HealthSpring℠

Out-of-Network Provider Manual

Medicare Advantage

5003070.0126

Table Contents

ABOUT THIS MANUAL

This provider manual has been created to help you and your office staff administer plans for your patients with Medicare Advantage plan coverage through HealthSpring. It contains important information about our policies and procedures, including claims payments and submission requirements, and prior authorization and referral requirements. Please make time to review the manual carefully.

MEDICARE ADVANTAGE PLANS OVERVIEW

This manual will guide you through the differences between our health maintenance organization (HMO) and preferred provider organization (PPO) plans.

The table below outlines things you need to know as you navigate through this manual.

Topic	What you need to know
Referrals	• **HMO:** Referrals are required in select plans. See the Plans that Require Referrals by State section to determine which markets require referrals. • **PPO:** Referrals are not required. However, before receiving services from providers who do not participate in our Medicare Advantage network, the member may want to ask for a previsit coverage determination.
Local network information	• Regional service-area maps are in the Appendix. • Market-specific contacts are located throughout this manual depending on the topic. • See 2026 HealthSpring Medicare Advantage Member ID Cards for high-level product and network information. Refer to the phone numbers on the ID card for assistance, and follow guidance for eligibility verification, referrals and prior authorizations.

HealthSpring contracts with the Centers for Medicare & Medicaid Services to offer Medicare Advantage plans. Members are able to select one of several plans offered based on their location, budget and health care needs.

Plan type	Selection of a primary care provider	Referrals to specialists	HealthSpring ID card
HMO	Members are: • Required to select a PCP • Allowed to select a different PCP at any time	See Plans that Require Referrals by State	The member's plan type is indicated at the top of their HealthSpring ID card. See the 2026 Member ID Cards in the Appendix.
PPO	• Referral requirements are indicated on the member's HealthSpring ID card. • Select service areas do not require the use of referrals.	Not required	

KEY CONTACTS

Availity® Essentials self-service portal

Availity Essentials HealthSpring Medicare Advantage payer space
If you aren't yet registered for Availity Essentials, **sign up at no cost**.
Payer ID: 52192

Provider Customer Service

1-800-230-6138, 6 a.m. to 8 p.m. CT, Monday-Friday

Claims processing

Claims questions: 1-800-230-6138

Electronic claims: HealthSpring – Payer ID 52192

Paper claims
HealthSpring
PO Box 23456
Chattanooga, TN 37421

Medical necessity claim disputes
HealthSpring Appeals
PO Box 188085
Chattanooga, TN 37422

Reconsideration requests
HealthSpring Reconsiderations
PO Box 20002
Nashville, TN 37202

Copayment information and eligibility verification

Call: 800-668-3813
Provider self-service portal: **Availity Essentials**

Compliance

Report by phone
Call: 855-249-6524
This toll-free Fraud Hotline is available 24 hours a day, seven days a week. You can remain anonymous or let us know if you want to be contacted.

Report by mail
HealthSpring
Special Investigations Department
300 E. Randolph St., 35th floor
Chicago, IL 60601

Part C appeals

Appeals questions:
- Call: 1-800-511-6943
- Fax: 1-800-931-0149

Mail or fax standard medical appeals to:
HealthSpring Medicare Advantage Appeals
PO Box 188081
Chattanooga, TN 37422

Fax: 855-350-8671

Mail or fax expedited medical appeals to:
HealthSpring Medicare Advantage Appeals
PO Box 188082
Chattanooga, TN 37422

Fax: 855-350-8672

Mail or fax postservice in-network provider appeals to:

	HealthSpring Medicare Advantage Appeals PO Box 188085 Chattanooga, TN 37422 Fax: 855-699-8985

Prior authorizations

Access our interactive prior authorization requirements on our **clinical review** page. To search our prior authorization guide for a code, enter Ctrl+F > the five-digit code.

To submit a prior authorization request

- **Call**
  Prior authorization: 1-800-453-4464
  Part B: 1-888-454-0013

- **Fax**
  Prior authorization: 1-866-287-5834
  Part B: 1-877-730-3858

For questions about supplemental benefits, call Provider Customer Service at 1-800-230-6138.

