Clover
Provider Manual

A guide to working better, together.

Meet Clover.

We are a health insurer changing the way people are cared for by capturing and analyzing patient data in powerful new ways.

Our goal is to improve the quality of life for our members while offering providers like you the resources and support you deserve.

By establishing a close, collaborative partnership with you, we can share and exchange rich health data about your patients—our members. We can identify opportunities to care for them, with your guidance, between visits with you. We can then start to catch conditions earlier and move a few steps closer to preventing them.

Together, we believe we can move healthcare in a new direction and help Medicare patients live longer, healthier, more fulfilling lives.

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Clover
Quick Reference Guide

DEPARTMENT	PHONE	FAX
Provider Services	1-877-853-8019	
Care Management	1-888-995-1689	
Authorization Requests (UM)	1-888-995-1690	1-800-308-1107
Pharmacy (CVS/Caremark)	1-855-294-5979	
Appeals & Grievances	1-877-853-8019	1-732-412-9706
Member Services	1-888-657-1207	

FREQUENTLY USED SERVICES	QUICK LINKS	
To request a pre-authorization, check the status of an existing request, or view a list of required services	Pre-Authorization Lookup Tool	
To view pharmacy pre-authorization criteria We typically respond to completed forms within 24 business hours.	via web: Pre-Authorization Request	via print/fax: Pre-Authorization Request Form
To submit a claim If you need to make any changes to an original claim you can resubmit a corrected claim using the above channels.	interconnect via Change Healthcare: Payer ID#: 77023	via mail: Clover Health P.O. Box 3236 Scranton, PA 18505
To find an in-network provider	Provider Directory	
To view pre-authorization criteria	Formulary	
To dispute a payment	Payment Dispute Form	
	via fax: 1-732-412-9706	via mail: Attn: Appeals and Grievances Clover Health P.O Box 471 Jersey City, NJ 07303
To appeal a pre-service denial	Clover Appeal Form	
To appeal a Part D denial	Request for Redetermination of Medicare Prescription Drug Denial Form	
For routine issues or operational items	Clover Provider Tools Page	

Legal Overview

Except where otherwise indicated, this Provider Manual is effective as of July 1, 2017 for providers currently participating in the Clover network.

This Provider Manual will serve as a resource for navigating Clover's operations and processes. In the event of a conflict or inconsistency between this Provider Manual and the express provisions of your Provider Agreement with Clover, including any regulatory requirements appendices attached to it, the provisions of your Provider Agreement will prevail. We reserve the right to periodically update this Provider Manual.

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Clover Members

We believe that you can care better for patients when your time with them is made more efficient and productive. This section outlines the benefits, rights, and responsibilities for Clover members, and shows you how to easily verify member eligibility.

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IDENTIFICATION OF CLOVER MEMBERS AND ELIGIBILITY

You (or your office staff) are responsible for verifying each member's eligibility prior to rendering any non-emergency services or treatment.

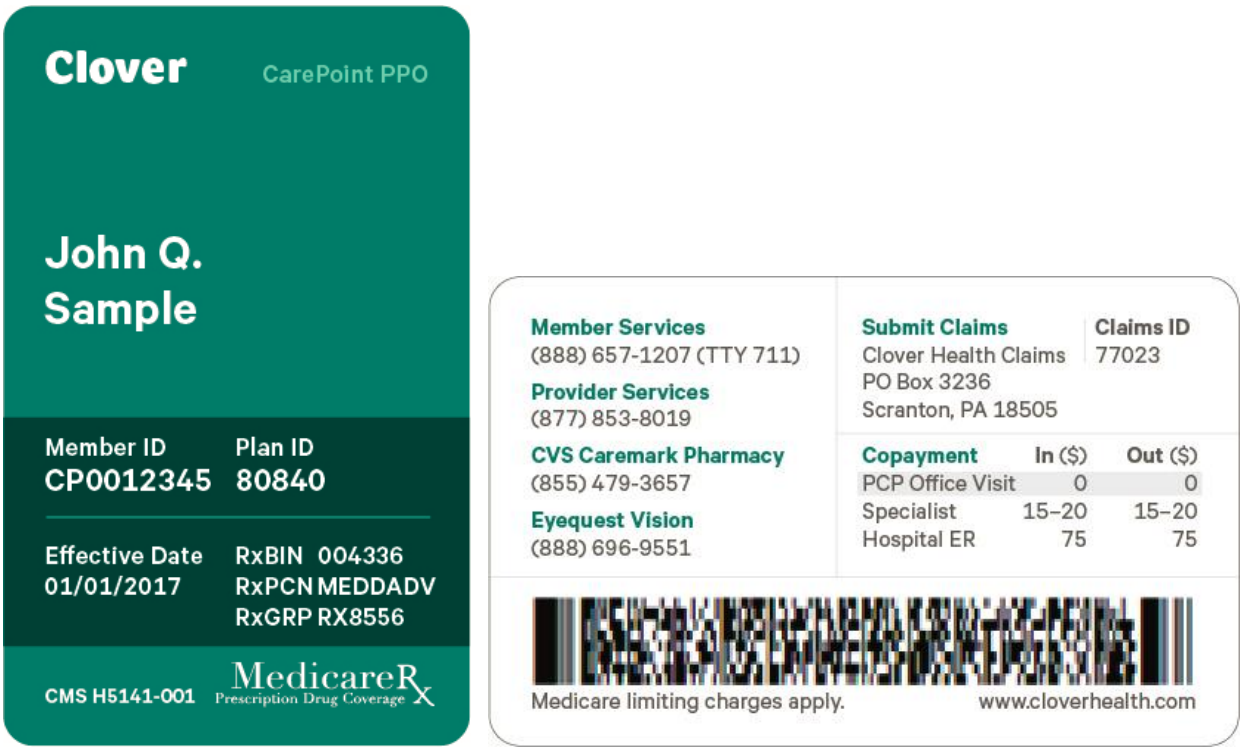
When members arrive in your office, you should confirm their eligibility by:

- Calling Provider Services at **1-877-853-8019** or
- Logging onto Navinet at navinet.navimedix.com (where applicable), selecting Clover Health, and entering in the member's ID number

Members should present to you a Clover Identification Card (sample provided below) with the following information:

- Member plan name (CarePoint Plan cards are in green, Classic in blue, Prestige in purple, and Premier in red)
- Member first and last name
- Member ID #
- Plan ID #
- Contact information for Claims and Provider Services

Please ensure all the information on the identification card is up-to-date and accurate.



Clover Members who have dual eligibility should present two identification cards—one for Clover and one from a state agency, which indicates that these members may have additional assistance to cover costs.

COVERED SERVICES

We provide our members with comprehensive benefit packages that afford the basic primary, preventive, and specialty care necessary for good health. Covered services must be medically necessary and appropriate. To verify covered or excluded services, please call Provider Services at **1-877-853-8019**, or refer to the **Evidence of Coverage (EOC)** booklet for a complete list.

A member may elect to receive medical care for services not included in the contract or services that are determined by us to be not medically necessary. In such cases, you should let the member know that the service is not covered by Clover and that they will be responsible for payment. In those instances, direct the member to the EOC, and document prior approval from the member for such out-of-pocket expenses. All services may be subject to applicable copayments, deductibles, and coinsurance.

Dental Benefits

Covered dental care includes procedures normally offered by a physician in a hospital, and those that may involve the following:

- The jaw or related structures
- Setting fractures of the jaw or facial bones
- Extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease
- Other related services

Additionally, Clover will pay for some dental-related hospitalizations. For example, we may cover treatment for a member who develops an infection after having a tooth pulled or requires observation during a dental procedure because of a health-threatening condition.

Dental care that is not covered includes any routine dental care procedures, and those that may be done after the underlying health condition has already been treated, such as:

- Tooth removal due to facial injury from a car accident
- Any dental care related to the car accident that may arise at a later time

Benefit grid

In 2017, we are offering the following 4 plans to our members:

CarePoint (001) Premiums and Benefits

PREMIUM/BENEFIT	MEMBER PAYS	PREMIUM/BENEFIT	MEMBER PAYS
Monthly Premium	$0	Emergency Room	$75
Part D Deductible	$150	Outpatient Surgery	$290
Max. Out-of-Pocket	$6,700	Vision Exams	$15
Primary Care	$0	Inpatient Hospital	$290 Days 1–6
Specialist	$15		$0 Days 7–365
Ambulance	$200		

CarePoint (001) Part D Coverage

$150 Deductible

INITIAL COVERAGE				COVERAGE GAP	CATASTROPHIC COVERAGE
Preferred network		Non-preferred network		When the annual total drug costs paid by a member and Clover reach $3,700–$4,950 during initial coverage, the member pays: 51% Generic drugs 40% Brand-name drugs	When a member's annual out-of-pocket costs exceed $4,950, the member pays: 5% or $3.30† Generic/Preferred drugs 5% or $8.25† All other drugs
Tier 1	$0	Tier 1	$5		
Tier 2	$10	Tier 2	$15		
Tier 3	$35*	Tier 3	$45*		
Tier 4	$85*	Tier 4	$95*		
Tier 5	25%*	Tier 5	25%*		

*These tiers apply to the deductible.

†Members pay whichever amount is greater; varies by drug.

