HealthSpring℠

Provider Resource Guide

May 2026

Agenda

- Welcome and introductions
- Who we are
- Provider resources
- Claim information
- Clinical operations
- Supplemental benefits
- Special Needs Plans
- Five-Star Quality Rating System
- Risk adjustment
- Additional resources
- Appendix

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Introductions

This material is for informational purposes only and is not a substitute for the independent medical judgment of a physician or other health care provider. Physicians and other health care providers are encouraged to use their own medical judgment based upon all available information and the condition of the patient in determining the appropriate course of treatment. The fact that a service or treatment is described in this material, is not a guarantee that the service or treatment is a covered benefit and members should refer to their evidence of coverage for more details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any service or treatment is between the member and their health care provider.

This information is not to be distributed or shared with unauthorized individuals without express approval.

Who we are

We are committed to helping you put your patients first.

A trusted partner

- We're part of Health Care Service Corporation, the country's largest customer-owned health insurer.
- With nearly a century of experience, we're built on provider and member relationships that last.
- We're your partner in supporting your practice and connecting your patients with care to live vibrant, healthy lives.
- We offer a diversified portfolio of Medicare Advantage plans and offerings.

Comprehensive care

- We offer Medicare-approved plans, such as:
  - Medicare Advantage (Part C)
  - Prescription Drug Plan (Part D)
  - Medicare Supplemental Plans
- We offer value-added services such as transportation, vision and disease management.

A caring experience

- We're invested in helping our members achieve their health goals through access to quality care.
- As a member of our provider network, you're at the heart of this experience.

Provider Resources

Tools to help you do business

HealthSpring.com/Providers

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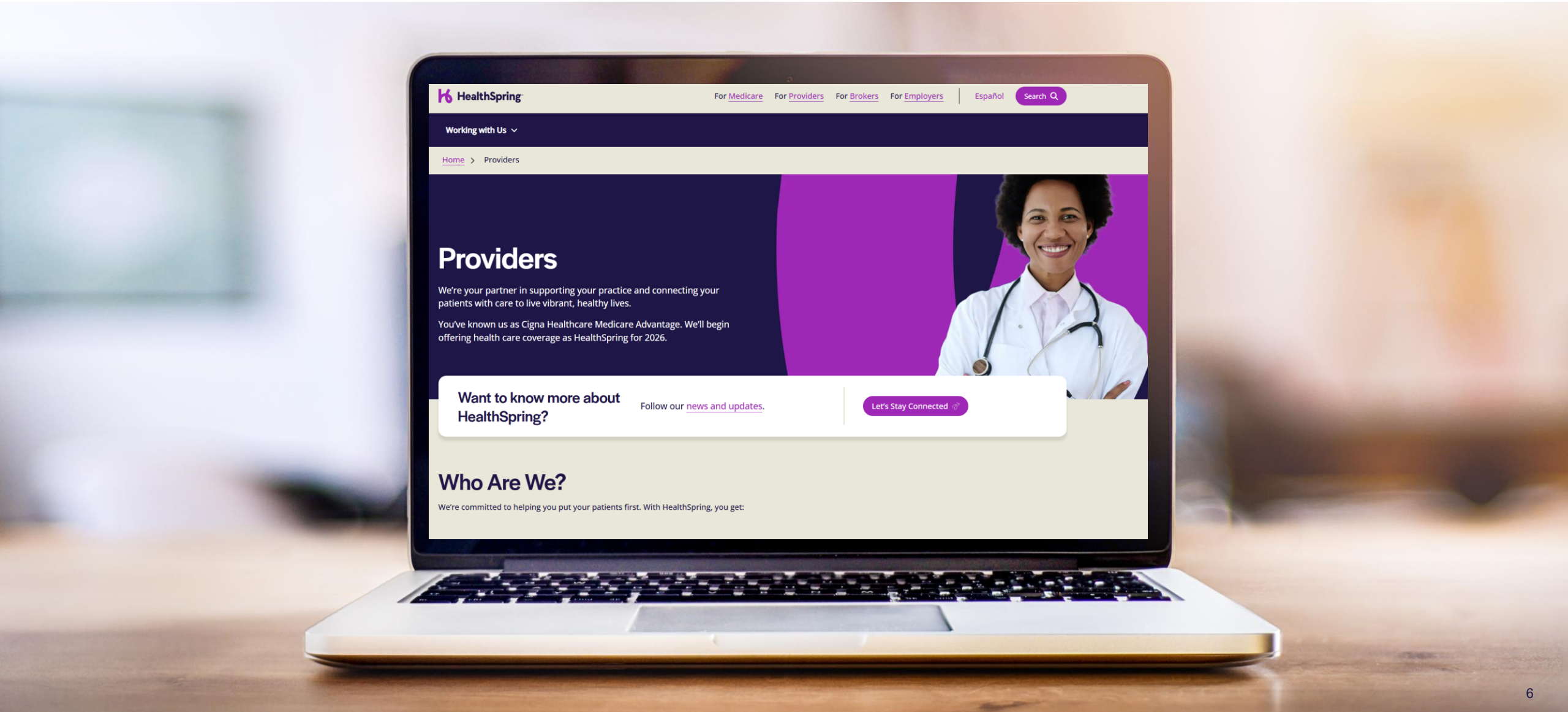
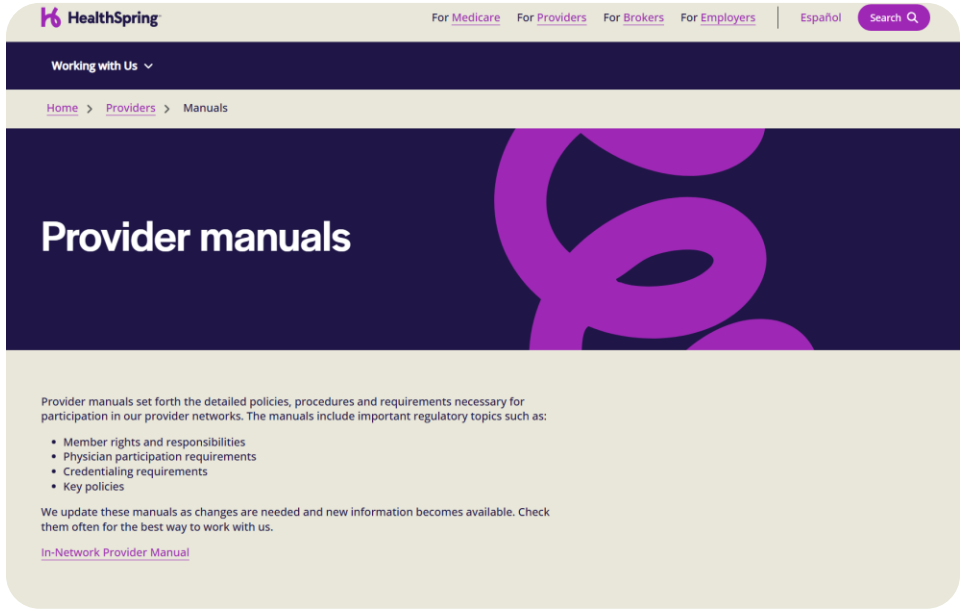
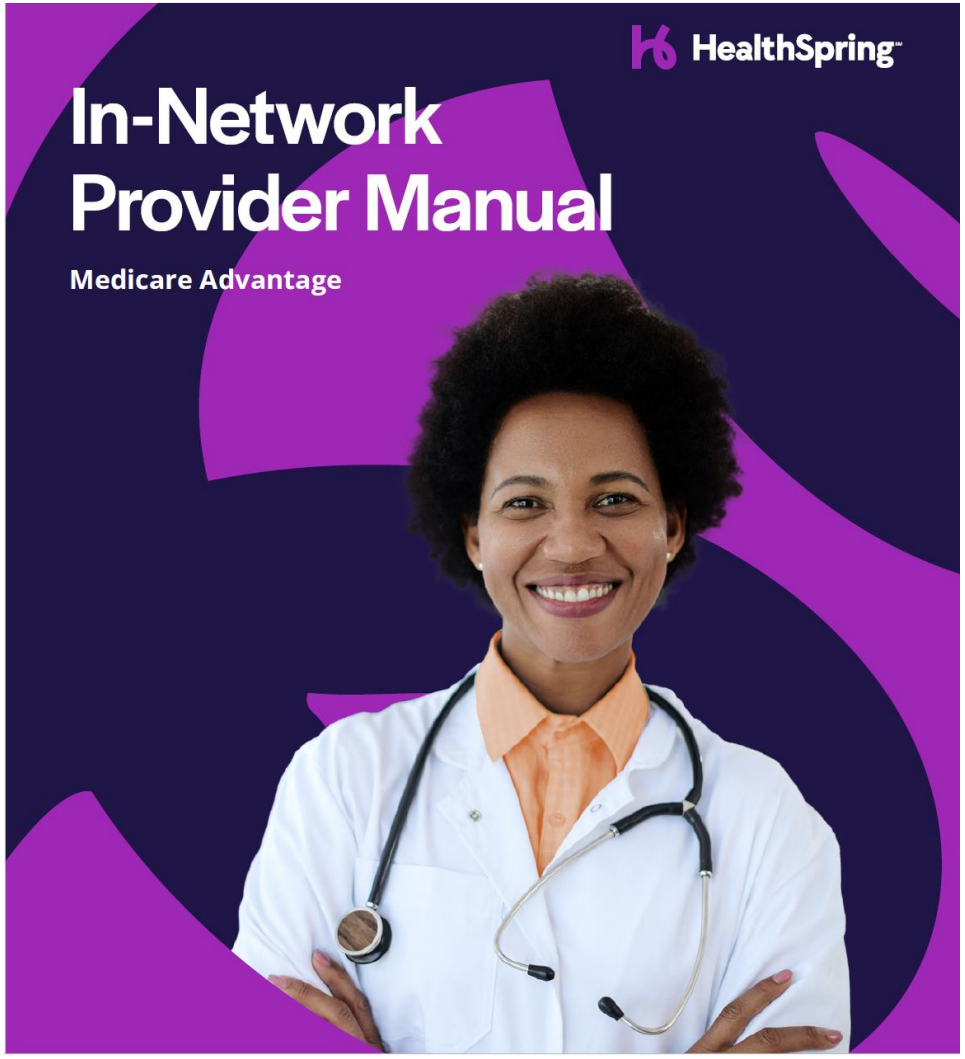


