you can add a line-of-business with a new registration code (provided by Payspan) to set up EFT/ERA with CCH.
  - Contact Payspan via email or phone: PayspanProviderSupport@zelis.com or 1-877-331-7154
- Providers can set up EFT for claim payments, AMH payments, and Tier 3 CM payments. AMH and CM payments are considered “ALT” payments and require a separate Payspan registration code.

Electronic Funds Transfer

To register for Payspan for the first time, you will need a registration code to get started. To begin registering, enter your PIN, TIN or EIN, and NPI. You can obtain your registration code in 1 of 3 ways:

1. Call 1-877-331-7154 to get your unique registration code (Monday thru Friday 8:00am to 8:00pm EST
2. Send an email to Payspan at providersupport@payspanhealth.com and request a registration code. Be sure to include your Tax ID# (TIN), Health Plan name, and your contact information in your email.
3. Request a registration code on the Payspan Health website.

Once you have your registration code, you will visit the Payspan Health website, Click Start Registration and enter the requested information. Once complete, click Confirm.

Within a few business days, you will receive a deposit of less than $1 from Payspan Health. Follow these steps to complete registration:

1. Log in to Payspan Health and click Payments.
2. Click the Account Verification link to the left side of the screen.
3. Enter the amount of deposit in this format: $X.XX.

Claim Correction Process Effective 4/1/26

- Claim correction: when a provider needs to make a correction to the initial submission. For example, to correct invalid or incorrect information in the initial submission.
- Contracted providers have 365 calendar days from the date of service to file a timely claim correction.
- Claim corrections can be submitted through the Availity Essentials, Secure Portal, EDI, or paper claim form.

Claim Dispute Process Effective 4/1/26

- Effective for claims with Dates of Service 4/1/26 and after, contracted providers have **90 calendar days** from the date of the Explanation of Payment (EOP) or Electronic Remittance Advice (ERA) to submit a claim dispute, unless otherwise designated by contract.
- Non-par providers have 60 calendar days from the EOP/ERA to submit a claim dispute. This was previously 365 calendar days for Carolina Complete Health.
- Claim disputes can be submitted through portal, fax, or mail:
  - Portal: provider.carolinacompletehealth.com
  - Fax: Select "Provider Claim Dispute" on the *Claim Appeal/ Disputes Form* and faxing the completed form to 833-641-0206. Please only submit one claim per form submission, with a maximum of 400 pages.
  - Mail: Select "Provider Claim Dispute" on the *Claim Appeal/ Disputes Form* and mail the completed form to
    Carolina Complete Health
    Attn: Medicaid Claim Disputes/Appeals Department
    PO Box 8040
    Farmington, MO 63640-8040

WellCare NC Legacy Systems and Historical Claims

- Legacy systems for WellCare of NC will remain operational for historical claim access.
- Historical claim access will be supported for 2 years post 4/1/2026. Two (2) years of historical claims will be accessible via the legacy provider portal.
- For dates of service prior to 4/1/26, providers with a WellCare claim should submit via the WellCare claim submission methods within 365 days of the service.
- Claims with dates of service prior to 4/1/2026, will be subject to the existing dispute and appeals process. Disputes and Appeals Cover Sheet

Disputes:
WellCare Health Plans
Attn: Claim Payment Disputes
P.O. Box 31368
Tampa, FL 33631-3368

Appeals and Reconsiderations:
WellCare Health Plans
Attn: Appeals Department
P.O. Box 31368
Tampa, FL 33631-3368

Claims Resources

- Carolina Complete Health Electronic Claim Submission Methods
- Claims and Billing FAQ
- FQHC Billing Guidance
- Payspan Provider Guide