Classic (004) Premiums and Benefits

PREMIUM/BENEFIT	MEMBER PAYS	PREMIUM/BENEFIT	MEMBER PAYS
Monthly Premium	$0	Emergency Room	$75
Part D Deductible	$150	Outpatient Surgery	$325
Max. Out-of-Pocket	$6,700	Vision Exams	$15
Primary Care	$0	Inpatient Hospital	$290 Days 1–6
Specialist	$15		$0 Days 7–365
Ambulance	$250		

Classic (004) Part D Coverage

$150 Deductible

INITIAL COVERAGE				COVERAGE GAP	CATASTROPHIC COVERAGE
Preferred network		Non-preferred network		When the annual total drug costs paid by a member and Clover reach $3,700–$4,950 during initial coverage, the member pays: 51% Generic drugs 40% Brand-name drugs	When a member's annual out-of-pocket costs exceed $4,950, the member pays: 5% or $3.30† Generic/Preferred drugs 5% or $8.25† All other drugs
Tier 1	$0	Tier 1	$5		
Tier 2	$10	Tier 2	$15		
Tier 3	$35*	Tier 3	$45*		
Tier 4	$85*	Tier 4	$95*		
Tier 5	25%*	Tier 5	25%*		

*These tiers apply to the deductible.

†Members pay whichever amount is greater; varies by drug.

Prestige (006) Premiums and Benefits

PREMIUM/BENEFIT	MEMBER PAYS	PREMIUM/BENEFIT	MEMBER PAYS
Monthly Premium	$225	Emergency Room	$50
Part D Deductible	$0	Outpatient Surgery	$50
Max. Out-of-Pocket	$6,700	Vision Exams	$0
Primary Care	$0	Inpatient Hospital	$100 Days 1–6
Specialist	$0		$0 Days 7–365
Ambulance	$0		

Prestige (006) Part D Coverage

$0 Deductible

INITIAL COVERAGE				COVERAGE GAP	CATASTROPHIC COVERAGE
Preferred network		Non-preferred network		When the annual total drug costs paid by a member and Clover reach $3,700–$4,950 during initial coverage, the member pays: 51% Generic drugs 40% Brand-name drugs	When a member's annual out-of-pocket costs exceed $4,950, the member pays: 5% or $3.30† Generic/Preferred drugs 5% or $8.25† All other drugs
Tier 1	$0	Tier 1	$5		
Tier 2	$7	Tier 2	$12		
Tier 3	$37	Tier 3	$47		
Tier 4	$80	Tier 4	$90		
Tier 5	25%	Tier 5	25%		

*These tiers apply to the deductible.
†Members pay whichever amount is greater; varies by drug.

Premier (007) Premiums and Benefits

PREMIUM/BENEFIT	MEMBER PAYS	PREMIUM/BENEFIT	MEMBER PAYS
Monthly Premium	$38.40	Emergency Room	$75
Part D Deductible	$220	Outpatient Surgery	$175
Max. Out-of-Pocket	$6,700	Vision Exams	$0
Primary Care	$0	Inpatient Hospital	$170 Days 1–6
Specialist	$0		$0 Days 7–365
Ambulance	$200		

Premier (007) Part D Coverage

$220 Deductible

INITIAL COVERAGE				COVERAGE GAP	CATASTROPHIC COVERAGE
Preferred network		Non-preferred network		When the annual total drug costs paid by a member and Clover reach $3,700–$4,950 during initial coverage, the member pays: 51% Generic drugs 40% Brand-name drugs	When a member's annual out-of-pocket costs exceed $4,950, the member pays: 5% or $3.30† Generic/Preferred drugs 5% or $8.25† All other drugs
Tier 1	$0	Tier 1	$5		
Tier 2	$7*	Tier 2	$12		
Tier 3	$30*	Tier 3	$40*		
Tier 4	$80*	Tier 4	$90*		
Tier 5	25%*	Tier 5	25%*		

*These tiers apply to the deductible.
†Members pay whichever amount is greater; varies by drug.

Supplemental benefits

Our plan offers, at no extra cost, the following supplemental benefits that are not covered by Original Medicare:

- One routine vision exam per year through eyeQuest*
- One $100 allowance per year for routine eyewear (lenses, frames, or contacts) after a $40 copay*
- One SilverSneakers® membership at participating fitness centers: silversneakers.com/locations
- 24/7 access to Teladoc, a phone consultation service with mental health professionals and board-certified doctors. For more information, call **1-800-835-2362** or visit teladoc.com

*Supplemental vision benefits are subject to the same appeals process as any other benefits.

Rewards and incentives

Our Hello to Healthy program rewards members for healthy behaviors like getting a flu shot or completing an annual wellness exam. All members receive a welcome kit with information about the program and can sign up at **cloverhealth.com/hellotohealthy**.

For more information, members can call, toll-free, **1-888-286-0069 (TTY 711)** Monday–Friday, 8 a.m.–10 p.m. EST, and Saturday, 10 a.m.–3 p.m. EST.

MEMBERS' RIGHTS AND RESPONSIBILITIES

We ensure the following rights and responsibilities for our members.

Member rights

- Protection and privacy of personal health information
- Timely access to covered services and drugs
- Clear, simple presentation of health-related information
- Fair and respectful treatment
- Opportunity to ask that we reconsider decisions made about their care
- Opportunity to make their own decisions about their care

Member responsibilities

- Familiarity with covered services and the rules required to receive them
- Full disclosure of plans enrolled in, and changes in health status, geography, and other pertinent health-related personal information
- Full and/or timely payments toward any and all amounts owed
- Adherence to health management, self-treatment, and/or home care plans as recommended by you

Members may always contact Member Services for help, questions, or concerns. For additional details on members' rights and responsibilities, please refer to the Clover 2017 **Evidence of Coverage** booklet or call Member Services.

MEMBERS' PRIVACY RIGHTS

Members have the following privacy rights:

- To see any and all information in their medical records
- To know when their medical records have been shared
- To receive a copy of their medical records
- To ask for additions or corrections to their medical records

CULTURAL COMPETENCY

To help integrate cultures of diverse backgrounds within Clover and across the organizations we partner with, we follow CLAS Standards—a collective set of linguistic services, mandates, guidelines, and recommendations issued by the United States Department of Health and Human Services Office of Minority Health.

Learn more at **thinkculturalhealth.hhs.gov**.

ADVANCE DIRECTIVES

In the event a member becomes incapacitated and/or unable to communicate his or her needs, we follow the instructions as outlined in the member's advance directive. Examples of advance directives include a living will, durable power of attorney for healthcare, healthcare proxy, or do not resuscitate (DNR) request.

Under advance directive guidelines, we defer to you to honor member requests. You should discuss advance directives with your patients (as appropriate) and file a copy of any advance directive document in the medical record. Each medical record that contains an advance directive should clearly indicate that such document is included.

New Jersey providers can find more information on advance directives on the New Jersey Department of Health website at **nj.gov/health/advancedirective**.

Provider Responsibilities

We think providing clear and transparent communication is key to a successful partnership. Here, we have outlined some of our expectations, guidelines on how to use us as a resource, and other ways we try to empower you to do your best work.

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STANDARDS OF PARTICIPATION

We like to update our provider information frequently. This section details what we kindly ask you to inform us about when there are changes to any of the following:

- Status
- Demographic or location
- Payment or credentialing information
- Tax identification number
- Office or billing entity location(s)
- National Provider Identifier(s)
- Any other relevant provider information

Acceptance of new patients

If you decide to no longer accept any new patients or additional Clover members, please give us 60 days' written notice.

Privileges

You and your group practices are required to have admission privileges with at least one of Clover's in-network hospitals. If you or any of your group practice providers lose privileges at any such hospital, please notify us no later than 10 business days following the date of the termination of privilege.

APPOINTMENTS AND ACCESS STANDARDS

We are dedicated to arranging quality access to care for our members. In doing so, we ask that you and your office staff adhere to the following recommendations:

- **Telephone coverage after hours:** An answering service or a telephone recording that directs a member to call another telephone number or 911 in the event of an urgent or emergent situation.
- **Telephone access during normal business hours:** Immediate responses to any urgent or emergency health events, within 4 hours for non-urgent calls, and within 1–2 business days for routine calls.
- **Covering provider:** When you are on extended leave (vacation, illness, etc.) you must arrange with another participating primary care provider or specialist to provide accessible 24-hour coverage. Coverage must extend beyond 911, except in the event of an emergency or urgent situation.
- **Appointments:** You must make every effort to see a member within the following timeframes:
- Emergent: Immediately. Member should be directed to call 911 in the event of an emergency or go the emergency room for treatment.
- Urgent: Within 24 hours.
- Routine/Symptomatic: Within 7 days.
- Wellness/Nonsymptomatic— Within 30 days.

- **Office waiting time:** Should not exceed 30 minutes from the time of the scheduled appointment.
- **Minimum office hours:** You must practice for a minimum of 16 hours a week and must promptly notify Health Plan of changes in your office hours and locations as soon as this information becomes available, but no later than 3 business days after the change takes effect. The minimum office hour requirement may be reduced under certain circumstances for good cause, with Health Plan's prior written approval.
- **Accessibility:** You are expected to meet the federal and state accessibility standards and those defined in the Americans with Disabilities Act of 1990. Healthcare services provided through Clover must be accessible to all members.