Provider resources

HealthSpring.com/Providers is a central hub of resources to help you do business with us.



Provider manual



Provider resources

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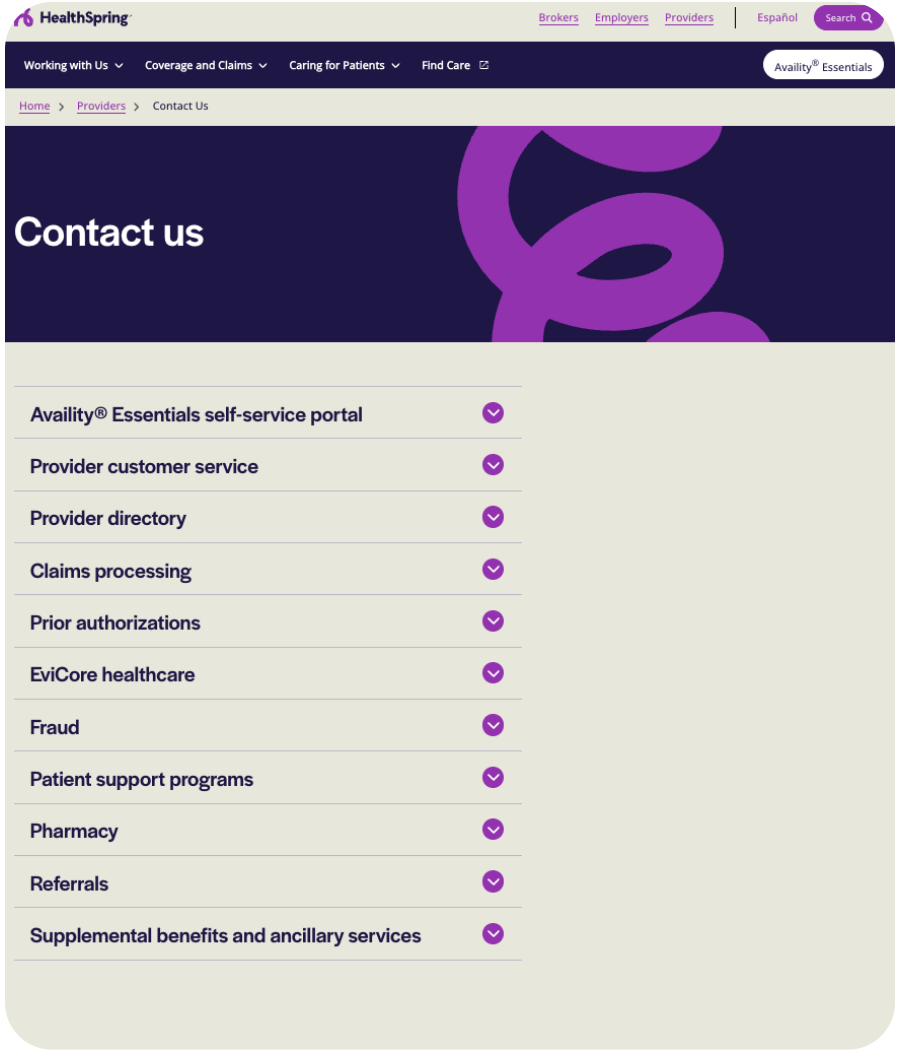
Contact information



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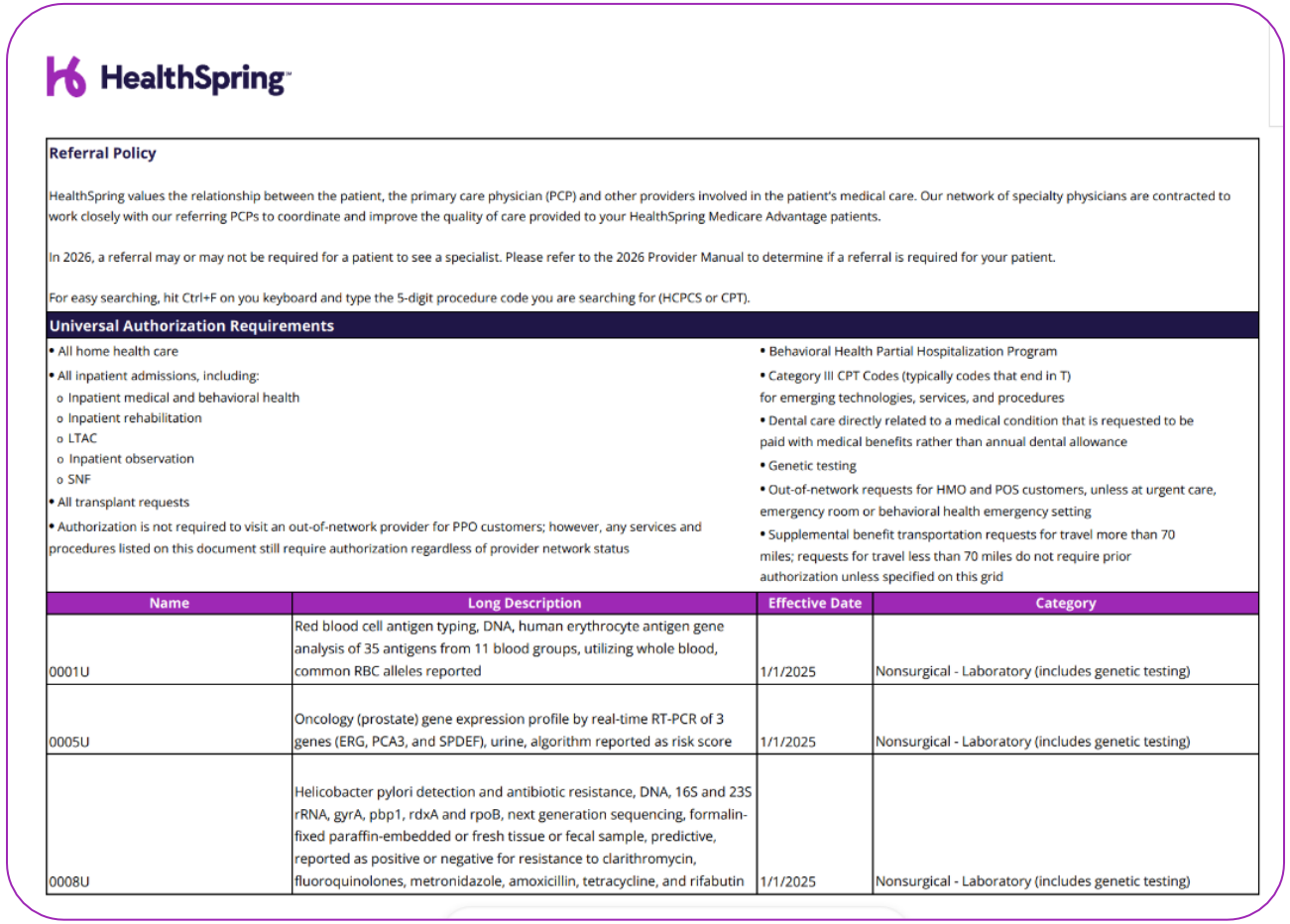