MEMBER ELIGIBILITY VERIFICATION

To verify patient's eligibility and benefits:

Method	Contact/resource information
Provider Customer Service	1-800-230-6138, 6 a.m. to 8 p.m. CT, Monday-Friday
HealthSpring ID card	Review the member's HealthSpring ID card to determine the following: • Plan code • Copayment • Effective date See the Appendix: 2026 HealthSpring Member ID Cards.

CLAIMS SUBMISSION AND ERA/EFT

HealthSpring prefers electronic submission of claims. However, both electronic and paper claims are accepted. Refer to Key Contacts for information about Part C appeals, reconsideration requests and claims questions. If you are interested in submitting claims electronically via electronic data interchange, call Provider Customer Service at **800-230-6138**.

Claims Submission

Electronic claims submission
Claims may be submitted electronically using **payer ID 52192.**

Paper claims submission
HealthSpring
PO Box 23456
Chattanooga, TN 37421

Supporting claim documentation
Send supporting claims documents – such as medical records, itemized bills and explanation of benefits − via fax to **615**-**401**-**4642** or mail them to:

HealthSpring Claims Intake
PO Box 20002
Nashville, TN 37228

Electronic Remittance Advice and Electronic Funds Transfer

ERA and EFT enrollment
You may enroll in ERA and EFT on the Zelis website. Visit **https://healthspring.epayment.center/** for more information.

ERA and EFT post-enrollment support
After enrolling in ERA and EFT, call 833-306-0337 if you need assistance.

Timely Filing

According to Medicare standards, out-of-network providers must submit claims within 365 days from the date of service. Claims received after 365 days will be denied for timely filing

REFERRAL GUIDELINES

HMO Plans

The PCP is often the member's primary point of entry into the health care delivery system for all outpatient specialist care. For select HMO plans, the PCP may be required to obtain a referral for most outpatient specialist visits for HealthSpring members. The member's ID card will indicate if a referral is required, except for Arizona.

- PCPs should make referrals to HealthSpring Medicare Advantage in-network specialists.
- Out-of-network specialist visits require prior authorization.

- Referrals must be obtained prior to specialist services being rendered.
- PCPs should not issue retroactive referrals.
- Most referrals are valid for 120 days starting from the issue date.
- All requests for referrals must include the following information:
  - Member name
  - Member date of birth
  - Member ID
  - PCP name
  - Specialist name
  - Date of referral
- Number of visits requested
- Diagnosis

If a member is in an active course of treatment with an out-of-network specialist at the time of enrollment into a HealthSpring Medicare Advantage plan, a PCP referral is not required. However, prior authorization must be obtained from the Clinical Operations department. For further details, refer to the Continuity of Care section.

If a member needs care from a specialist, it is preferred they obtain the referral from their PCP.

PPO Plans

Referrals are not required for PPO plans. However, before receiving services from providers that do not participate in the network, the member may want to ask for a previsit coverage determination.

Plans That Require Referrals by State

In the table below, checkmarks indicate the types of Medicare Advantage plans that are available in each market listed. Diamonds indicate plans that require a referral to see an in-network specialist, with the exception of behavioral health (outpatient mental health) specialists for an HMO plan.

Market	HMO	HMO POS	PPO
Alabama			
Arizona			
Arkansas			
Colorado			
Connecticut (New England)			
Delaware			
Central Florida	✓ ♦	✓	✓
North Florida	✓	✓	✓
South Florida	✓ ♦		✓
Georgia	✓		✓
Illinois	✓	✓	✓
Kansas City	✓		

Maryland	✓		
Mississippi (Southern)	✓		
Nevada	✓ ♦		
New Jersey	✓		✓
New Mexico			
North Carolina			
Ohio			
Oklahoma	✓ ♦	✓	✓
Oregon (Portland)	✓	✓	✓
Pennsylvania	✓	✓	✓
South Carolina	✓	✓	✓
St. Louis/Southern Illinois	✓	✓	✓
Tennessee	✓	✓	✓
Texas	✓ ♦	✓	✓
Utah			
Virginia			
Washington	✓		✓
Washington, D.C.			