Clover tracks and evaluates issues relating to waiting times for appointments, appropriateness of referrals, and other indications of capacity.

Please refer to your specific Provider Agreement for additional details.

ACCESS TO MEDICAL RECORDS

Clinical documentation of disease burden is central to collaborative management and is the cornerstone to care. As needed, Clover will request medical records to ensure an accurate representation of patients' clinical disease and needs.

MEDICAL RECORD STANDARDS

We believe that updated, complete documentation is an essential component to the delivery of quality medical care and collaboration. We reserve the following rights to ensure our member profiles are comprehensive.

Access and confidentiality

We reserve the right to inspect (at reasonable times) any and all records, specifically any medical records you maintain pertaining to members. This includes assessing quality of care, collecting data for Healthcare Effectiveness Data and Information Set (HEDIS®) reporting, coordinating medical care evaluations and audits, and determining on a concurrent basis the medical necessity and appropriateness of any care being provided. Federal and state regulatory bodies may determine other purposes for having access to members' medical records.

For information on member rights as they relate to the above, please refer to the Members' Privacy Rights section of this Provider Manual.

Medical Record Documentation

- Medical information must be legible and follow a logical and consistent format.
- The record should contain documentation of all services provided by the physician as well as other non-physician services (e.g., physical therapists, diagnostic or laboratory services, home healthcare).
- The record must indicate:
    - All illnesses and medical conditions
    - Medications list
    - Consultations/referrals
    - Present issue
    - Treatment plan
    - Follow-up plan
    - Preventive screenings and health education offered
    - Documentation on advance directives
- Information should be stored within a secure folder in a safe place.
- No record should be altered, falsified or destroyed. If a correction is introduced, the individual correcting the record should draw a single line through the item to be corrected, and date and initial the correction.
- All telephone messages and consult discussions must be clearly identified and recorded.
- The medical record system should provide a mechanism to ensure member confidentiality.

Electronic medical record integrations

We recognize that the medical record retrieval process can interfere with daily operations of your practice. To minimize the impact this may have on your office, we partner directly with Electronic Medical Record (EMR) and integration vendors to automate the transmission of member charts via a secure and HIPAA-compliant connection.

Integrations automate the transmission of member charts to Clover without any additional effort or disruption to your practice. Under no circumstances does Clover have access to patient data for non-Clover members as a result of this integration. Benefits of participating in a Clover EMR integration include:

- Enhanced care coordination with Clover through incorporation of EMR data into Clover's advanced analytics platform
- Giving time back to your office staff that may be otherwise spent responding to traditional medical record requests
- Reduced waste and environmental impact of printing charts, made possible through a paperless medical record retrieval
- Automated identification and transmission of member charts to Clover

Medical Record Retention

In accordance with New Jersey state law, we ask that hospitals retain medical records for 10 years following a patient's discharge and that you maintain patient records for 7 years. Please refer to applicable state law for the most up-to-date regulations.

NONADHERENT CLOVER MEMBERS

We recognize that you may need help in managing nonadherent members. If you have an issue with a member regarding behavior or treatment cooperation and/or completion, or if you have a member who cancels or does not appear for necessary appointments and fails to reschedule, even after follow-up attempts by you and/or your office, please contact Provider Services at **1-877-853-8019**.

MEDICARE RISK ADJUSTMENT PROCESS

We understand that meeting patients' medical needs is the first step to improving their health. Accurately defining members' risk levels allows us to better meet patients' needs and manage their care. In light of this, we use standard Centers for Medicare and Medicaid Services (CMS) Medicare guidelines to measure our members' health relative to their peers using a risk adjustment model that considers their demographic and diagnoses. We then use these measures to assess healthcare utilization needs and cost, allowing both you and payers to organize around these needs.

PROVIDER DATA COLLECTION

Directory validation

On a quarterly basis, Clover conducts outreach to every provider within the current provider directory in order to validate demographic and contact information. Outreach is performed either via e-mail or phone.

Updating provider information

You can submit requests for updating your provider information by visiting the Clover website and completing the appropriate request form:

- Provider Update Request Form: Used primarily for address and contact information changes
- Provider Tax ID Update Form: Used to update Tax ID and payment information (Note: For this form to be processed, you must also attach an updated W9)

Please contact Provider Services at **1-877-853-8019** for other inquiries or issues regarding completing these forms.

COMPLIANCE WITH FEDERAL LAWS AND NONDISCRIMINATION

The Code of Federal Regulations (42 CFR 422.504) requires that Medicare Advantage Organizations have oversight for contractors, subcontractors, and other entities. The intent of these regulations is to ensure services provided by these parties meet contractual obligations, laws, regulations, and CMS instructions. Clover is held responsible for the compliance of its providers and subcontractors with all contractual, legal, regulatory, and operational obligations.

Clover does not discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location. Payments received by contracted providers from Medicare Advantage plans for services rendered to plan members include federal funds; therefore you, as a contracted provider, are subject to all laws applicable to recipients of federal funds, including but not limited to: Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, and all other laws that apply to organizations that receive federal funding.

Claims and Billing

We are always trying to make it easier for you to manage paperwork, so you can spend more time focusing on your patients. Here is what you need to know to better manage claims processes, and how we go about paying you well and on time.

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CLAIMS SUBMISSION

Electronic submission

To help expedite the claims process, we recommend an electronic submission process that is faster, more reliable, and less prone to front-end process rejections. Clover supports electronic submission via the HIPAA transaction set (837P and 837I) and upholds Medicare guidance requiring electronic claim submission as defined by the American Simplification Compliance Act.

Please submit claims via Change Healthcare (formerly known as Emdeon) with Clover's Payer ID #77023.

Paper submission

Clover also accepts the CMS-1500 and CMS-1450 (UB-04) paper claim forms.

Paper claims must be submitted to:

Clover Health
P.O. Box 3236
Scranton, PA 18505

Timely filing of claims

You should refer to your Provider Agreement for filing guidelines and documentation requirements. Unless otherwise specified in your Provider Agreement, Clover's standard timely filing limit is 90 days from the claim date of service for in-network providers. As set forth in your Provider Agreement, you may not bill members for services submitted beyond the timely filing limit. Corrected claims must also be submitted within our timely filing requirements.

CLAIMS PROCESSING

We use a combination of guidelines established by CMS and internal claims processing policies to assist in determining proper coding. These guidelines and policies dictate claims edits, adjustments to payment, and/or a request for review of medical records that relate to the claim.

Clean claims

Clover uses the CMS Medicare Advantage definition for a clean claim, which consists of a properly completed claim that can be processed as soon as it is received. Clean claims include:

- Complete coding
- Provider information
- Itemization
- Date of service
- Billed amounts
- Substantiating documentation needed to meet the requirements of an encounter with a member

Failure to submit a clean claim may result in a delay of payment and/or rejection of a claim. Common types of errors include incomplete fields, invalid codes, lack of supporting medical records, and provider data mismatches.

Timely processing of claims

Clover is required to uphold standard claims timeliness guidelines, which either are stipulated in your Provider Agreement or follow CMS timeliness requirements.

Refer to the CMS guidelines for more information.

CLAIMS PAYMENT

You will be reimbursed according to the compensation provisions of the Compensation Schedule included in your Provider Agreement.

Claims corrections

We will deny a claim if it is determined to be incorrect or incomplete due to missing or invalid information. In this event, you may resubmit a corrected claim within the timely period as indicated in the Timely Filing of Claims section above.

Overpayment recovery

We abide by CMS guidelines for overpayment recoupments, which include provider notification, opportunity for rebuttal, and possibility of auto-recoupments from future claims payments. Clover may reopen and revise its initial determination or redetermination on a claim on its own motion:

- Within 1 year from the date of the initial determination or redetermination for any reason; or
- Within 4 years from the date of the initial determination or redetermination for good cause as defined in CMS Medicare Handbook §10.11; or
- At any time if:
    - There exists reliable evidence that the initial determination was procured by fraud or similar fault as defined in the Code of Federal Regulations (42 CFR §405.902); or
    - The initial determination is unfavorable, in whole or in part, to the party thereto, but only for the purpose of correcting a clerical error on which that determination was based. Third party payer error does not constitute clerical error.

Clover will not seek more than one reimbursement for overpayment of a particular claim. At the time the reimbursement request is submitted to you, Clover will provide written documentation that identifies the error made by Clover in the processing or payment of the claim that justifies the reimbursement request. Clover will not base a reimbursement request for a particular claim on extrapolation of other claims, except under any of the following circumstances:

- In judicial or quasi-judicial proceedings, including arbitration
- In administrative proceedings

- Where relevant records you were required to maintain have been improperly altered or reconstructed, a material number of the relevant records are otherwise unavailable
- Where there is clear evidence of fraud by you, and Clover has investigated the claim in accordance with its fraud prevention plan

In seeking reimbursement from you for any overpayment you may have received, except as expressly otherwise stated in the Provider Agreement, Clover attempts to collect the funds for reimbursement according to the following guidelines:

- The amount may be deducted from the next subsequent payment due to you.
- If you dispute the request and initiate an appeal after Clover has sent you the reimbursement request, we will not collect the amount until after your rights to appeal the request for reimbursement have been exhausted.
- Clover may assess the amount against payment of any future claims you submit or after your rights to appeal the reimbursement request have been exhausted. Clover will collect the funds after sending a written explanation to you that has sufficient detail to allow you to reconcile each enrollee's bill.