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Referral Policy

HealthSpring values the relationship between the patient, the primary care physician (PCP) and other providers involved in the patient's medical care. Our network of specialty physicians are contracted to work closely with our referring PCPs to coordinate and improve the quality of care provided to your HealthSpring Medicare Advantage patients.

In 2026, a referral may or may not be required for a patient to see a specialist. Please refer to the 2026 Provider Manual to determine if a referral is required for your patient.

For easy searching, hit Ctrl+F on you keyboard and type the 5-digit procedure code you are searching for (HCPCS or CPT).

Universal Authorization Requirements

- All home health care
- All inpatient admissions, including:
  - Inpatient medical and behavioral health
  - Inpatient rehabilitation
  - LTAC
  - Inpatient observation
  - SNF
- All transplant requests
- Authorization is not required to visit an out-of-network provider for PPO customers; however, any services and procedures listed on this document still require authorization regardless of provider network status
- Behavioral Health Partial Hospitalization Program
- Category III CPT Codes (typically codes that end in T) for emerging technologies, services, and procedures
- Dental care directly related to a medical condition that is requested to be paid with medical benefits rather than annual dental allowance
- Genetic testing
- Out-of-network requests for HMO and POS customers, unless at urgent care, emergency room or behavioral health emergency setting
- Supplemental benefit transportation requests for travel more than 70 miles; requests for travel less than 70 miles do not require prior authorization unless specified on this grid

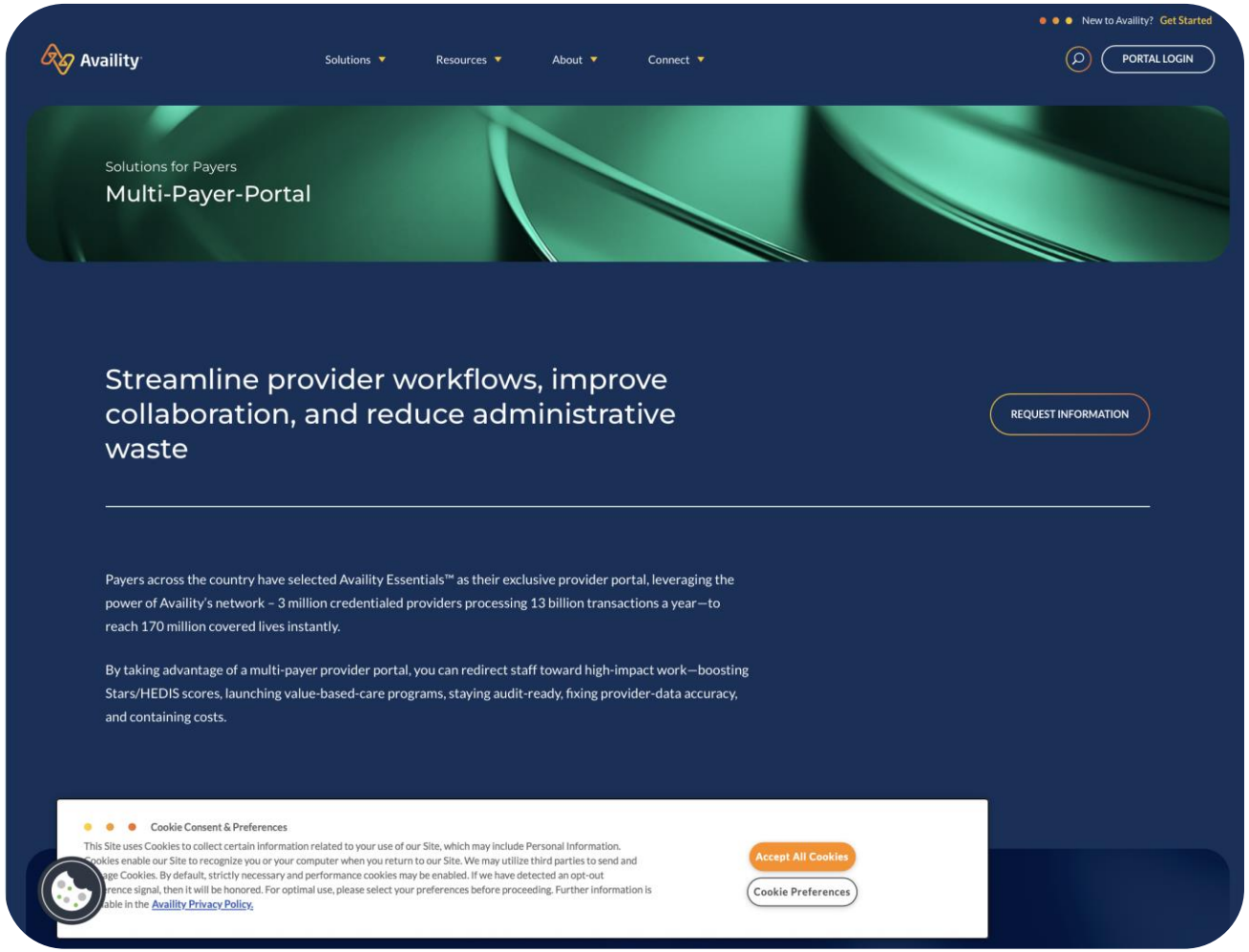
Name	Long Description	Effective Date	Category
0001U	Red blood cell antigen typing, DNA, human erythrocyte antigen gene analysis of 35 antigens from 11 blood groups, utilizing whole blood, common RBC alleles reported	1/1/2025	Nonsurgical - Laboratory (includes genetic testing)
0005U	Oncology (prostate) gene expression profile by real-time RT-PCR of 3 genes (ERG, PCA3, and SPDEF), urine, algorithm reported as risk score	1/1/2025	Nonsurgical - Laboratory (includes genetic testing)
0008U	Helicobacter pylori detection and antibiotic resistance, DNA, 16S and 23S rRNA, gyrA, pbp1, rdxA and rpoB, next generation sequencing, formalin-fixed paraffin-embedded or fresh tissue or fecal sample, predictive, reported as positive or negative for resistance to clarithromycin, fluoroquinolones, metronidazole, amoxicillin, tetracycline, and rifabutin	1/1/2025	Nonsurgical - Laboratory (includes genetic testing)

Prior authorization guidelines

Provider resources

HealthSpring.com/Providers is a central hub of resources to help you do business with us.