How to Obtain a Referral

There are four ways a PCP can obtain a referral to a specialist:

- **Provider self-service portal Availity Essentials (preferred method):** Our provider portal is available 24 hours a day, 365 days a year. You can submit and follow the request online, which will help ensure accurate and timely processing of referrals. Log in to Availity.com and access the referral portal through the HealthSpring Medicare Advantage Payer Space.
- **Fax:** Complete the referral form on our **forms page** and fax it to our Referral department at the number indicated on the form.
- **Mail:** Complete the referral form and mail it to HealthSpring Medicare Advantage, Attn: Precertification Department, 500 Great Circle Road, Nashville, TN 37228
- **Phone:** If the referral is for an emergency, you may obtain a referral by phone by calling the appropriate phone number below for your state.

Market	Contact
Alabama	800-962-3016
Arizona	Arizona plans do not require referrals.

Colorado, Utah, New Mexico, Nevada, Oregon and Washington	800-230-6138	
Florida	800-962-3016	
Southern Mississippi	866-949-7103	
Georgia (all counties except Catoosa, Dade and Walker)	866-949-7103; fax 855-420-4717	
North Carolina	866-949-7099	
South Carolina	866-949-7101	
Kansas City	888-454-0013	
Tennessee, Northern Georgia, and Arkansas.	800-453-4464	
Illinois, Ohio and Indiana	800-230-7298	
Oklahoma City, Texas and Southern Arkansas	HealthSpring prior authorization • Phone: 800-511-6932 or 832-553-3456 (local) • Fax: 888-856-3969 or 832-553-3426 (local)	Durable medical equipment • Phone: 800-511-6932 or 832-553-3313 (local) • Fax: 888-205-8658
Delaware, Maryland, New Jersey, Pennsylvania and Washington D.C.	888-454-0013; Fax 866-464-0707	

Prior Authorization

HealthSpring requires prior authorization for certain services, medications, procedures and equipment before they are performed or provided. This process helps prevent unnecessary utilization while ensuring members have access to the most appropriate, medically necessary care. The prior authorization is typically requested by the ordering provider but may also be initiated by the rendering provider.

Out-of-network providers are responsible for requesting prior authorization on behalf of the member when required, at least seven calendar days in advance of the admission, procedure or service when possible. Requests must include all pertinent clinical information to support the medical necessity of the services requested. The member may also request a determination prior to delivery of services. If this occurs, HealthSpring or the delegated utilization management agent will contact you for the clinical information needed to support the request.

If prior authorization cannot be obtained in a timely manner, HealthSpring or the delegated utilization management agent and the appropriate participating provider must be notified, as applicable, as soon as possible, but no later than 24 hours after providing or ordering the covered services, or on the next working day. Failure to comply with request and/or notification timelines could result in an adverse determination.

Access our interactive prior authorization requirements at **HealthSpring.com/Providers** > Coverage and Claims > **Clinical Review.** To search our prior authorization guide for a code, enter Ctrl+F > the five-digit code. If you are uncertain about the prior authorization requirement for a specific procedure, you may also contact Provider Customer Service.

To access the prior authorization forms, go to **HealthSpring.com/Providers** > Working With Us > **Forms**. Please complete forms in their entirety and attach pertinent clinical information.

Prior authorization is a determination of medical necessity and is not a guarantee of claims payment. Claim reimbursement may be impacted by various factors, including the member's eligibility, plan participation status, benefits at the time the service is rendered and adherence to request and/or notification timeline requirements.

The presence or absence of a service or procedure on the list does not determine coverage or benefits.

How to Request Prior Authorization

HealthSpring offers multiple ways to request prior authorization:

Through our self-service portal: Log in to **Availity Essentials** or call Provider Customer Service at 800-230-6138 to verify a member's benefits, coverage and eligibility. After confirming eligibility and benefits, access the prior authorization portal through the HealthSpring Medicare Advantage Payer Space and submit all supporting documentation.