Clover may also collect a monetary penalty against a reimbursement request including, but not limited to, an interest charge.

If we determine upon investigation that our overpayment was a result of fraud you have committed, we will report the fraud to the Office of the Insurance Fraud Prosecutor as required by law. We may then take action to collect an overpayment by assessing it against payment of any future claim submitted by you.

Payment integrity (pre- and postpayment review)
As a partner of CMS, we are obligated to monitor for signs of fraud, waste, and abuse, ensuring well-managed care through a payment integrity review, including both pre- and postpayments. Clover uses software tools designed to identify providers and facilities whose billing practices indicate suspect conduct.

If a claim, provider, or facility is identified as a behavioral outlier, further investigation is conducted by Clover to determine the reason(s) for the outlier behavior or approximate explanation for an unusual claim, billing, or coding practice. If the investigation results in a determination that the provider's or facility's actions may involve fraud, waste or abuse, the provider or facility is notified and given an opportunity to respond, and Clover may institute an overpayment recovery process as described above.

These claim types, providers, or facilities may also then be placed under prepayment review and may be subject to one or more clinical utilization management guidelines. The impacted providers and/or facilities are notified of a request for additional clinical information in support of the medical necessity of services billed for/coded on the identified claims in prepayment review.

ACCESS TO MEDICAL RECORDS

Medical records access is central to our assessment of payment integrity and the evaluation of medical necessity. In the processing of claims, if more clinical data is required, our team or a trusted third party requests medical records and pends the processing of the claim until the records are received and evaluated.

MEMBER COST-SHARE

As a provider, you play a critical role in our network and in the provision of healthcare services to our members. In accordance with CMS regulations and as included in your Provider Agreement, you may not bill or collect payment for services rendered to our members, except for applicable copayments, coinsurance, or deductibles.

Clover encourages you to collect all applicable copayments at the time services are rendered but to defers the collection of coinsurance and outstanding deductibles until Clover has processed the claim and an explanation of payment (EOP) has been received. Please refer to the member's Clover identification card for the copayment amounts of the most common services. You may also check a member's copayment, coinsurance, or deductible by calling Provider Services at **1-877-853-8019** or logging onto Navinet at **navinet.navimedix.com** (where applicable).

If you collect an amount from a member that exceeds the payment responsibility, you must reimburse the excess amount to the member. To determine the member's responsibility, please refer to the EOP. If a correction to a claim or a payment must be made, the result of which indicates that the original amount collected in member cost-share exceeds the member's actual responsibility, it is your responsibility to reimburse the excess amount to the member. Furthermore, you must advise members of any charges they will accrue that are not covered by Clover and obtain prior approval from the member before requesting payment for such out-of-pocket expenses.

Balance billing and inappropriate billing of members

Inappropriate billing of members includes billing members for services where payment from Clover has not been obtained due to claim cleanliness issues or other billing issues.

If you are a Medicare-participating provider or you contract with Clover, you may not balance bill or inappropriately bill members. Any such billing is a violation of the Provider Agreement and applicable state laws. Providers who willfully or repeatedly balance bill members will be referred by Clover to the relevant regulatory agency for further action.

COORDINATION OF BENEFITS (COB)

Coordination of Benefits and Services (COB) is intended to avoid duplication of benefits and at the same time preserve certain rights to coverage under all plans in which the member is covered. COB is an important part of Clover's overall objective of providing healthcare to members on a cost-effective basis. Clover members may not be billed for covered services rendered except for any copayments for which the member may be

responsible. Clover members who have Medicaid QMB (Qualified Medicaid Beneficiary Program) as other coverage are not responsible for copayment. Your contract with Clover requires you to accept Clover's payment as payment in full.

DEFINITIONS

Primary plan:
Determines a member's health benefits without taking into consideration the existence of any other plan.

Secondary plan:
Pays the remaining costs after the primary plan has paid.

All Clover members must follow these procedures:

- All Clover members, excluding those on Medicaid, will pay copayments at the time of their office visit
- If Clover is the secondary insurance, attach the explanation of benefits from their primary carrier and send the claim for the remaining balance to Clover
- Under no circumstances may members be directly billed beyond the amount due for their cost-share

Coordination of benefits for Medicare Advantage members with Medicaid

Clover members who have limited income and resources may receive help paying out-of-pocket medical expenses from Medicaid. If a member is identified as having secondary insurance coverage through Medicaid, you should obtain a copy of the member's Medicaid card to bill Medicaid after receiving the EOP from Clover. No copayment should be collected at the time of the visit from a member with Medicaid coverage. For further information, your office can contact Provider Services at **1-877-853-8019** or the number listed on the member's Medicaid card.

Coordination of benefits for Medicare Advantage members with multiple payer sources

If a member has coverage from more than one payer or source, we coordinate benefits with the other payer(s) in accordance with the provisions of the member's benefits. If you have knowledge of alternative primary payer(s), you must bill the other payer(s) with the primary liability based on such information prior to submitting claims for the same services to Clover.

You are also expected to provide us with relevant information you may have collected from members regarding coordination of benefits and to bill payer(s) with the primary liability based on such information prior to submitting bills for the same services to Clover. To the extent permitted by law, if Clover is not the primary payer, your compensation by Clover will be no more than the difference between the amount paid by the primary payer(s) and your applicable rate, less any applicable copayments or coinsurance.

Because members accept Clover benefits by their participation in the COB program, they are legally responsible to adhere to the rules and regulations required of all Clover members, such as use of the PCP and/or prior approval for out-of-plan services.

Clover cannot deny a claim, in whole or in part, on the basis of "coordination of benefits," unless we have a reasonable basis to believe that the member has other insurance coverage that is primary for the claimed benefit. In addition, if we request information from the member regarding other coverage and do not receive the information within 45 days, we must adjudicate the claim. However, the claim cannot be denied on the basis of nonreceipt of information about other coverage.

Utilization Management

Our goal at Clover is to help provide the right care to your patients at the right time. Our utilization management (UM) program was designed to apply evidence-based criteria to our clinical decision making to ensure members have access to quality care that is medically necessary.

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PRE-AUTHORIZATION REVIEW

Pre-authorization review is the process of assessing the need for an elective admission, procedure, or service for the purpose of authorizing it prior to the member's admission, procedure, or service. A pre-authorization review request must be as specific as possible and contain sufficient clinical information to substantiate the need for the requested service.

Submission of a pre-authorization review request and obtaining the subsequent and necessary pre-authorization are your responsibility, not member's. If pre-authorization is not obtained before the service is provided by you or received by the member, the claim for services may be denied and you, as provider, will be held financially responsible. Only if you are a contracted provider may authorization be given, and only on a limited basis, after the service is provided. Pre-authorization review is required for all elective inpatient admissions.

Please contact the UM Department at **1-888-995-1690** for more information regarding services requiring pre-authorization.

PLEASE NOTE: Pre-authorizations and notifications are not required for emergent or urgent care.

To initiate the pre-authorization process:

- Visit preauth.cloverhealth.com/pre_auth
- Call **1-888-995-1690**
- Fax **1-800-308-1107**

Plan staff may make approval determinations; however, only a licensed physician under the clinical direction of Clover's medical director with knowledge of the requested service may make a denial determination.

Timelines for approvals and denials are as follows:

Urgent or expedited pre-authorization

> Within 72 hours or less after Clover receives your pre-authorization request. In the event Clover requires additional information to determine whether to approve, deny, or limit the requested authorization, Clover will notify you within 24 hours after receiving the request.
>
> Approvals and denials will be communicated through e-mail, telephone, fax, and mail.

Denials or limitations on routine/standard pre-authorization

> Requests are communicated to you within a time frame appropriate to the medical exigencies of the case, but not more than 14 calendar days after the request for pre-authorization.

You are notified of the determination by telephone and in writing in the case of urgent or expedited requests, and by writing in the case of standard requests.

Written notification of adverse determinations includes instructions regarding reconsideration options, an explanation of the reason for the determination, and other rights and information.

If Clover requires additional information to determine whether to approve, deny, or limit the requested service, Clover will notify you via fax or e-mail no later than 14 calendar days after receiving the request.

Clover staff are available between 10 a.m. and 6 p.m., 5 days a week to respond to authorization requests within the time frames set above, and are available 24/7 for expedited authorization requests.

Failure by Clover to make a determination within the required time periods constitutes an adverse organization determination and may be appealed.

INITIAL DETERMINATIONS

Clover strictly prohibits compensation or incentives to employees or agents based on the outcome of the determination; number or volume of adverse determinations; and reductions or limitations on care/services, benefits, or frequency of contacts with healthcare providers or members. Clover does not use incentives to encourage barriers to care and service. Similarly, Clover strictly prohibits any activity intended to discourage any member, member representative, or you from seeking appropriate care for a Clover member.

Clover responds to requests for authorization of healthcare services by issuing determinations based on the member's health benefit plan and the medical necessity of the service.