Availity® Essentials self-service portal



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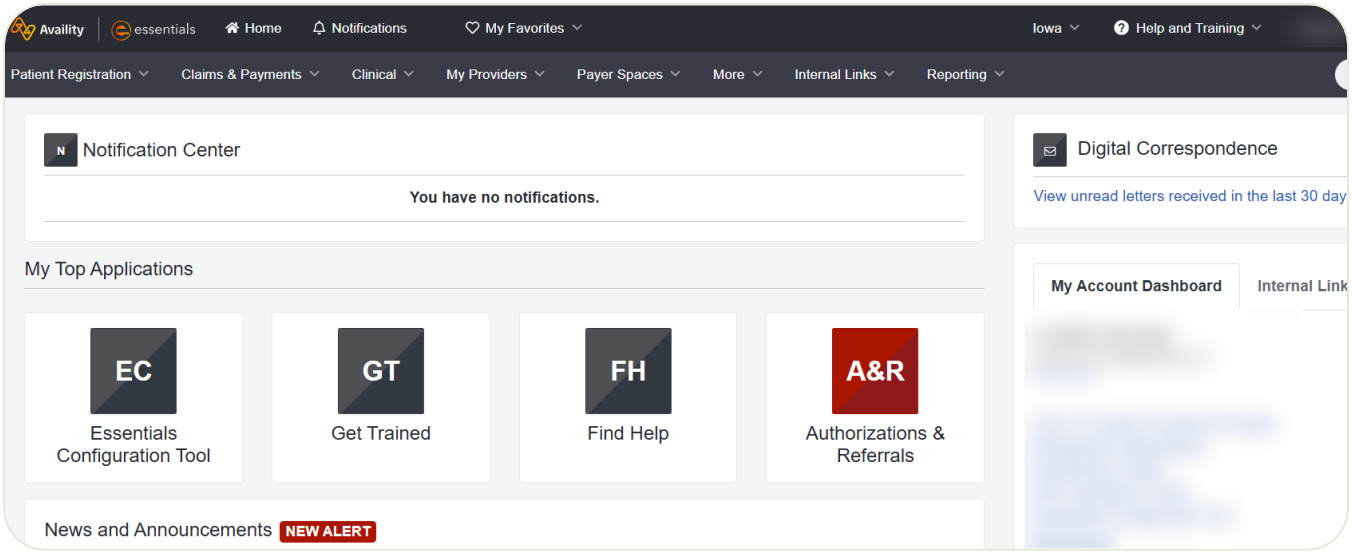
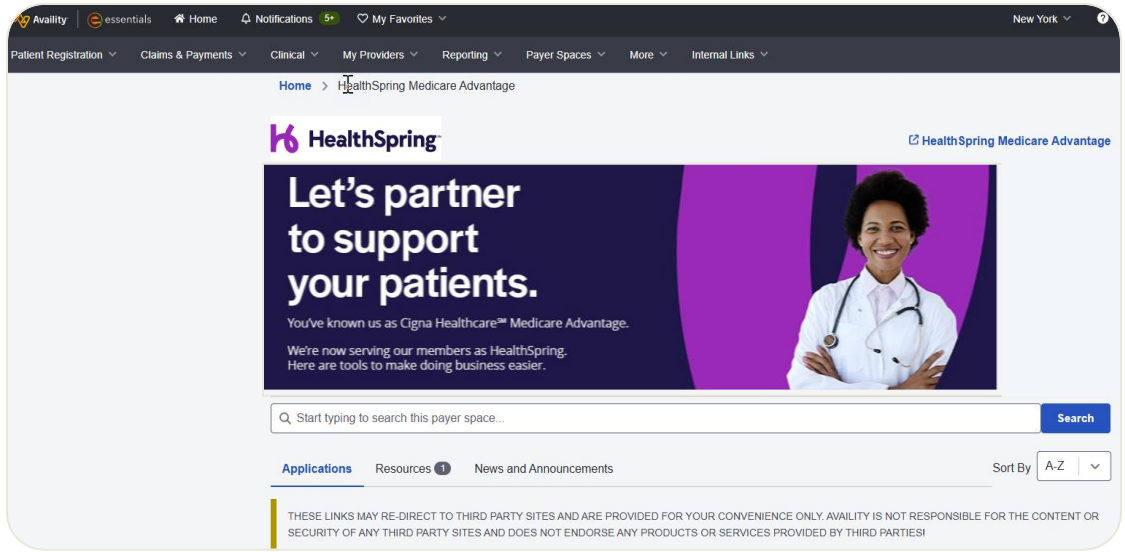


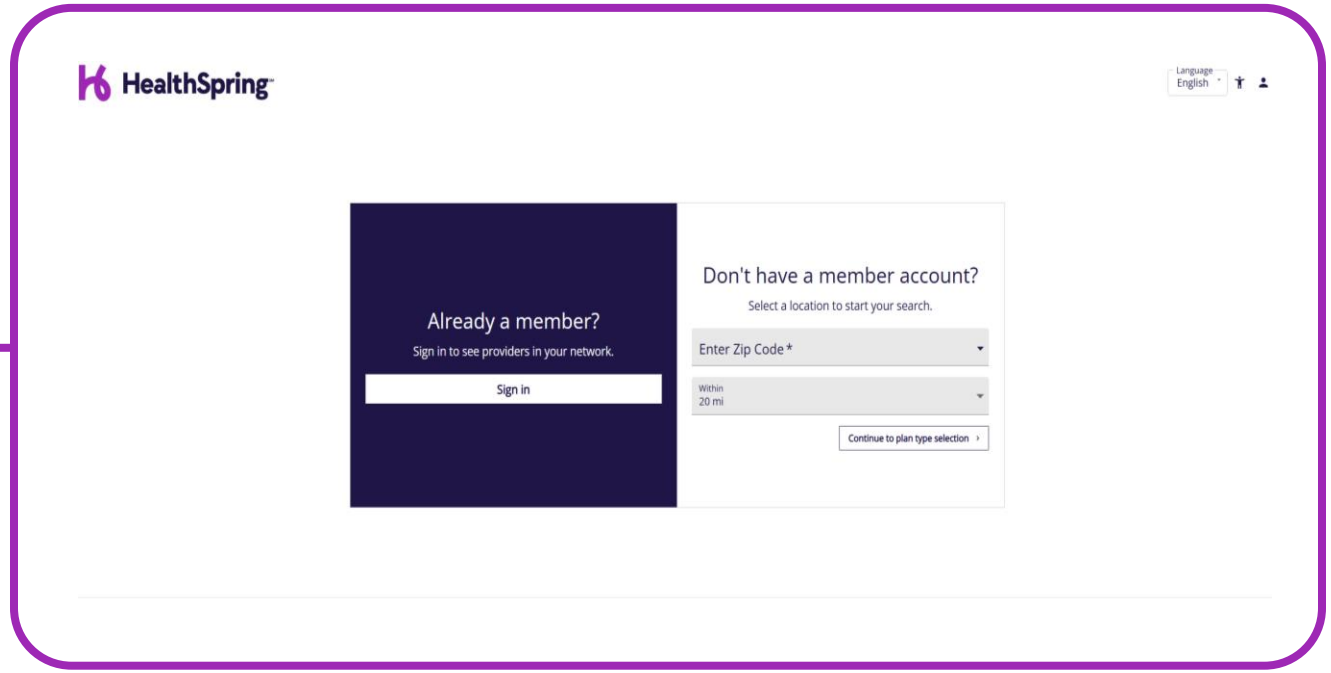


Use our self-service portal at Availity.com to:

- Verify eligibility and benefits
- Verify primary care provider
- View member ID cards
- Submit professional and institutional claims
- Check claims status
- View remittance advice
- Access specific HealthSpring Medicare Advantage resources through our dedicated payer space.

Online provider directory

- **To review your directory information,** visit Find Care and enter your name. Review your practice information for accuracy, including your address, contact information and specialty.
- **If you need to update your information**, sign in to the CAQH Provider Data Portal and update your information as soon as possible. If you have questions, call CAQH at 888-600-9802 or refer to their help page.