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Utilization Management

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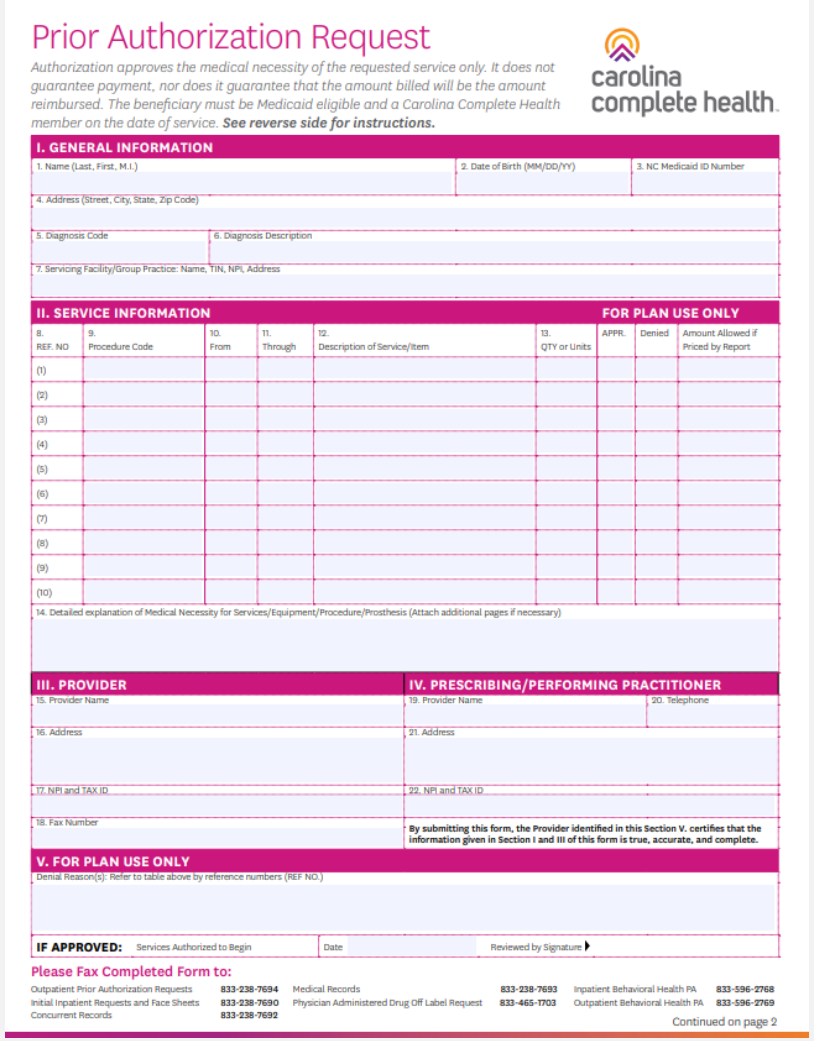
PA Submission Methods



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.***

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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