In the case of a pre-authorization request, the determination must be given within the following time frames according to the medical exigencies of the case:

- Expedited cases are handled within 72 hours of the receipt of the request
- All other case decisions are rendered within 14 days of receipt of the request

If Clover requires additional information in order to make a determination, Clover notifies the member and/or provider by fax, e-mail, or other means of written communications within the time frames for issuing a determination and identifies the specific information required. Clover grants an extension of 14 calendar days in cases where additional information is required/requested or if you or the member requests the extension. Clover reserves the right to convert a request for expedited processing to a standard/routine time frame if you do not state why applying the standard time for making a determination could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

If the member and/or you fail to respond to Clover's request for additional information necessary to render a determination, the request for authorization is denied.

An adverse determination is issued when Clover does not authorize a service as requested in whole or in part. UM staff may only issue administrative denials based upon eligibility, benefits that are not covered, and benefit exhaustion. All determinations to deny or limit an admission, service, procedure, or extension of stay are rendered by the medical director or his/her appropriately qualified and licensed designee based on medical necessity or experimental/investigational services. The medical director has access to consultation with peer reviewers for any adverse determination. If the original peer reviewer is not available, Clover makes another peer reviewer available for consultation.

A provider is available immediately in urgent or emergency cases and on a timely basis for all other cases as required by the medical exigencies of the situation. The provider is under the clinical direction of the medical director responsible for medical services provided to the members. Such determinations are made in accordance with clinical and medical necessity criteria.

When an adverse determination is issued, Clover sends a written denial notice or "Notice of Denial of Medical Coverage." The notice is in writing and meets the language and format requirements to ensure understanding. The form indicates the following for both the member and provider:

- Results of the resolution process and the effective date of the denial, reduction, stoppage, or termination of service, or other medical coverage determination
- The action taken by Clover on the request for re-authorization and the reason for such action, including clinical rationale
- A member's right to a standard or expedited appeal and the right to appoint a representative who will act on the member's behalf
- The availability, upon request, of the clinical review criteria relied upon to make the determination
- A member's right to have benefits continued pending resolution of the appeal and how to request that benefits be continued

In no circumstance does Clover apply pre-authorization requirement and utilization controls that effectively withhold or limit medically necessary services, or establish pre-authorization requirements and utilization controls that might result in a reduced scope of benefits for a member.

CONCURRENT REVIEW

Concurrent review is conducted on hospitalizations and other services that require it for continued care, including UM decisions (approvals or denials) made within 48 hours of admission or within 1 business day of receiving all pertinent information to render a determination. Information needed for hospitalization may include:

- Case management (CM)
- Utilization review (UR) notes
- Emergency department notes
- Attending physician records
- Laboratory results

- Radiology reports
- Consultation notes

Clover utilization review policies, CMS National and Local Coverage Determinations, and Milliman Care Guidelines® are used to evaluate medical necessity and length of stay. Discharge planning/case management needs are addressed as described above.

If a member's discharge is expected to be greater than the length of stay as determined in the preceding decision, clinical documentation must be provided to support the continued stay.

For concurrent review of inpatient psychiatric hospitalizations, partial hospitalization programs, and intensive outpatient programs, a UM decision is made within 24 hours of admission or within 1 business day of receiving all pertinent information.

Administrative denials

If, based upon review of member enrollment, eligibility status, and benefits coverage, the member is found to not be eligible for the requested service, one of the following statements of administrative denial is issued:

- The member was not enrolled in a benefit plan on the date(s) of service in question
- The service being requested is not covered by the benefit plan in which the member is enrolled (e.g., benefit exclusions)

The denial notification clearly and directly addresses the member or designee to ensure the member/designee can make an informed judgment about filing an appeal or grievance with Clover. The denial notification includes the following:

- Appeals or grievances filing instructions
- Time frames within which an appeal or grievance determination must be made
- A stipulation of the member's right to designate a representative to file an appeal or grievance on his or her behalf

Peer-to-peer review for organization determinations

You or the Clover medical director may initiate a peer-to-peer (P2P) review prior to or after rendering a decision on an organization determination. This gives you the opportunity to discuss the case with the Clover physician reviewer responsible for the determination.

To initiate a P2P review request, please call **1-888-995-1690**.

- Inpatient hospitalizations: For contracted hospitals where members are held harmless per the Provider Agreement, the denial or termination issued on the Notice of Denial of Coverage for Services (NDCS) must be based on medical necessity to qualify for P2P.
- A P2P may be initiated after a Notice of Medicare Non-Coverage (NOMNC) has been issued only if there is a change in the member's medical condition after the NOMNC has been issued and before the last covered date (LCD). To be eligible for the P2P, initiation of P2P review for continued stay

terminations are only valid if a timely NOMNC is received by Clover no later than noon (12 p.m.) in the service area on the day before the LCD. If there is no change in the member's medical condition after a NOMNC is issued, the appeal is filed with the Quality Improvement Organization (QIO) if done prior to noon in the service area on the day before the LCD or with Clover's Appeals and Grievances (A&G) team if the cutoff time for the QIO appeal is missed.

- For pre-service requests, the adverse determination issued on the Notice of Denial of Medical Coverage (NDMC) may not be reversed (overturned) by a P2P discussion if conducted after the determination has been made by the Clover medical director.
- P2P is not available for retrospective requests.

RETROSPECTIVE REVIEW

Our retrospective utilization review process includes determinations of medical necessity after a service has been provided, based on the same accepted standards of those for pre-authorizations and review processes for similar conditions and diagnoses.

Retrospective reviews may also be used to validate approved services in the pre-authorization process.

Clover may reverse its approval of a pre-authorized treatment, service, or procedure on retrospective review when:

- Relevant medical information presented to Clover upon retrospective review is materially different from the information that was presented during the pre-authorization review
- Clover was not aware of the existence of, or provided with, the applicable information at the time of the pre-authorization review or determination

DISCHARGE PLANNING

When discharge is anticipated or institutional placement is required, planning should be initiated immediately upon admission to the hospital.

Discharge planning includes collaboration between Clover and hospital case management to support preparation of the patient for the next level of care and arrangement for placement in the appropriate care setting.

The attending physician and/or the hospital discharge planner should contact Clover's UM Department if assistance is needed to select a post-acute care provider and/or to request authorization of post-acute care services.

Clover's nurse practitioners (NPs) work, under your guidance, to make a post-discharge call and/or visit members after discharge to ensure coordination and continuity of care based on the severity and/or complexity of their clinical condition(s).

Clover NPs also provide medication reconciliation and education, and complete a health risk assessment where appropriate.

DECISION-MAKING CRITERIA

The Clover Medical Management Committee and Quality Improvement (QI) Committee review and approve clinical criteria on a yearly or ad hoc basis. Currently, Clover utilizes the Clover Utilization Review Policies, CMS National and Local Coverage Determinations, and Milliman Care Guidelines®. This suite of guidelines cover the spectrum of inpatient, outpatient, rehabilitation, and care for medical, surgical, and behavioral health issues.

Clover consults with participating providers in adherence to Clover's medical policies, treatment protocols, medical management policies, and the like, as determined by Clover.

MEDICAL MANAGEMENT INFORMATION SYSTEM

The Medical Management Information System is a unique health information technology platform developed by our engineering, data, and medical teams to be utilized by:

- The Utilization Management Department for case development and medical necessity decision-making
- Care managers to coordinate care and develop, monitor, and modify plans of care, and check on members' gaps in care
- The Appeals and Grievances Department for processing reconsiderations and complaints
- Customer experience representatives to check eligibility and process inbound telephone pre-authorization requests

Disputes, Appeals, and Resolutions

We want to make sure you understand your options if you have any questions about—or disagree with—a decision we've made about billing, claims, or pre-authorizations. This section will walk you through appeals and disputes, grievances, and more.

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PAYMENT DISPUTES

If you do not agree with Clover's decision to deny payment of services, you are able to dispute payment. This includes:

- A dispute of medical necessity or administrative determinations resulting in no payment, or
- A dispute of the amount Clover paid on a claim and a request to obtain a higher level of payment

You may create your dispute within the contractually agreed-upon time frame upon receipt of your remittance notice or within 90 days if not specified otherwise in your Provider Agreement. Submissions can be made on your company's letterhead or with a **Claims Payment Dispute Form** and either faxed to **1-732-412-9706** or mailed to:

Clover Health
P.O. Box 471
Jersey City, NJ 07303

Along with your dispute, please submit the following relevant documents:

- A copy of the original claim form
- Date(s) of service
- The basis for the dispute
- The remittance notice showing the denial
- Any clinical records supporting your request for reimbursement

We make reasonable efforts to review and resolve a dispute within 60 days of receipt of the **Provider Claim Adjustment Form** and supporting documentation. The resolution may result in reprocessing of the claim(s) and issuing an EOP and/or payment and letter of determination of the outcome of the request. All decisions made in connection with our review are final.

Medical necessity determination disputes

If the claim determination indicates that the healthcare services for which the claim was submitted were (i) not medically necessary, (ii) experimental or investigational, (iii) cosmetic (rather than medically necessary), or (iv) dental rather than medical, a Clover physician reviewer will review the dispute within the time frame listed above.

Administrative determination disputes

If the claim determination indicates that the services for which the claim was submitted involved issues *not* related to medical necessity, then Clover's Disputes Management Team, in consultation with our Claims Team, reviews the dispute within the time frame listed above.