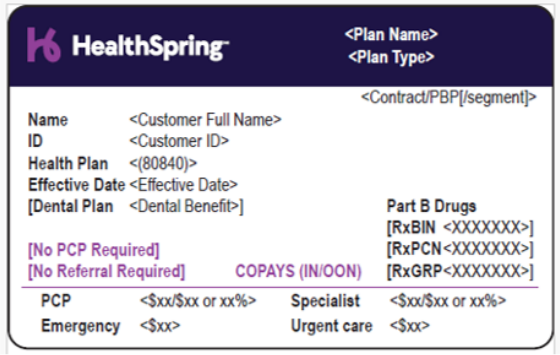


Claim Information

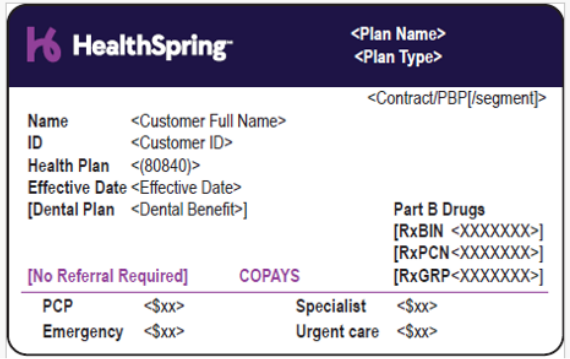
Sample ID cards, claims submissions and appeals

Sample ID cards

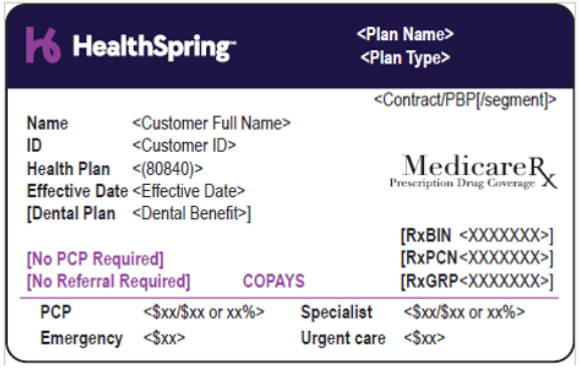
PPO: HealthSpring Medicare Advantage



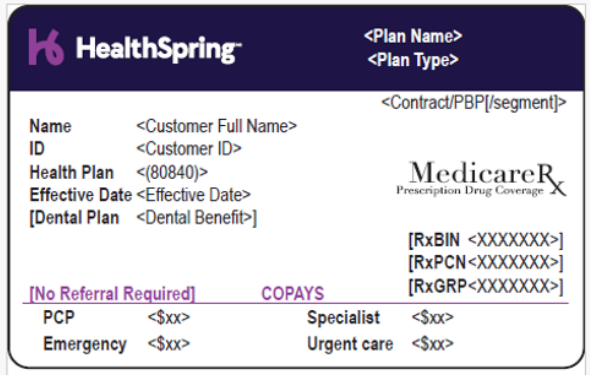
HMO: HealthSpring Medicare Advantage*



PPO: HealthSpring Medicare Advantage Prescription Drug



HMO: HealthSpring Medicare Advantage Prescription Drug*



Member ID cards have helpful information, including:
ID number to use for all claims and inquiries

- Effective date of coverage
- Copayment due at the time of service
- Dental coverage
- Prescription drug coverage
- Customer service numbers

For more information, refer to our key to member ID cards.

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

Claims submission – Payer ID

Electronic claims can be submitted to us through Availity Essentials using **payer ID 52192** or through your preferred vendor.

Paper claims:
HealthSpring
Medicare Advantage Claims
PO Box 23456
Chattanooga, TN 37421

Refer to our provider manual for more information on submitting claims.

Provider Claims questions:
1-800-230-6138

Reconsideration requests:
HealthSpring Reconsiderations
PO Box 20002
Nashville, TN 37202

Appeals/Reconsideration questions:
1-800-511-6943

Medical necessity claim disputes:
HealthSpring Appeals
PO Box 650065
Dallas, TX 75265

Claims and appeals

Claim submissions

- You must submit clean claims within the time frame outlined in your provider agreement.
- If you submitted a claim to HealthSpring and received a denial, you can appeal.

Appeal submissions

You must submit an appeal within the time frame outlined in your provider agreement. Include the following information:

- Explanation of what you are appealing and the rationale for the appeal
- Copy of your denial
- Medical records that support medical necessity for the service

Appeal type	Address	Fax number
Medical – standard	PO Box 650059 Dallas, TX 75265	855-350-8671
Medical – expedited	PO Box 650058 Dallas, TX 75265	855-350-8672
Fast track (Quality Improvement Organization)	PO Box 650040 Dallas, TX 75265	855-594-4432
Contracted provider (post-service)	PO Box 650065 Dallas, TX 75265	855-699-8985

Request appeal or reconsideration form

Claim appeal

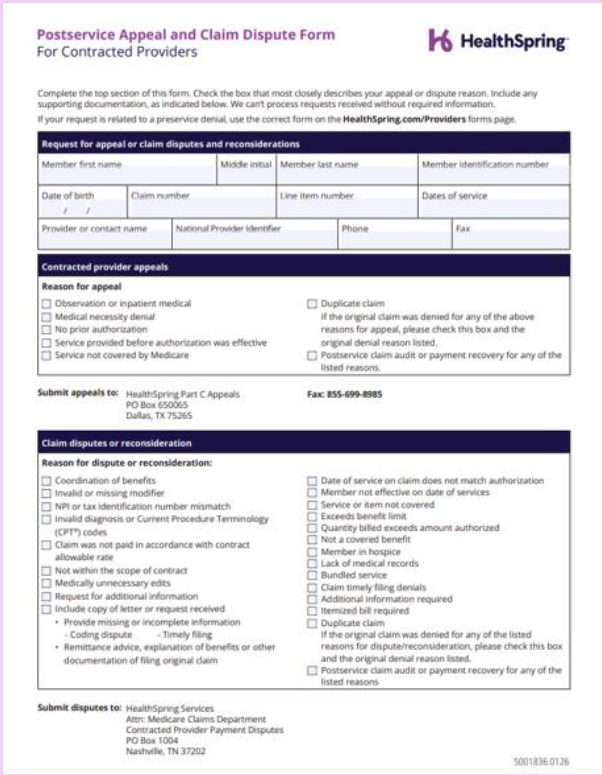
Submit within 65 days from the original decision to request review of a previously made decision related to medical necessity, clinical guidelines, prior authorization or referral requirements.

Claim reconsideration

Submit up to 180 days from the claim payment date for disputes such as:

- Denials involving coordination of benefits, timely filing or missing information
- Underpayment
- Overpayment
- Coding disputes

For appeal and reconsideration forms, visit the forms page.



Postservice Appeal and Claim Dispute Form
For Contracted Providers

HealthSpring

Complete the top section of this form. Check the box that most closely describes your appeal or dispute reason. Include any supporting documentation, as indicated below. We can't process requests received without required information.
If your request is related to a preservice denial, use the correct form on the **HealthSpring.com/Providers** forms page.

Request for appeal or claim disputes and reconsiderations

Member first name	Middle initial	Member last name	Member identification number

Date of birth / /	Claim number	Line item number	Dates of service

Provider or contact name	National Provider Identifier	Phone	Fax

Contracted provider appeals

Reason for appeal

- ☐ Observation or inpatient medical
- ☐ Medical necessity denial
- ☐ No prior authorization
- ☐ Service provided before authorization was effective
- ☐ Service not covered by Medicare
- ☐ Duplicate claim
  If the original claim was denied for any of the above reasons for appeal, please check this box and the original denial reason listed.
- ☐ Postservice claim audit or payment recovery for any of the listed reasons.