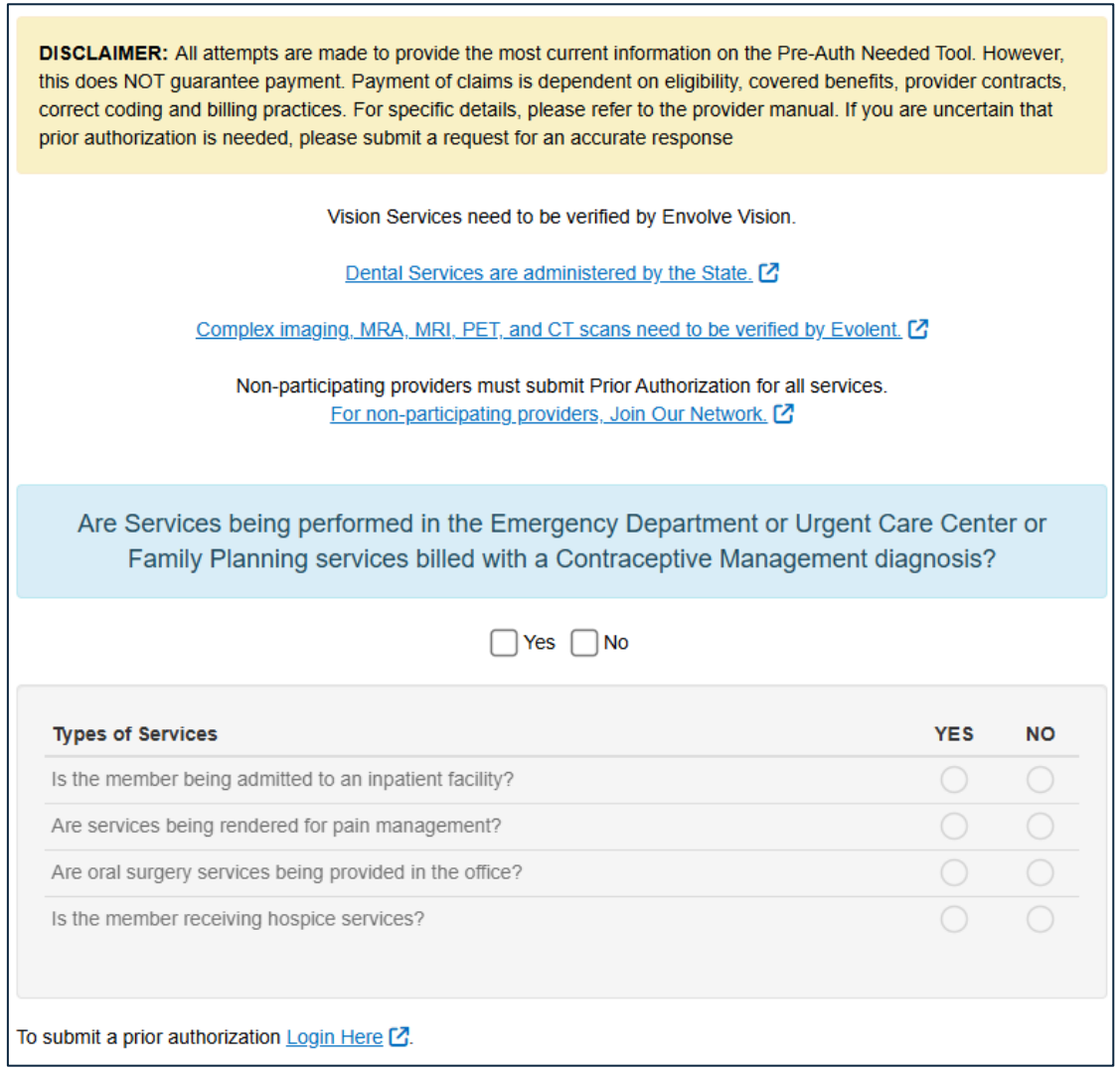
Please Fax Completed Form to:

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. Carolina Complete Health-Current PA-Form.pdf
- 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

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Prior Authorization Reminders and Resources

- Emergency / Urgent services do not require prior authorization
- All out-of-network (non-par) services and providers require prior authorization (excluding emergency services, family planning, post-stabilization services and table-top X-rays)
- 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

Services that Require Prior Authorizations

Ancillary services:

•Air Ambulance Transport (non-emergent fixed wing airplane)

•Home healthcare services including home hospice, home infusion, skilled nursing, personal care services, and therapy

•Orthotics/Prosthetics billed with an “L” code costing $500 or more or rental of $250 or more

•Hearing Aid devices including cochlear implants

•Genetic Testing

Inpatient Services:

•All elective/scheduled admissions at least 14 business days prior to the scheduled date of admit (including deliveries) Note: Normal newborns do not require an authorization unless the level of care changes or the length of stay is greater than normal newborn

•All services performed in out of network facility

•Hospice care

•Rehabilitation facilities

•Skilled nursing facility

•Transplant related support services including pre-surgery assessment and post-transplant follow up care

•Notification for all Urgent/Emergent Admissions:

•Within one (1) business day following date of Admission Newborn Deliveries must include birth outcomes

Procedures/Services:

•All procedures and services performed by out-of-network providers (except ER, urgent care, family planning, and treatment of communicable disease)

•Potentially Cosmetic including but not limited to:

•bariatric surgery, blepharoplasty, mammoplasty, otoplasty, rhinoplasty, septoplasty, varicose vein procedures

•Experimental or investigational

•High Tech Imaging (i.e. CT, MRI, PET)

•Hysterectomy

•Oral Surgery

•Pain Management

**This list is not all-inclusive. Use the Pre-Auth Needed Tool to check if a specific services or procedure requires PA's*

PA, Notification, & Determination Timeframes

Authorization Type	Timeframe for Provider to Notify CCH	Timeframe for Determination by CCH upon receipt of medical necessary medical information.
Standard Service Auth	Prior Authorization required at least fourteen (14) business days prior to the scheduled admission date or as soon as the need for service is identified	Current: Within fourteen (14) calendar days from receipt of necessary medical information. **Effective Jan 1, 2027: Within seven (7) calendar days from the receipt of necessary medical information. If the request lacks clinical information, Carolina Complete Health may extend the review time frame for up to 7 calendar days (max 14 calendar days for review).**
Emergent/Urgent	Notification within one (1) business day of the admission for ongoing concurrent review and discharge planning or as soon as the need for service is identified.	For urgent/expedited requests, a decision and notification is made within seventy-two (72) hours of the receipt of the request. If the request lacks clinical information, Carolina Complete Health may extend the review time frame for up to 14 calendar days (max 17 calendar days for review). **Effective Jan 1, 2027: If the request lacks clinical information, Carolina Complete Health may extend the review time frame for up to 11 calendar days (max 14 calendar days for review).**
Concurrent Review	Notification within one (1) business day of the admission for ongoing concurrent review and discharge planning.	For concurrent review requests, a decision and notification is made within seventy-two (72) hours of the receipt of the request. If the request lacks clinical information, Carolina Complete Health may extend the review time frame for up to 14 calendar days (max 17 calendar days for review). **Effective Jan 1, 2027: If the request lacks clinical information, Carolina Complete Health may extend the review time frame for up to 11 calendar days (max 14 calendar days for review).**
Retrospective Review	If the request is received within 90 days from the date of service (DOS) or the date of admission (DOA) and extenuating circumstances are clearly defined, the request will be reviewed for medical necessity .	The health plan will have 30 calendar days to review and finalize a decision.

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
S9480 – Mental Health Intensive Outpatient Program	PA required for non-par providers	Not an NC Medicaid covered code	PA required

UM Vendor Programs

- **EviCore:** Lab Management for genetic testing (effective no earlier than 5/1/26)
  - Clinical Guidelines
  - eviCore Provider Web Portal: https://www.evicore.com/
  - Phone: 1-888-333-8641
- **Evolent**: Radiation Oncology, Musculoskeletal Surgery, Interventional Pain Management, Advanced Imaging.
  - Web resources: https://www1.radmd.com/all-health-plans/carolina-complete-health
  - Provider Portals: https://www.evolent.com/provider-portal
    - Rad Oncology: Utilize the CarePro Provider Portal
    - Advanced Imaging, MSK, and IPM utilize the RadMD™ Provider Portal
  - Phone: 1-800-424-4889
- **TurningPoint:** Cardiovascular Procedures (effective no earlier than 5/1/26)
  - Portal: http://www.myturningpoint-healthcare.com
  - Phone: 984-377-8573 | 855-909-5444
  - Fax: 833-986-1059

Vendor Programs Before and After

	Current Carolina Complete Health vendor	Current WellCare of North Carolina vendor	Carolina Complete Health Integrated Plan
Radiation Oncology	None	Evolent	Evolent: effective no earlier than 5/1/26
Musculoskeletal Surgery	None	Evolent	Evolent: effective 4/1/26
Interventional Pain Management	None	Evolent	Evolent: effective 4/1/26
Advanced Imaging	Evolent	Evolent	Evolent: continue 4/1/26 as you do today.
Physical, Occupational, Speech Therapy	None	Evolent	None. Submit directly to health plan.
Cardiovascular Procedures	None	Evolent	TurningPoint: effective 5/1/26
Sleep Diagnostics	None	EviCore	None. Submit directly to health plan.
Genetic Testing	None	EviCore	EviCore effective no earlier than 5/1/26.
Vision Services	Centene Vision Services	Centene Vision Services	Centene Vision Services
NEMT	Modivcare	Medical Transportation Management (MTM)	Medical Transportation Management (MTM)