Disputes of eligibility-related determinations

If the claim determination indicates that the person to whom healthcare services for which the claim was submitted is ineligible for coverage because (i) the healthcare services are not covered under the terms of the relevant health benefits plan, or (ii) the individual is not a Clover member, you may submit a complaint if you wish to do so.

For more information about the complaint submissions process, please contact Provider Services at **1-877- 853-8019**.

APPEALS

Pre-service appeals

When you have not yet rendered services, a member, a member representative, and you or any other provider acting on behalf of the member with the member's consent may appeal any adverse determination made by Clover's Utilization Management Team that resulted in a denial, termination, or other limitation of covered healthcare services.

For Clover Medicare Advantage members, the appeals process consists of an internal review by Clover (Stage 1 appeal) and a formal external review (Stage 2 appeal) by an Independent Review Entity (IRE). Further stages of appeals include an Administrative Law Judge hearing, a Medicare Appeals Council review, and a judicial review.

Stage 1 appeals must be requested within 90 days of receipt of an adverse benefit determination. Stage 2 appeals are sent by Clover to an IRE within 30 days of receipt of the original pre-service reconsideration.

Pre-service appeals can be submitted in writing or verbally. Written appeals can be submitted to:

Clover Health
P.O. Box 471
Jersey City, NJ 07303

Verbal appeals can be initiated by calling Provider Services at **1-877-853-8019**.

Appeals (reconsiderations) involving medical necessity are reviewed by Clover staff members who are licensed healthcare professionals. If Clover issues a partial or fully denied determination, that determination is made by a provider who has a current and unrestricted license to practice medicine and who was not involved in the original determination.

Expedited pre-service appeal

You are allowed to submit an expedited appeal in the following situations:

1. For continued or extended healthcare services
2. For procedures, treatments, or additional services provided for a member undergoing a course of continued treatment as prescribed

3. When you determine a member's life, health, or ability to regain maximum function is at stake
4. When you and/or Clover determines the member had received an unfavorable decision for care

If Clover requires information necessary to conduct an expedited appeal, Clover immediately notifies the member and you by phone or fax.

Clover will make a determination on expedited appeals within 72 hours and communicate the determination to the member, member's designee, and/or you—as provider—acting on behalf of the member. Responses are made in person and then by mail within 3 calendar days of the communication.

Under certain circumstances, Clover may extend the time frame for an expedited appeal determination by up to 14 calendar days at either the member's request or Clover's. Clover will inform the member of his/her right to file an expedited grievance, should he/she not agree with the request for an extension.

Expedited appeals that do not result in a satisfaction to the appealing party are automatically forwarded to the IRE, and the member, member representative, or you are notified within 72 hours of Clover resolution. If Clover fails to make an appeal determination within the outlined time period, Clover's initial adverse determination will take precedent and the determination will be forwarded to the IRE.

If Clover does not accept the request for an expedited appeal, Clover sends the appeal to the member or member's designee within 24 hours. Clover provides an explanation of the member's right to file an expedited grievance and to submit additional supporting information from you explaining the basis for the expedited request.

Clover does not expedite post-service disputes involving payment.

Standard pre-service appeal

Standard appeals are available for pre-service issues. These appeals must be filed verbally or in writing by the member or his/her designee, or by you—as provider—acting on behalf of the member. A standard appeal can be made within 90 calendar days of an initial adverse determination. Clover may grant a good-cause late filing exception under certain circumstances.

Clover sends a written acknowledgment of receipt of the appeal to the appealing party within 5 calendar days of the date of the receipt. If the plan requires information to conduct the appeal, the plan identifies and requests the necessary information from the member and from you, as the member's provider. Clover assigns a clinical peer reviewer different from the one who rendered the adverse determination.

The appeal determination is rendered within 30 calendar days from receipt of the request for an appeal. If the initial adverse organization determination is affirmed, the member, member's designee, and/or you—acting on behalf of the member—are notified and the case is forwarded to the IRE with a detailed explanation. If Clover fails to make an appeal determination within the applicable time periods, such failure constitutes an affirmation of Clover's initial adverse determination and Clover forwards the entire file to the IRE.

Higher-level appeals

Medicare Advantage members' cases are automatically sent to the Independent Review Entity (IRE) when an original adverse determination is upheld as result of a pre-service appeal process and the member is notified.

Files are sent to the IRE within 30 calendar days of receipt of the request for a standard pre-service, within 24 hours of the final adverse determination for an expedited pre-service appeal, and, if a request for post-service appeal is made, within 60 calendar days of receipt of the request for a post-service appeal.

If the IRE reverses a final adverse determination, Clover must approve or provide the services no later than 14 calendar days from the standard pre-service appeal overturn date or 72 hours from the expedited appeal overturn date.

Clover must complete payment of the claim within 30 calendar days of a post-service appeal overturn date.

If the member, member designee, or you as provider—acting on behalf of the member—are dissatisfied with the determination of the IRE, the member, member designee, or you can request within 60 calendar days of receipt of the IRE adverse determination a hearing with the Administrative Law Judge (ALJ), provided that the minimum monetary threshold is met.

If the member and member designee or you—acting on behalf of the member—are not satisfied with the ALJ determination, the member and member designee or you can request within 60 calendar days or receipt of the ALJ determination a review by the Medicare Appeals Council (MAC). The request should be sent to the following address:

Department of Health and Human Services Department Appeals Board,
MS6127 Medicare Appeals Council
330 Independence Avenue, S.W. Cohen Building, Room G-644 Washington, DC 20201

If the member and member designee or you—acting on behalf of the member—are not satisfied with the MAC determination, the member and member designee or you can request, within 60 days of receipt of the MAC determination a judicial review, provided that the minimum monetary threshold is met.

Furthermore, any reconsideration can be requested to be reopened within 1 to 4 years after final determination depending on the circumstance.

Provider complaints not involving claims payment or medical necessity issues

If you have a dispute or complaint with Clover that is not within the scope of the above Claims Payment Disputes sections and that does not relate to compensation matters, a claim determination, or a utilization management decision, you should first seek to informally resolve such dispute or complaint by contacting Provider Services at **1-877-853-8019**. A Provider Services representative will work to resolve the dispute or complaint on an informal basis.

If the dispute is not resolved on an informal basis, you may submit a formal written complaint to:

Clover Health c/o Director, Network Management
Harborside Financial Center, Plaza 10, Suite 803
Jersey City, NJ 07311

You may submit formal complaints directly to the address above without having previously tried to resolve the matter informally.

Upon receipt of a formal, written complaint from you, Clover conducts an internal review. Such review will be conducted at no cost to you.

Clover uses commercially reasonable efforts to complete the internal review and communicate the results of such review in writing to you within 30 business days of receipt of the complaint. The written response will include:

- The names, titles, and qualifying credentials of the persons participating in the internal review
- A statement of your complaint
- The decision of the reviewer(s), together with a detailed explanation of the basis for such decision (if applicable)
- A description of the evidence or documentation that supports the decision

Part D appeals

If your coverage request is denied, you have the right to appeal by asking for a review of the prior decision by our Pharmacy Benefit Manager, CVS Caremark. You must request this appeal within 60 calendar days from the date of our first decision. Standard requests must be filed in writing. We accept expedited requests by telephone and in writing.

Follow these guidelines for efficient processing of your appeal requests:

1. Complete the Request for Redetermination of Medicare Prescription Drug Denial form.
2. Fax to CVS Caremark at **1-855-633-7673**. Wait for CVS Caremark to notify you via fax of approval.
3. Or, mail appeals to:

CVS Caremark Part D Svcs/Appeals MC 109
P.O. Box 52000
Phoenix, AZ 85072-2000

Expedited appeal requests can be made by phone by contacting CVS Caremark Part D Svcs/Appeals department at **1-855-479-3657**. Speech- and hearing-impaired: call **1-866-236-1069**.

GRIEVANCES

Member grievances and resolution overview

This section contains information on the rights of a Clover member to submit grievances.

Federal law guarantees Clover members the right to make complaints if they are in any way dissatisfied with a part of their coverage. Medicare has established a variety of rules around how members should file complaints and how Clover must process them. If a Clover member files a complaint, we must process it fairly. A Clover member cannot be disenrolled or penalized in any way for making a complaint. Depending on the subject, a complaint is handled as an organization determination, an appeal, or a grievance.

A grievance is any expression of dissatisfaction regarding the health plan and/or provider, including quality of care, concerns, disputes, and requests for reconsideration or appeal made by the member or the member's representative.

Clover members or their representatives may file a grievance by contacting Member Services, filing a grievance by mail, or fax. Member Services coordinators are available to help members file a grievance.

How can a Clover member file a grievance?

A Clover member may file a grievance by contacting Member Services at **1-888-657-1207 (TTY 711)**. We are open 8 a.m.–8 p.m. EST, 7 days a week. From February 15 through September 30, alternate technologies (for example, voicemail) will be used on the weekends and holidays. A Clover member may also write or fax to us at:

Clover Health
Attention: Appeals and Grievances
PO Box 471
Jersey City, NJ 07303

Fax: **1-732-412-9706**

If a Clover member files a grievance, Clover sends an acknowledgment letter to the member within 5 calendar days of receipt. We are required to notify them of the results of our investigation no later than 30 days after we receive their grievance. However, in some occasions, after the conclusion of the 30 days, Clover may initiate an extension of up to 14 calendar days in order to appropriately resolve the grievance. Clover members are notified in writing if an extension is taken.