Submit appeals to: HealthSpring Part C Appeals
PO Box 650065
Dallas, TX 75265

Fax: 855-699-8985

Claim disputes or reconsideration

Reason for dispute or reconsideration:

- ☐ Coordination of benefits
- ☐ Invalid or missing modifier
- ☐ NPI or tax identification number mismatch
- ☐ Invalid diagnosis or Current Procedure Terminology (CPT®) codes
- ☐ Claim was not paid in accordance with contract allowable rate
- ☐ Not within the scope of contract
- ☐ Medically unnecessary edits
- ☐ Request for additional information
- ☐ Include copy of letter or request received
  - Provide missing or incomplete information
    - Coding dispute - Timely filing
  - Remittance advice, explanation of benefits or other documentation of filing original claim
- ☐ Date of service on claim does not match authorization
- ☐ Member not effective on date of services
- ☐ Service or item not covered
- ☐ Exceeds benefit limit
- ☐ Quantity billed exceeds amount authorized
- ☐ Not a covered benefit
- ☐ Member in hospice
- ☐ Lack of medical records
- ☐ Bundled service
- ☐ Claim timely filing denials
- ☐ Additional information required
- ☐ Itemized bill required
- ☐ Duplicate claim
  If the original claim was denied for any of the listed reasons for dispute/reconsideration, please check this box and the original denial reason listed.
- ☐ Postservice claim audit or payment recovery for any of the listed reasons

Submit disputes to: HealthSpring Services
Attn: Medicare Claims Department
Contracted Provider Payment Disputes
PO Box 1004
Nashville, TN 37202

5001836.0126

Zelis – Claims payment

HealthSpring uses Zelis to issue claims payments.

Want to receive digital payments instead? Visit HealthSpring.ePayment.Center to enroll.

Clinical Operations

Prior authorization, clinical reviews and patient support programs

Prior authorization

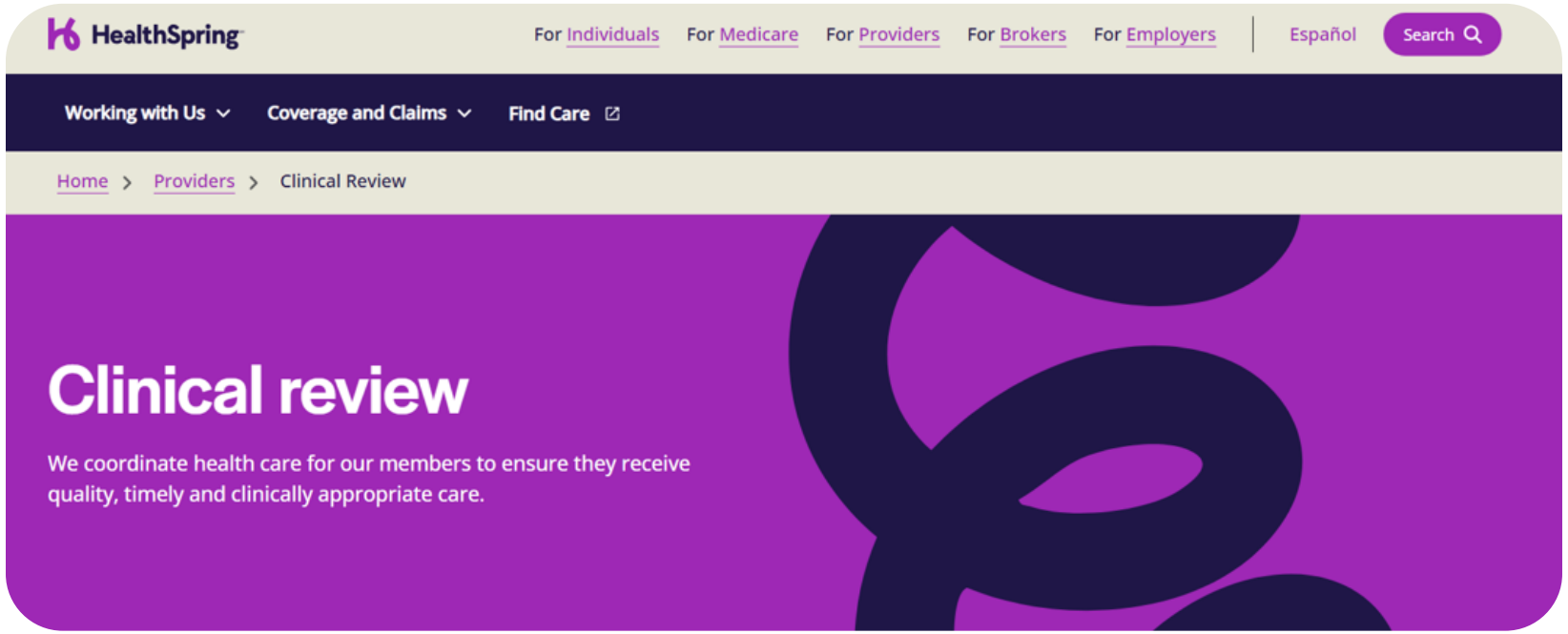
To process a prior authorization request, we need the following information:

- Member identifiers, including ID number
- Ordering and servicing provider information, including National Provider Identifier
- Requested date(s) of service
- Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System codes, if applicable
- Diagnosis and ICD-10 codes
- Provider orders
- Clinical documentation that supports the request − this is important

Requests missing the above information may be delayed or returned.

Prior authorization requirements

For a list of services, items and medications that require prior authorization, refer to the clinical review page.



How to submit prior authorization

Provider self-service portal (fastest)

- Log in to your Availity Essentials account
- Select **HealthSpring MA** from the payer spaces drop-down
- Click the Provider Portal application to access the prior authorization portal

Phone
800-453-4464

Fax

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

Some radiology, radiation therapy and cardiac imaging services require prior authorization by EviCore.

EviCore healthcare

HealthSpring works with EviCore, a specialty medical benefits management company, to manage prior authorization of the following services:

- High-tech radiology and diagnostic cardiology
- Medical oncology (excludes Part D coverage) and radiation therapy
- Musculoskeletal procedures

Preferred method for requesting prior authorizations from EviCore:

- To register, go to EviCore.com > Register Now.

Clinical Operations

The HealthSpring Medicare Advantage Clinical Review Services team processes all nonvendor utilization management requests.

Requests are accepted via phone, fax or the provider portal.
Phone: 888-454-0013

- All inpatient and observation admissions require notification and prior authorization, including:
  - Approved outpatient procedures that change to an admission, and
  - Admissions via the emergency room
- Evidence-based care guidelines via our clinical hierarchy are applied to medical necessity decisions.
- Observation admissions are not expected to exceed 48 hours. Discharge or admission to inpatient must occur after 48 hours of observation.

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Post-acute admission authorization requests

Providers must submit prior authorization requests to the HealthSpring clinical team for skilled nursing facility and subacute rehabilitation, inpatient acute rehabilitation and long-term acute care.

Required information

- Patient identifiers
- Admission date
- Hospitalization details, including primary and secondary diagnoses, procedures performed, etc.
- Completed prior authorization form
- Provider peer-to-peer (clinical consultation) contact information
- Provider and facility information, including NPI and contact information

Additional facility-specific required information

Skilled nursing facility and subacute rehabilitation requests

- Wound care: Measurements and treatment plan
- IV therapy: Medication dosage and frequency and end date
- For therapy: Acute-care physical and occupational therapy evaluations and notes, including the patient's prior functional level

Inpatient acute rehabilitation requests

- Acute care physical, occupational and speech therapy evaluations, including information to support patient's ability to participate in three hours of therapy per day
- Provider oversight required

Long-term acute care hospital requests

- Ventilator settings and documentation on weaning trials
- Medical necessity supporting clinical complexity requiring long-term acute care admission, including provider oversight

Effective **Jan. 1, 2026**, HealthSpring began managing prior authorizations for post-acute care services, including skilled nursing facility, inpatient rehabilitation, long-term acute care and home health.

Effective **March 1, 2026,** HealthSpring began managing durable medical equipment prior authorization.