Medical Management

Carolina Complete Health Medical Management department hours of operation are Monday through Friday from 8:00 a.m. to 5:00 p.m., EST (excluding holidays)

Medical Management

Phone: 1-833-552-3876

Fax: 1-833-238-7689

Medical Management services include:

Utilization management

Care management

Disease management

Quality review

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Referrals

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Specialty Referrals

When a member need to visit a specialist know that:

- ***Referrals are not required for members to seek care with in-network specialists***
- Carolina Complete Health educates them to seek care or consultation with their Primary Care Provider (PCP) first
- When medically necessary care is needed beyond the scope of what a PCP provides, PCPs should initiate and coordinate the care members receive from specialist providers

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Grievances and Appeals

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Provider Grievances

A **Grievance (complaint)** is a verbal or written expression by a provider that indicates dissatisfaction or dispute with Carolina Complete Health policies, procedure, or any aspect of Carolina Complete Health functions, such as health plan policy, health plan information systems, or referral processes. Carolina Complete Health's Grievance and Appeal Department will acknowledge, resolve, log and track all grievances whether received verbally or in writing.

Providers may submit grievances:

1. Secure Provider Portal
2. Phone at 833-552-3876
3. Email to: CCHGrievancesAppeals@carolinacompletehealth.com
4. Mail: Carolina Complete Health
   Appeals and Grievances
   PO Box 10363
   Van Nuys, CA 91410-0353

Provider Appeals

Providers may submit a **Provider Claim Appeal** in response to an initial adverse authorization determination made by the health plan. Provider claim appeals must be submitted within sixty (60) days of the original authorization notice date. After sixty (60) calendar days, the original authorization determination becomes final. Requests for Provider Claim Appeals may be submitted via:

Providers may submit Claim Appeals:

1. Secure Provider Portal
2. Fax by selecting "Provider Claim Appeal" on the *Claim Appeal /l Disputes Form* and faxing the completed form to: 833-641-0206. Please only submit one claim per form submission, with a maximum of 400 pages.
3. Mail: Carolina Complete Health
   Attn: Medicaid Claim Disputes/Appeals Department
   PO Box 8040
   Farmington, MO 63640-8040

Member Grievances & Appeals

A beneficiary **grievance** is defined as any beneficiary expression of dissatisfaction about any matter other than an "adverse action."

- The grievance process allows the beneficiary, the beneficiary's authorized representative acting on behalf of the beneficiary or **Provider acting on the beneficiary's behalf with the beneficiary's written consent**, to file a grievance either orally or in writing at any time.
- Carolina Complete Health will acknowledge, in writing within five (5) calendar days of receipt of each grievance. For grievances related to the denial of an expedited appeal request, Carolina Complete Health will acknowledge the receipt of the grievance, in writing via trackable mail, within twenty-four (24) hours of receipt of the grievance.
- Carolina Complete Health will acknowledge, in writing within five (5) calendar days of receipt of each standard **appeal** request, whether it was received either orally or in writing.

How to File a Beneficiary(Member) Grievance or Appeals:

- Call Beneficiary Services at 833-552-3876
- Email to: CCHGrievancesAppeals@carolinacompletehealth.com
- In Person at: Carolina Complete Health, 1701 North Graham St. Suite 101 in Charlotte, NC.
- Mail: Carolina Complete Health
  Appeals and Grievances
  PO Box 10363
  Van Nuys, CA 91410-0353

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Clinical Policy

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Clinical Policy

Guidelines to support health plan benefits, including prior authorization and payment rules.