Clover members also have the right to file complaints directly with Medicare by filling out the **Medicare Complaint Form**.

Part D grievances

A Part D grievance is any complaint other than one that involves a coverage determination related to prescription drug benefits. A grievance is filed if Clover members have any type of problem with us or one of our network pharmacies that does not relate to coverage for a prescription drug. Medicare Part D grievances

related to the following topics are processed by Clover's contracted Pharmacy Benefit Manager (PBM) CVS Caremark:

- Benefits
- Confidentiality and privacy
- Customer service
- Exceptions
- Pharmacy network
- Quality of care
- Mail order

Members can contact CVS Caremark at **1-855-479-3657** to file a grievance, or mail the grievance to:

CVS Caremark Medicare Part D—Grievances
P.O Box 53991, MC 121
Phoenix AZ 85072-3991

Part D grievances related to the following are handled by Clover:

- Enrollment/disenrollment
- Fraud and abuse
- Marketing
- Other premium billing

Members may file these types of grievances using the contact information listed under the "**How can a Clover member file a grievance?**" section of the Provider Manual.

Care Management Program

One of the core components of our company is our care management program, which includes our customer experience and clinical care visit teams. Here, you'll see how this vital ecosystem works—in unison with your guidance and expertise—to deliver better patient outcomes.

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PREVENTIVE HEALTH AND CHRONIC CARE MANAGEMENT

Clover works with you and with members to improve members' well-being by encouraging them to pursue healthy lifestyles. This includes ensuring that members obtain needed immunizations and screenings, empowering members to actively participate in the management of the signs and symptoms of their chronic conditions, and encouraging them to maintain optimal wellness.

As part of these initiatives, Clover focuses on the following clinical areas:

- Behavioral health
- Breast health and mammography
- Cardiac care
- Cholesterol management
- Colorectal cancer screening
- Diabetes management
- Drug and alcohol use screening
- Hypertension management
- Influenza and pneumonia vaccinations
- Medication management and safety
- Osteoporosis and musculoskeletal health
- Prevention of hospitalizations and readmissions
- Respiratory management (COPD and asthma)
- Weight management

CLINICAL PRACTICE GUIDELINES

Clover encourages the use of clinical practice guidelines (CPGs) for assistance in the treatment of acute, chronic, and behavioral health issues. However, they are not intended as a substitute for your professional assessment, but rather as tools to help in the management of certain types of clinical care.

Clover's CPGs are evidence-based and were adopted from nationally known organizations such as the Advisory Committee on Immunization Practices, the American Academy of Family Physicians, the Agency for Healthcare Research and Quality, American Cancer Society, and the American Diabetes Association. They are reviewed annually by the Clover's Medical Management Committee. All guidelines reflect the most current view of the relevant medical community as reflected in the scientific evidence, professional standards, and expert opinion from recognized sources. They include:

- Diabetes management
- Cardiac care
- Heart failure prevention/treatment
- Cholesterol management
- Hypertension management
- Chronic obstructive pulmonary disease treatment/management

- Detection and treatment of depression
- Substance abuse screening and counseling
- Osteoporosis treatment
- Low back pain treatment/management
- Tobacco cessation
- Adult obesity issues
- Asthma treatment/management
- Disease prevention for adults

For the most up-to-date clinical practice guidelines, visit the Provider Portal on the Clover **website** or call the Quality Improvement line at **1-888-995-1691**.

CASE MANAGEMENT PROGRAM

Clover's case management program supports members with multiple comorbidities, complex needs, and catastrophic, high-cost, high-risk conditions in their journey to wellness. Complex conditions and therapeutic areas include:

- HIV/AIDS
- Oncology
- Transplant
- Nonhealing wounds
- Multiple chronic conditions
- Other general complex conditions

TEAM-BASED CARE MANAGEMENT

Clover's Care Management Team is a multidisciplinary team composed of registered nurses, advanced practice registered nurses, licensed clinical social workers, clinical pharmacists, and medical directors who work with members, their families, their PCPs, and other physicians and healthcare professionals, as part of an interdisciplinary team to coordinate the most appropriate healthcare services. This team offers education about health conditions and the impact those conditions have on members' lives, assists in securing any authorizations in advance of services, and provides information on and coordination with community resources. Care management services are a combination of telephone and on-site services provided at the discretion of the care management team. Care management is voluntary and free to all eligible members.

Members are identified as eligible for care management through:

- Health Risk Assessment
- Analysis of claims and encounter data
- Readmission reports
- UM data
- Pharmacy data
- Member and provider referrals

For additional information about the care management program, you should contact Provider Services at **1-877-853-8019**. You may also direct interested members to the Member Services line at **1-888-657-1207**.

Quality Improvement Program

As a data-driven company focused on the care of your patients, our goal is to continually evolve and adapt to meet your needs. Our Quality Improvement Program is designed to hold ourselves to the highest quality of care now and, as our technology evolves, on a broader level in the future.

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GOALS AND OBJECTIVES

We strive to continually improve the quality of care and service members receive. To that aim, the specific goals of our Quality Improvement (QI) Program are to:

- Act on opportunities for improvement on the health status of members through the development and implementation of health promotion, preventive health education, and disease and case management programs
- Maximize safety and quality of healthcare delivered to members through the continuous quality improvement process
- Maintain a high-quality provider network through a formalized credentialing and recredentialing process
- Ensure that adequate resources are arranged to provide available, appropriate, accessible, and timely healthcare services to all members according to evidence-based guidelines
- Ensure appropriate coordination of care between clinical and behavioral health providers within various clinical areas, and ensure appropriate discharge planning
- Ensure easy and timely access to accurate information through customer experience representatives, written materials. and our website
- Resolve inquiries, complaints, grievances, and appeals in a timely manner
- Maintain compliance with local, state, and federal regulatory requirements

Furthermore, our QI Program is designed to assess and improve Healthcare Effectiveness Data and Information Set (HEDIS) and Medicare Stars scores, member satisfaction based on the CAHPS® (Consumer Assessment of Healthcare Providers and Systems) survey and HOS® (Health Outcomes Survey) to implement initiatives that improve members' safety.

MEDICARE STAR RATING SYSTEM

The Medicare star rating system is used by CMS to rate the quality of Medicare Advantage plans on a 1- to 5-star scale (5 representing the highest and best score) and to allow members to compare plans. Clover's program is designed to ensure that the quality-of-care opportunities that are identified as priorities by CMS are comprehensively covered.

Clover's Star rating strategy is consistent with CMS's three aims:

1. Better care through continuous improvement
2. Healthier people/healthier communities through continuous improvement
3. Lower cost through continuous improvement

HEDIS

CMS deployed its Star rating system, in part, from the measures set forth by HEDIS. HEDIS is a set of standardized performance measures created by the National Committee for Quality Assurance (NCQA) to report and compare health plans on the basis of quality of care, services, and performance. It is utilized by

Clover to assess, compare, and report the quality of care that Clover and its contracted providers, practitioners, and delegated entities provide to Medicare Advantage members. HEDIS reporting covers the following:

- Effectiveness of care
- Access/availability of care
- Experience of care
- Utilization of services and relative resource use
- Health Plan descriptive information

More specifically, the HEDIS Stars reporting (i.e., the types of HEDIS measures used in Stars calculations) highlights how well a health plan performs in the following:

- Preventive service
- Chronic care management
- Acute care management
- Resource allocation

When applicable, Clover asks that providers adhere to HEDIS guidelines and specifications for all members during each measurement year and to collaborate in the data collection process by facilitating Clover staff access to members' medical records. Clover will communicate HEDIS results to members and providers to encourage the use of preventive measures and thus improve healthy behaviors and outcomes.

PROGRAM REVIEW

Our interdisciplinary Quality Improvement Committee is tasked with reviewing and analyzing QI activities at Clover for impact and effectiveness. With that aim, we work with our provider network to promote best practices, which employ evidence-based guidelines, and to make modifications to our program when opportunities for improvement are identified.

Pharmacy Services

We want to ensure your patients have the most cost-effective prescriptions and drug therapy treatments available to them. That is why, in addition to providing unique offerings like 100-day prescriptions, we make sure to contract with the highest-quality pharmacies to administer them.

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FORMULARY OVERVIEW

Clover contracts with CMS to provide drug coverage for Medicare Part D members using the Medicare Part D Drug Formulary, utilization management programs, and pricing structure. The pharmacy benefit does not cover all medications. Some medications require pre-authorization or have limitations on age, dosage, and/or maximum quantities. Clover works with CVS Caremark to administer pharmacy benefits, including the pre-authorization process.

The Clover Medicare Advantage Formulary is organized by sections. Each section is divided by therapeutic drug class primarily defined by mechanism of action. Products are listed by generic name or by brand name, depending on formulary coverage. Unless exceptions are noted, generally all applicable dosage forms and strengths of the drug cited are included in the Clover Medicare Advantage Formulary.

Medications selected for inclusion in the Clover Medicare Advantage Formulary are reviewed by Clover's Pharmacy Benefit Manager's pharmacy and therapeutics committee (P&T). Members of the P&T come from various clinical specialties and are practicing physicians and pharmacists. The P&T meets regularly to keep the formulary current, while providing optimal results for our members and controlling the cost of medication therapy.