Clinical reviews

Initial review

- Submit required information within **one business day** of admission.
- Submit notice of admission and/or request via the self-service portal Availity Essentials.
- Complete the **Inpatient Admission Request Form** and submit it to the **Inpatient Clinical Review Services team.** You can find the form on the forms page.
- Phone: **888-454-0013** | Fax: **866-234-7230**

Required information

- Route of admission, such as emergency room, scheduled or direct
- Inpatient level of care being requested
- Provider and facility information, including National Provider Identifier and contact information
- Admitting diagnosis or chief complaint
- Pertinent prior medical history
- Medical necessity documentation utilized to support the level of care being requested
- Current treatment plan and pertinent lab, radiology and test results
- Any procedures that have been completed or ordered
- Discharge plan and transition-of-care barriers
- Patient's prior level of function and social history

Continued stay review

Required information

- Any procedures completed or ordered
- Updated medical necessity documentation and working diagnosis
- Concurrent treatment plan
- Pertinent clinical information, including lab and radiology results and physical therapy evaluations
- Discharge plan and transition-of-care barriers
- Specific information, as needed, to support an alternate level of care if one is ordered or anticipated

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Discharge review

Required information within one business day of discharge

- Discharge date
- Discharge summary,[1] including discharge instructions and medication reconciliation information
- Discharge diagnosis
- Patient's functional level
- Discharge disposition:
  - If discharged to "home," provide alternate phone numbers, if available.
  - If discharged with home health care or durable medical equipment, provide name of the provider.
  - If discharged to a skilled nursing facility, rehabilitation or long-term acute care, obtain the required prior authorization via HealthSpring Post Acute.
  - Outpatient follow-up – primary care provider, specialist or outpatient treatment

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[1] Discharge summary must include medication reconciliation required for the Special Needs Plan model of the Centers for Medicare & Medicaid Services' Five-Star Quality Rating System.

Medicare Advantage patient support programs

We offer the following:

- Ancillary clinical services program
- Behavioral health programs
- Disease-specific programs
- Medicaid low-income subsidy assistance programs
- Medical care management programs
- Nonclinical support programs
- Social determinants of health and quality-of-life programs
- Specialty care management programs

Program benefits for your practice and patients:

- Short-term and complex care management
- Help coordinating services and community resources
- Targeted efforts to prevent or manage complications
- Regular reporting from treatment partners

For our members, the programs can encourage:

- Improved self-management skills
- Better medication adherence
- Closed gaps in preventive care measures

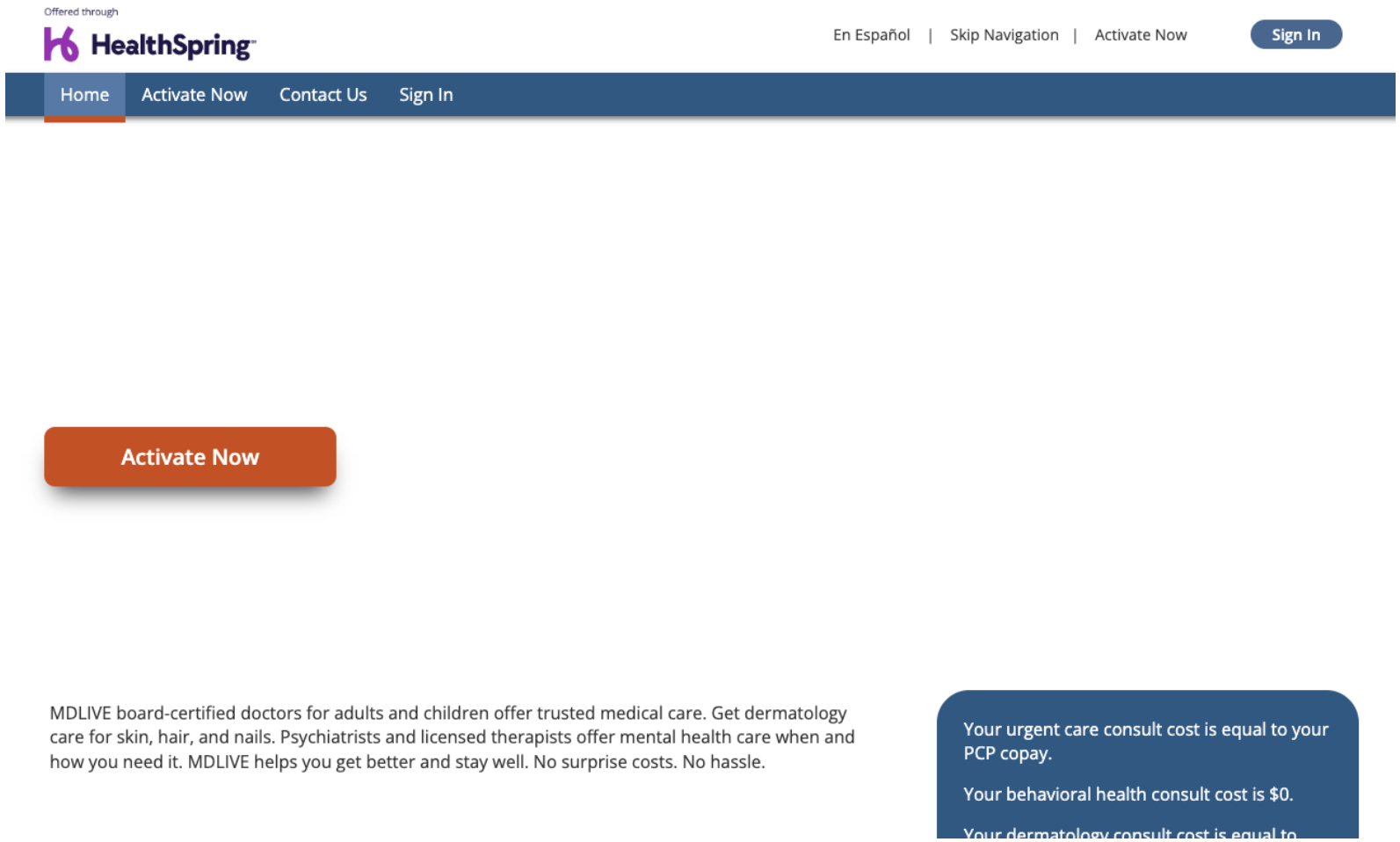
To refer a member, check eligibility or learn more, contact our care management support team. Include in your email:

- Provider name and phone number
- Member name and health plan ID number

Use secure email when sending personal health information or diagnostic information.

Supplemental Benefits

Telemedicine - MDLIVE



Special Needs Plans

What is a Special Needs Plan?

A SNP is a Medicare Advantage-coordinated care plan specifically designed to provide targeted care and limited enrollment to individuals with special needs.

Two types of SNPs

- Chronic Condition Needs Plan (C-SNP)
- Dual Eligible Special Needs Plan (D-SNP)

An individual with special needs may:

- Be dual eligible or
- Have a severe or disabling chronic condition, as specified by the Centers for Medicare & Medicaid Services

A SNP may be any type of Medicare Advantage-coordinated care plan, including a:

- Local preferred provider organization
- Regional preferred provider organization
- Health maintenance organization
- HMO point-of-service

What is a SNP-MOC?

A Special Needs Plan Model of Care is the evidence-based process by which we integrate benefits and coordinate care for members enrolled in HealthSpring Medicare Advantage SNPs.

Why is a MOC important?

MOCs facilitate:

- Early assessment, as well as the identification of health risks and major changes in members' health status
- Coordination of care to improve members' overall health, as well as understanding of the care management program for members enrolled in SNPs

Annual CMS-required SNP training for providers

- Learn about the types of SNPs, how they help the SNP population and how they help improve care coordination and health outcomes
- Understand your role in our SNP-MOC and its impact on CMS Star ratings

CMS and National Committee for Quality Assurance guidelines serve as the foundation of our SNP-MOC.

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Five-Star Quality Rating System

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Five-Star Quality Rating System

What is the Five-Star Quality Rating System?