- **By mail:**

  HealthSpring Medicare Advantage
  Attn: Prior Authorization
  500 Great Circle Road
  Nashville, TN 37228

- **Or call or fax for prior authorization:**

Contact	Phone	Fax
Behavioral health (all markets)	866-780-8546	866-949-4846
Drugs/biologics Part B	888-454-0013	877-730-3858
CareAllies	844-359-7301	866-233-6235
Clinical operations	800-453-4464	866-287-5834

Phone lines are staffed Monday through Friday, 7 a.m. to 5 p.m. CT.

The Clinical Review Services department, under the direction of licensed nurses, clinical pharmacists and medical directors, documents and evaluates requests for prior authorization, including:

- Confirmation that the member is eligible for HealthSpring plan coverage at the start of care
- Verification that the requested service is a covered benefit under the member's benefit package
- Determination of the appropriateness of the services (medical necessity)
- Validation that the service is being provided by the appropriate provider and in the appropriate setting

The Clinical Review Services department documents and evaluates requests using CMS guidelines, nationally recognized criteria and publicly accessible internal coverage guidelines to make a

determination of coverage. The provider may be notified electronically, orally or in writing within the regulated CMS time frames.

It is essential to submit clinical information at the time of the request. HealthSpring may outreach to you for information needed to make a determination. Requests received without supporting documentation may experience delays in processing up to the regulatory time frames, as CMS rules require that appropriate information be requested before decisions are rendered. See the Prior authorization request time frames section for details regarding decision and notification time frames.

For members who go to an emergency department for treatment, an attempt should be made in advance to contact the PCP unless it is not medically feasible due to a serious condition that warrants immediate treatment.

If a member appears at an emergency department for nonemergency care, the PCP should be contacted for direction. Members may utilize urgent care facilities to treat conditions that are nonemergencies but require immediate treatment. HealthSpring must be notified whenever any of its members visit an emergency department for observation or inpatient care. Please be prepared to discuss the member's condition and treatment plan with our nurse case manager.

Prior Authorization Forms

To access our prior authorization forms, go to **HealthSpring.com/Providers** > Working With Us > **Forms**. It is important to use the forms when faxing a prior authorization request (along with the supporting clinical information) to ensure we have all the information needed to make a determination.

We update prior authorization requirements on a quarterly basis to align with program or Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System code changes. For that reason, it is important to check the prior authorization requirements before delivering planned services.

HMO Plans

HealthSpring Medicare Advantage HMO plans do not have out-of-network benefits. However, if any of the following apply, you can submit a prior authorization request. If approved, HealthSpring will reimburse the provider at the Medicare reimbursement rate.

- There is a continuity-of-care issue.
- A network gap has been identified.
- There are medically necessary circumstances in which the member's need cannot be met in network (e.g., a service or procedure is not provided in network, or delivery of services is needed at a closer location or sooner than provided or allowed by the HealthSpring access or availability standards).

Inpatient Coordination of Care and Concurrent Review

Concurrent review is the process of initial assessment and continual reassessment of the medical necessity and appropriateness of care during observation, inpatient (acute, long-term acute care, rehabilitation) and skilled nursing facility admissions to ensure:

- Covered services or supplies must be medically reasonable and necessary and provided at the appropriate level of care by a physician, hospital or other health care provider licensed by the appropriate state or federal agency, or as otherwise approved by HealthSpring.

- Services must align with the member's symptoms, diagnosis, condition, disease, ailment or injury, and must not be experimental or investigational.
- Services should not be primarily for the personal comfort or convenience of the member, their family or the physician, hospital or other health care provider.
- Services must represent the safest and most appropriate supply or level of services, adhering to the accepted standards of good medical practice.
- Services must be delivered in accordance with the terms of the facility's contract.