- Cover **medical technologies, procedures, and pharmacy treatments**
- Determine **medical necessity** using:
  - Accepted medical standards and peer-reviewed literature
  - Government approvals and evidence-based guidelines
  - Input from practicing physicians and clinical experts

Clinical Policies, Proposed Policy Revisions, Policy Updates, and Clinical policy Workgroups can be found here: https://network.carolinacompletehealth.com/resources/clinical-policies.html or for more information call **Medical Management 1-833-552-3876.**

Provider-Led Clinical Policy

- The Medical Affairs Committee's role and charter will remain intact.
- Carolina Complete Health's **Medical Affairs Committee (MAC)** is a sub-committee of the CCH Board of Directors and is a majority North Carolina Medicaid physicians.
- The MAC has board authority to make clinical policy decisions for CCH using feedback from specialty reviewers and clinical policy/advisory workgroups.
- **Carolina Complete Health Network** (CCHN) facilitates five specialty matched clinical policy/advisory workgroups:

Primary Care | Emergency Medicine | Behavioral Health | Pediatrics | Obstetrics

- Current WellCare only providers will be eligible to participate in a Clinical Policy workgroup as a CCH provider.
- Monthly, CCHN notifies providers of which policies contain proposed revisions and requests feedback from all providers.

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Carolina Complete Health Network, formed in 2016, is a subsidiary of the North Carolina Medical Society and co-owned by the North Carolina Community Health Center Association and Federally Qualified Health Centers (FQHC).

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Onboarding & Annual Trainings

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Additional Trainings

- **Cultural Competency**: At Carolina Complete Health, we are deeply committed to fostering health equity and improving the quality of care for all our members. This Health Equity webinar shares resources available to promote health literacy and how we are addressing health disparities and incorporating health equity.

- **Tribal CLAS Training**: PHPs, in collaboration with the State and each of the 8 tribes in North Carolina, developed a streamlined Provider Tribal Training. This is intended to provide information and to assist providers with cultural awareness and sensitivity when serving Native American tribal members. This training represents an updated map of tribal coverage in NC, as well as feedback from the afore mentioned groups.

- **Infection Prevention and Control for Professionals**

- **EPSDT Annual Training:** Medicaid offers its covered children and youth under age 21 a comprehensive benefit for preventive health and medical treatment. Carolina Complete Health adheres to and offers or arranges for the full scope of preventive and treatment services available within the federal EPSDT benefit. Preventive (wellness) services are offered without copays or other charges, per the periodic schedule established by the state of North Carolina. Early Periodic Screening services include physical exams, up to date health histories, developmental, behavioral and risk screens, vision, hearing and dental health screens and all vaccines recommended by the Advisory Committee on Immunization Practices.

- Available on https://network.carolinacompletehealth.com/resources/education-and-training.html

Compliance Training

- As a Carolina Complete Health medical provider you are provided with a General Compliance and Fraud, Waste and Abuse Training for Medical Providers Training
- This training includes the following topics:
  - Privacy & Confidentiality
  - General Compliance & Business
  - Fraud, Waste & Abuse
  - Administrative Firewalls
  - Conflict of Interest
  - Gifts, the Workplace and You
- Please complete the following Attestation for Compliance Training when completed.

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Resources

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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

New Provider To Do List:

☐ Register for Carolina Complete Health Secure Portal
http://provider.carolinacompletehealth.com/
☐ Register for Availity
https://www.availity.com/documents/learning/LP_AP_GetStarted/index.html#/
☐ Register for Payspan
https://www.payspanhealth.com/ or call 1-877-331-7154
☐ Review Provider and Billing Manual on the CCHN Website:
https://network.carolinacompletehealth.com/manuals
☐ Sign Up for Provider Announcements
https://network.carolinacompletehealth.com/communications
☐ Connect with your Provider Engagement Administrator
providerengagement@cch-network.com

Evaluation

We value your feedback!

Please take the time to attest that you have completed the new provider orientation and evaluate the course and add any comments you may have!

- https://www.surveymonkey.com/r/YYZH2KB

Thank You!