- CMS created the Five-Star Quality Rating System to improve the quality of care for Medicare beneficiaries electing Medicare Advantage coverage from health plans versus traditional Medicare.
- Star ratings are designed to improve quality of care, overall health outcomes and access to affordable health care, while helping Medicare beneficiaries select the best Medicare Advantage plan for their health care needs.
- Many of the measures in Star ratings assess patients' interaction with providers.

How do Star ratings affect your practice? The ratings:

- Provide one of the many ways that health care consumers make informed choices about their health plan and providers
- Affect payments to Medicare providers and managed care organizations
- Help patients enhance relationships with providers and health plans by ensuring accessibility to care, enhanced quality of care and optimal customer service
- Place greater focus on preventive care and early detection of disease
- Increase investments in health plan benefits that help your patients

Refer to the quality resources page for information on Star ratings.

Risk Adjustment

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Refer to the quality resources page for information on Star ratings.

What is risk adjustment?

The federal government contracts with health plans to administer Medicare Advantage benefits to a beneficiaries electing Medicare Advantage products.

If Medicare beneficiaries select a Medicare Advantage plan (Part C), CMS pays the selected private health plan based on a capitated or “risk” payment for each member to cover all the health care costs of that individual annually.

Risk adjustment is used to calculate payments to health plans based on demographic factors and health status of at-risk patient populations.

The HealthSpring risk adjustment program

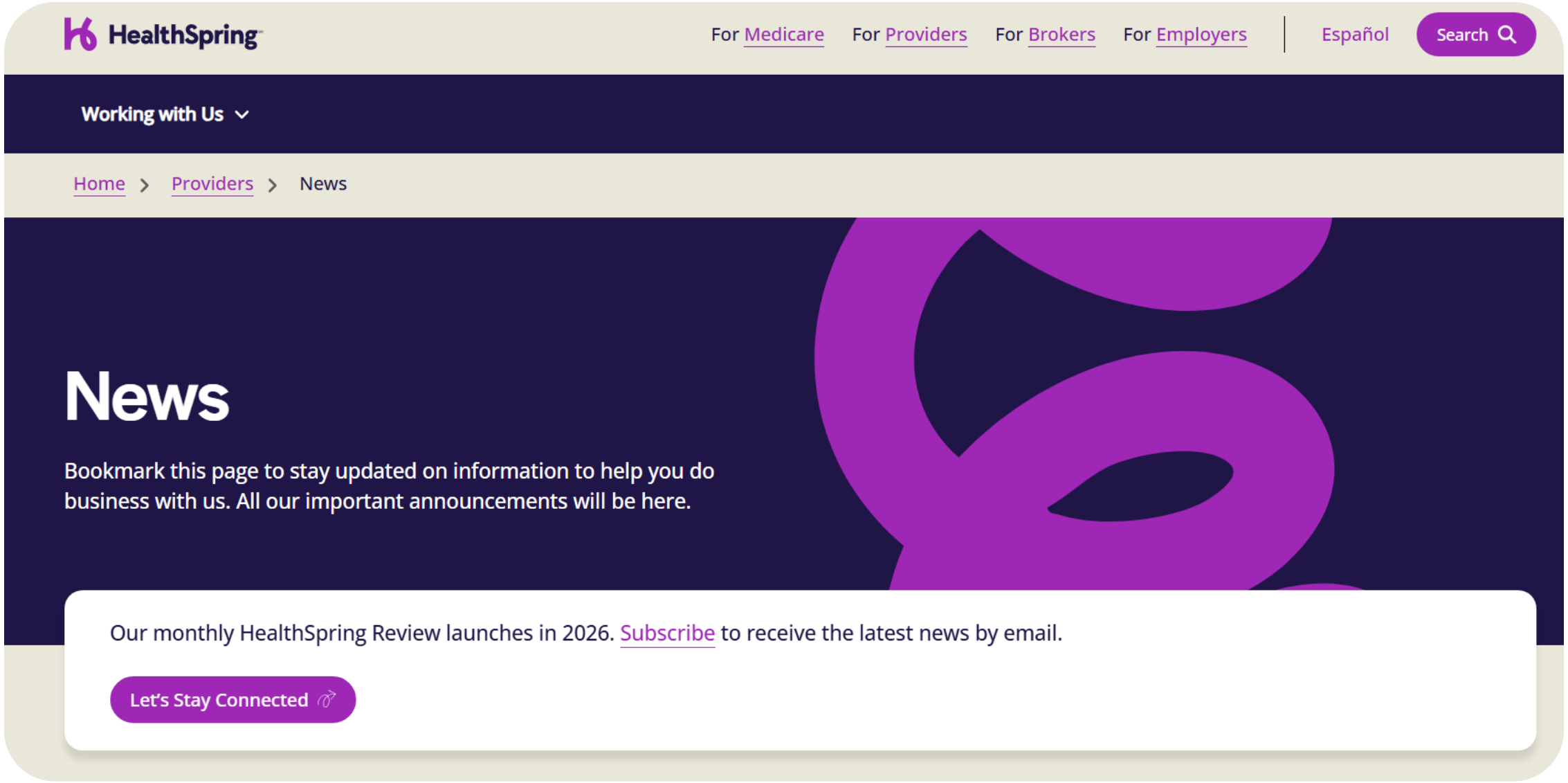
Our risk adjustment program is based on a solid compliance foundation with a goal of accurate data submissions to CMS. The key to achieving this goal is focusing collaborative efforts on the complete and accurate documentation and coding of medical conditions.

HealthSpring provides analytical data, materials and tools to assist providers with complete documentation of each patient’s medical conditions and accurate assignment of diagnosis codes, all in compliance with CMS and official coding guidelines.

Accurate documentation and coding establish a complete record of health status; enhance quality of care by facilitating continuity and consistency of care, reducing medical errors, quality and safety monitoring; and can provide access to special care management programs for beneficiaries.

Additional Resources

News


HealthSpring
For Medicare
For Providers
For Brokers
For Employers
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Working with Us
Home
Providers
News
News
Bookmark this page to stay updated on information to help you do business with us. All our important announcements will be here.
Our monthly HealthSpring Review launches in 2026. Subscribe to receive the latest news by email.
Let's Stay Connected

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Appendix

Member Rights and Responsibilities

Members have the following rights:

- The right to be treated with dignity and respect
- The right to the privacy of medical records and personal health information
- The right to know treatment choices and participate in decisions about their health care
- The right to make complaints or appeals
- The right to obtain information about their health care coverage and drug costs
- The right to receive more information about members' rights
- The right to take action if they think they have been treated unfairly or their rights are not being respected
- The right to use advance directives (such as a living will or a power of attorney)

Member Rights and Responsibilities

Members have the following responsibilities:

- Becoming familiar with their HealthSpring coverage and the rules they must follow to get care as a member. They can use their HealthSpring evidence of coverage and other information we provide them to learn about their coverage, what we have to pay and the rules they need to follow. They should call customer service if they have any questions or complaints.
- Knowing which providers are part of our network because, with limited exceptions, they can contact customer service for assistance in finding an in-network provider: 800-668-3813 (all providers except Arizona HMO) − 800-627-7534 (Arizona HMO).
- Advising HealthSpring and their providers if they have other health insurance coverage.
- Notifying providers when seeking care (unless it is an emergency) that they have HealthSpring Medicare Advantage plan coverage and presenting their ID card to the provider, when possible.
- Giving their doctors and other providers the information needed to provide care for them and following agreed-upon treatment plans and instructions. Members are encouraged to ask questions they have of their doctors and other providers.
- Paying their plan premiums and any copayments or coinsurances they may have for the covered services they receive. They must also meet their other financial responsibilities as described in their evidence of coverage.
- Informing HealthSpring if they have any questions, concerns, problems or suggestions regarding their rights, responsibilities, coverage or HealthSpring operations.
- Notifying HealthSpring customer service and their providers of any address or phone number changes as soon as possible.
- Using their HealthSpring plan only to access services, medications and other benefits for themselves.