All requests for admission, including observation and inpatient level of care, are subject to a medical necessity review. The mere fact that a provider has prescribed, performed, ordered or coordinated a service or course of treatment does not automatically make it medically necessary. In making determinations as to whether a particular covered service is medically necessary, HealthSpring will consider the terms of the member's benefit plan, Medicare statutes and regulations, national and local coverage guidelines, widely used treatment guidelines or clinical literature and such complex medical factors as the member's history and comorbidities, the severity of signs and symptoms, current medical needs and the risk for an adverse event, as supported by the medical record. No service is a covered service unless it is medical necessary.

HealthSpring requires admission notification for the following:

- Elective observation and acute admissions
- Emergent/urgent observation and acute admissions
- Intent to transfer to acute rehabilitation, long-term acute care or a skilled nursing facility, as these admissions require prior authorization
- Observation and acute admissions following outpatient procedures

Emergency or urgent admission notification must be received via fax or phone within 24 hours of admission or the next business day, whichever is later, even when the admission was prescheduled. Failure to comply with notification timelines could result in an adverse determination.

If the member's condition is unstable and the facility is unable to determine coverage information, HealthSpring requests notification as soon as it is determined, including an explanation of the extenuating circumstances. Timely receipt of clinical information supports the care coordination process to evaluate and communicate vital information to hospital professionals and discharge planners. Failure to comply with notification timelines or failure to provide timely clinical documentation to support admission or continued stay could result in an adverse determination.

The HealthSpring preferred method for concurrent review is EHR access. We can also receive concurrent review documentation via fax. We encourage live dialogue between our Concurrent Review nursing staff and the facility's utilization management staff to assist with discharge planning and needs. We should receive admission notification and clinical information within 24 hours of admission or observation status. If we do not receive clinical information within 72 hours of admission or the last covered day, we will review the case for medical necessity with the information we have available.

Observation level of care is an alternative to an inpatient admission that is a well-defined set of specific, clinically appropriate services. This includes ongoing short-term treatment assessment and reassessment that are furnished while a decision is being made about whether the member will require further treatment as a hospital inpatient or if they are able to be discharged from the hospital. Observation level of care is not expected to exceed 24 hours but may extend to 48 hours. Discharge or admission must occur less than 48 hours after the member is admitted to observation status. There will be no reimbursement for observation

services in excess of 48 hours. Observation services in excess of 48 hours are subject to administrative denial.

Facilities may submit the member's clinical information within 24 hours of notification using the appropriate contact information below.

Area	Website	Phone	Fax
Inpatient/observation admissions	N/A	888-454-0013	866-234-7230
Texas CareAllies inpatient/observation admissions	N/A	844-359-7301	888-205-9577

Following an initial determination, the concurrent review nurse will request additional updates from the facility on a case-by-case basis. The criteria used for the determination is available to the provider or facility upon request. HealthSpring will render a determination within three calendar days after receipt of complete clinical information. The HealthSpring nurse will make every attempt to collaborate with the facility's utilization or case management staff and request additional clinical information in order to provide a determination. Clinical update information should be received 24 hours prior to the next review date.

A medical director reviews all acute confinements that do not meet medical necessity criteria and issues a determination. If the medical director deems that the inpatient confinement does not meet medical necessity criteria, the medical director will issue an adverse determination (a denial). The Concurrent Review Nurse or designee will notify the provider(s) (e.g., facility, attending or ordering provider) of the adverse determination via a notice of denial.

Under the guidelines established by CMS for the Acute Hospital Care at Home program, participation by Medicare Advantage plans is not mandatory. HealthSpring has chosen not to participate in the hospital at home program and, therefore, Revenue Code 0161: Hospital at Home, will not be reimbursed.

The HealthSpring Clinical Review Services department complies with individual facility contract requirements for concurrent review decisions and time frames. HealthSpring nurses, utilizing CMS guidelines and nationally accepted, evidence-based review criteria, will conduct the medical necessity review. HealthSpring is responsible for final prior authorization.

Rendering of adverse determinations (denials)

Every effort is made to obtain all necessary information, including pertinent clinical information and original documentation from the treating provider to allow the medical director to make appropriate determinations. Only the medical director may render an adverse determination (denial) based on medical necessity. The medical director, in making the initial decision, may discuss an alternative covered service to the requesting provider. If the medical director makes a determination to limit an admission or deny an extension of stay, HealthSpring notifies the requesting provider of partial approval of service, documenting the original request that was denied and, if applicable, the alternative approved service, along with the process for provider payment reconsideration. If the medical director makes a determination to deny an admission, HealthSpring notifies the requesting provider of the denial of service, documenting the denial rationale and the process for appeal.

HealthSpring gives providers the opportunity to discuss utilization management authorization determinations with a plan medical director. A one time, pre-decision, opportunity to discuss (peer to peer) may be eligible to

be performed during the initial concurrent review process for hospital admission authorizations, prior to the UM determination being made. Please relay any intent for a pre-decision peer to peer discussion and physician and NP/PA contact information within the initial concurrent UM review and as soon as possible.
Following an adverse determination, a change in decision cannot be made outside of the appeals process. Peer-to-Peer requests in the absence of an appeal will be informational only and cannot change a UM decision.

New or additional information, including but not limited to: a change in status, new event or decompensation in clinical status for reconsideration of a denial may only be submitted via appeal.

Non-contracted provider appeals must include a signed, valid, Waiver of Liability statement upon submission of the appeal. Failure to submit the Waiver of Liability statement may delay appeals processing or result in a dismissal.

A copy of the Waiver of Liability statement is accessible via **CMS.gov > Forms** and on the **Non-Contracted Provider Appeals and Disputes Form [PDF]** on our **forms** page.

Notification of Adverse Determinations (Denials)

The reason for each denial – including the specific utilization review criteria with the pertinent subset/information or benefits provision used in the determination of the denial – is included in the written notification and sent to the provider and member, as applicable. Written notifications are sent in accordance with CMS and National Committee for Quality Assurance requirements to the provider and/or member as follows:

- For urgent concurrent decisions: Within 72 hours of the request
- For postservice decisions: Within 30 calendar days of the request

Vendor-Specific Networks

HealthSpring may elect to offer or obtain certain covered services exclusively through arrangements with national or regional vendor networks. It is important for participating providers to be aware of these vendor-specific networks to avoid potential claims issues and member confusion.

HealthSpring currently utilizes three vendor-specific networks:

- TruHearing for routine hearing-related benefits and supplies
- EyeMed for routine vision services and supplies
- American Specialty Health® for chronic lower back pain acupuncture services

Our HMO plans may only cover hearing, vision and acupuncture services when supplied by providers that participate in the applicable network listed above.

Our PPO plans may only cover hearing, vision and acupuncture services at the in-network benefit and cost-sharing levels when supplied by providers that participate in the applicable network listed above. Providers are encouraged to call the customer service number on the member's ID card if they have any questions about services that may or may not be covered.

Please inform members if you participate in any of these vendor-specific networks before providing related services. To explore participating in these vendor-specific networks, visit the vendors' websites.

- TruHearing: TruHearing.com > For Providers > Join us
- EyeMed: EyeMed.com > Providers: Providers Home > Get More Information
- American Specialty Health: ASHLink.com > Join Our Network: Providers

REIMBURSEMENT OF OUT-OF-NETWORK PROVIDERS

Depending on your Medicare-participation status, you will be paid as followed for covered plan services:

- If you are not contracted with HealthSpring Medicare Advantage but are a Medicare-participating provider (you **always** accept assignment), then you will be reimbursed the Medicare allowed amount minus any applicable patient cost share. Per CMS requirements, you must accept the HealthSpring payment and any associated cost share as payment in full. Under a HealthSpring Medicare Advantage PPO plan, you may **only** bill patients for their cost-share amounts and for any noncovered services. You may not balance bill patients or HealthSpring for covered services in excess of the Original Medicare rate.

- If you are not contracted with HealthSpring Medicare Advantage and are not a Medicare-participating provider (you accept assignment on a **case-by-case basis**), you will be reimbursed as follows:

  - If **you accepted assignment** for the services and affirmatively indicated acceptance on the submitted claim, you will be reimbursed the Medicare allowed amount minus any applicable patient cost share. You must accept the HealthSpring payment and any associated cost share as payment in full. Under a HealthSpring Medicare Advantage PPO plan, you may bill patients for their cost-share amounts and for any noncovered services. You may not balance bill patients or HealthSpring for covered plan services in excess of the Original Medicare rate.

  - If **you did not accept assignment** for the services, you will be reimbursed up to the Original Medicare limiting charge minus any applicable patient cost-share amount. Under a HealthSpring Medicare Advantage PPO plan, you may bill patients for their cost-share amounts and for any noncovered services. You may not balance bill patients for covered plan services in excess of the plan cost share. HealthSpring is responsible for paying you the difference between a patient's cost share and the Original Medicare limiting charge.

Rate Letters from A/B MAC – Critical access hospitals and rural health clinics

Provider must provide a copy of their most recent interim rate letter from their A/B Medicare Administrative Contractor (MAC) to HealthSpring, and to forward to HealthSpring any changes or adjustments to such per diems or rates as soon as possible, but no later than thirty (30) days following CMS' notification to each individual facility regarding any changes or adjustment to such rates. HealthSpring will not retroactively adjust under-compensation. If HealthSpring has not received an updated rate letter from the provider in more than 12 months, claims may be denied.

CMS Preclusion List

CMS publishes a Preclusion List of providers and prescribers who are precluded from receiving payment for Medicare Advantage items and services or Part D drugs.

Why is this important?

CMS makes the Preclusion List available to Part D sponsors and Medicare Advantage health plans on a monthly basis. The preclusion list requirements are:

- Medicare Advantage plans must deny payment for a health care item or service furnished by an individual or entity on the Preclusion List.
- Part D sponsors must reject pharmacy claims (or deny a beneficiary request for reimbursement) for a Part D drug that is prescribed by an individual on the Preclusion List.

Who is on the list?

Individuals or entities will be on the Preclusion list when they:

- Are currently revoked from Medicare, are under an active reenrollment bar, and CMS has determined that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program.
- Have engaged in behavior for which CMS could have revoked the individual or entity to the extent applicable if they had been enrolled in Medicare, and CMS determines that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program.

Are providers notified when they are placed on the Preclusion List?

Yes. In advance of their inclusion on the Preclusion List, CMS sends an email and letter to providers using the Provider Enrollment Chain and Ownership System (PECOS) address or National Plan and Provider Enumeration System (NPPES) mailing address. The communications include the reason for the preclusion, its effective date, and the applicable rights to appeal. View the **Preclusion List**.

APPLY TO JOIN THE HEALTHSPRING MEDICARE ADVANTAGE NETWORK

To apply to join the HealthSpring Medicare Advantage network, visit **HealthSpring.com/Providers** > Network Participation and submit a Network Interest Form.

All practitioner and organizational applicants to HealthSpring must meet basic eligibility requirements and complete the credentialing process prior to becoming an in-network provider. These requirements are the same whether the provider is credentialed by HealthSpring, or another entity delegated by HealthSpring to credential Medicare Advantage network providers. HealthSpring credentialing standards and processes are designed to comply with CMS regulations and applicable laws.

HealthSpring does not discriminate in terms of participation or reimbursement, or based on the population of members serviced, against any health care provider who is acting within the scope of their license or certification under state law. To participate in the HealthSpring network, providers undergo a screening process before a contract can be extended to them.

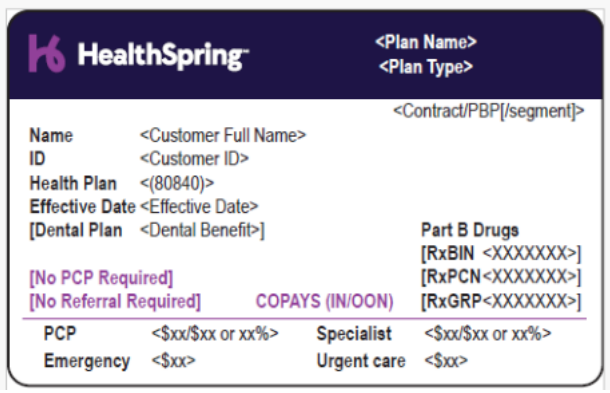
Provider notification

All initial applicants who successfully complete the credentialing process are notified in writing of the effective date or dates of their participation in the HealthSpring Medicare Advantage HMO, PPO or HMO/PPO network. Providers are advised to not see HealthSpring members until they receive this notification in writing. Applicants who are denied by the Credentialing Committee will be notified in writing within 30 days of the decision

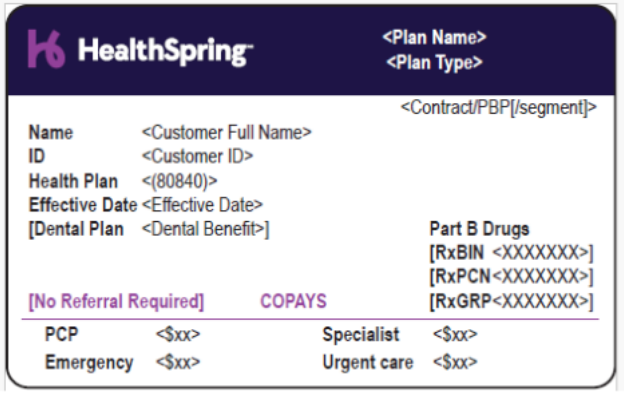
detailing the reason or reasons for the denial, unless local state or federal laws require a different time frame.

APPENDIX
2026 HEALTHSPRING MEMBER ID CARDS

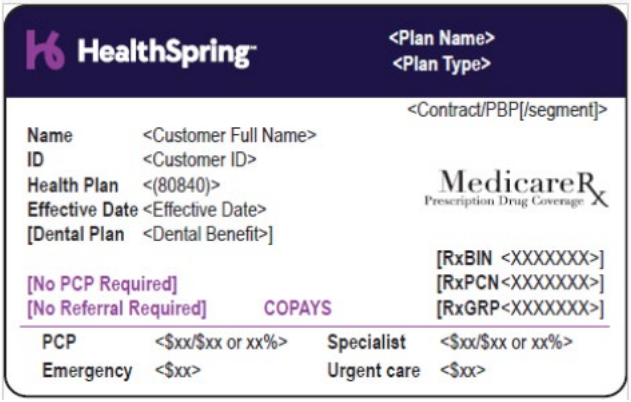
PPO: HealthSpring Medicare Advantage



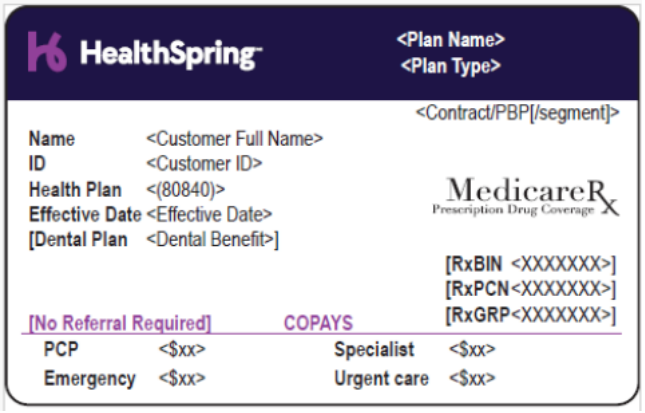
HMO: HealthSpring Medicare Advantage*



PPO: HealthSpring Medicare Advantage Prescription Drug



HMO: HealthSpring Medicare Advantage Prescription Drug*



* This sample ID card is for members with an HMO plan that does not require referrals. IDs card for members with an HMO plan that requires referrals will not show "[No Referral Required]."