Formulary documents can be found on the Clover website: **cloverhealth.com/en/members/formulary**.

UTILIZATION MANAGEMENT

Certain prescription drugs on the formulary have additional requirements or limits on coverage. These requirements and limits ensure that members use these drugs in the most effective way and help to control drug costs.

Certain drugs require pre-authorization. This means that you will need to get approval from us before the members fill their prescription. If they don't get approval, we may not cover the drug.

Pre-authorization criteria can be found on the Clover website: **cloverhealth.com/en/members/formulary**.

Quantity limits

For certain drugs, there are limits on the amount we will cover per prescription or for a defined period of time.

Step therapy

In some cases, we require the members to try one drug for treatment of a condition before we cover another drug for the same condition. For example, if Drug A and Drug B both treat a certain medical condition, we may require you to prescribe Drug A first. If Drug A does not work for the member then we will cover Drug B.

More about step therapy can be found on the Clover website: **cloverhealth.com/en/members/formulary**.

MEDICARE ADVANTAGE FORMULARY COVERAGE EXCLUSIONS

The following is a list of noncovered (i.e., excluded) drugs and/or categories:

- Agents when used for anorexia, weight loss, or weight gain (even if used for a noncosmetic purpose, such as for morbid obesity)
- Agents when used to promote fertility
- Agents when used for cosmetic purposes or hair growth
- Agents when used for the symptomatic relief of cough and colds
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Nonprescription over-the-counter (OTC) drugs
- Covered outpatient drugs that the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee
- Agents when used for the treatment of sexual or erectile dysfunction; erectile dysfunction drugs will meet the definition of a Part D drug when prescribed for medically accepted indications approved by the Food and Drug Administration (FDA) other than sexual or erectile dysfunction (such as pulmonary hypertension)

FORMULARY TIERS

Drugs represented in the Clover Medicare Advantage Formulary may have varying costs to the plan member. We categorize costs of prescription drugs with the following tiered format:

Tier 1 (preferred generic drugs)

- Generic drugs only
- Lowest cost

Tier 2 (generic)

- Generic drugs plus some brand-name drugs
- Often have Tier 1 alternatives
- Low-to-mid range cost

Tier 3 (preferred brand)

- Preferred select brand-name drugs and some non-preferred generic drugs classified by Clover as such based on safety, efficacy, and cost
- Mid-range costs

Tier 4 (non-preferred drugs)

- Non-preferred brand-name and some non-preferred generic drugs for which alternatives are available at lower tiers
- Mid-to-higher-range costs

Tier 5 (specialty drugs)

- Specialty drugs that are typically self-injected and used to treat complex medical conditions
- These drugs may require more involvement from you, and may require special storage and handling
- Highest copayment cost or coinsurance amount

COVERAGE DETERMINATIONS

What is a coverage determination?

A coverage determination is an approval or denial decision made by Clover when members ask for coverage or payment of a drug they believe Clover should provide.

You, as well as members, can ask for a coverage determination. Members can also appoint someone else (such as a relative) to request a coverage determination on their behalf.

Upon receipt of any request, Clover responds to coverage determination requests within 72 hours of routine requests and within 24 hours of expedited requests.

You must provide medical history and/or other pertinent patient information when submitting a **Request for Medicare Prescription Drug Coverage Determination** form for formulary exceptions.

A coverage determination request is required for:

- Drugs not listed on the formulary
- Drugs listed on the formulary with a pre-authorization
- Duplication of therapy
- Prescriptions that exceed the FDA daily or monthly quantity limits, or prescriptions that exceed the permitted limit noted on the formulary
- Drugs with a step edit, where the first-line therapy is inappropriate

The goal of the coverage determination program is to ensure that medication regimens that are high-risk, have a high potential for misuse, or have narrow therapeutic indices are used appropriately and according to FDA-approved indications.

Follow these guidelines for efficient processing of your Medicare prescription drug coverage determination requests:

1. Complete the "Request for Medicare Prescription Drug Coverage Determination" Form found on the Clover website
2. Fax to CVS Caremark at **1-855-633-7673**
3. Await approval after CVS Caremark notifies the prescriber by fax

If the request is approved, information in the online pharmacy claims processing system changes to allow the specific members to receive this specific drug.

If the request is denied, information about the denial will be provided to you.

In the event you or a member disagrees with the decision regarding coverage of a medication, you may request a free copy of the criteria or guidelines used in making the decision and any other information related to the determination by calling CVS Caremark toll-free at **1-800-294-5979**.

PART D APPEALS

Link to "Part D Appeals" section

PART D GRIEVANCES

Link to "Part D Grievances" section

Laboratory Services

We believe in catching conditions earlier and doing our best to prevent them from developing in the first place—and that the best way to do both is with regular lab work. We encourage you to refer your patients' samples to one of our trusted laboratory partners:

LabCorp
Laboratory Corporation of America

Quest Diagnostics®

Accurate Diagnostics

BioReference LABORATORIES

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Credentialing

To ensure that everyone we partner with meets the industry regulatory requirements, all Clover network providers, physicians, nonphysician healthcare professionals, and ancillary providers must get credentialed. This section will show you how.

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CREDENTIALING PROCESS

If you fall under any of the following categories, you require credentialing:

- Medical doctors (MD)
- Osteopathic doctors (DO)
- Doctoral-level and master-level psychologists (PhD, MS)
- Chiropractors (DC)
- Dentists—oral maxillofacial surgeons (DMD)
- Ophthalmologists (MD)
- Podiatrists (DPM)
- Certified nurse midwives (CNM)
- Master-level clinical social workers (MSW, CSW)
- Physical therapists (PT), occupational therapists (OT), speech/language therapists (ST)
- Audiologists (AUD)
- Nutritionists and dietitians (RD)
- Certified nurse practitioners (CNP), clinical nurse specialists (CNS), nurse practitioners (NP)
- Physicians assistants (PA)
- Acupuncturists
- Licensed marriage and family therapists (LMFT), licensed mental health counselors (LMHC), licensed psychoanalysts, licensed professional counselors (LPC)

Clover's Credentialing Committee is composed of a community of physicians representing several specialties and is responsible for the approval and oversight of all participating providers. The Credentialing Committee recommendations are reviewed and acted upon by our Chief Medical Officer.

Clover may delegate credentialing and recredentialing activities as appropriate. If any portion of the process is delegated, Clover's delegated credentialing and recredentialing policies are followed. We monitor compliance with our policies and procedures of all delegated entities at least annually.

Clover completes credentialing activities for a "clean" file within 90 days of receiving a completed application and signed contract. If additional information is needed, we will reach out to you to amend or correct any incomplete or erroneous information.

INITIAL CREDENTIALING AND APPLICATION SUBMISSION

Physician and nonphysician healthcare professionals

You must send Clover a completed application form, a current signed and dated attestation of correctness and completeness not to exceed 180 days from the credentialing date, and a signed agreement. You can submit one of the following options:

1. We strongly prefer the Council for Affordable Quality Healthcare (CAQH) application, as it ensures a compliant application and a timelier, online process. You only need to provide your CAQH ID.
2. A Universal Physician Application can be submitted, but the time line for review may be significantly longer because the review process is manual.

Either credentialing application must include the following items:

1. Current attestation—CAQH requires a quarterly update
2. Current valid professional medical license for the practicing state
3. Current Drug Enforcement Administration (DEA) and Clinical Decision Support (CDS) certificate for the practicing state, required for physicians and, if applicable, for that state (physicians unable to meet this requirement should provide a letter explaining why a DEA and/or CDS will not be obtained and how prescriptions will be covered)
4. Current Board Certification or copy of the confirmation of registration to sit for a board certification, if applicable
5. Current proof of adequate professional malpractice Insurance, a minimum of $1,000,000/$3,000,000
6. Summary of professional work history (going back a minimum of 5 years) with explanation(s) for any gaps of 6 months or more
7. Documentation or certificates of education and training
8. Summary of hospital privileges if available

In addition to an updated and complete credentialing application, the following documents must also be submitted:

- Completed W-9 Form.

During the credentialing process, we will check the following entities:

1. National Practitioner Data Bank (NPDB)
2. Applicable licensure agencies for information on sanctions or limitations on licensure
3. Office of Inspector General, Department of Health and Human Services (OIG) for the List of Excluded Individuals/Entities
4. System for Award Management (SAM) for information on providers debarred from participation or otherwise declared ineligible to participate in federal procurement or nonprocurement programs
5. Medicare Opt-Out or other federal reimbursement program for excluded or opt-out providers

Ancillary providers

You must send Clover a completed Facility/Ancillary Provider Credentialing Application that is signed and dated within 180 days of the credentialing date, as well as a signed agreement, and the following documents:

1. Current valid state operational license
2. Other applicable state/federal licensures (e.g., Clinical Laboratory Improvement Amendments [CLIA], DEA, pharmacy, or Department of Health)

3. Accreditation/certification by a governmental accrediting body (e.g., CMS, Joint Commission on Accreditation of Healthcare Organizations [JCAHO]), if applicable
4. Current general liability coverage (i.e., documentation showing the amounts and dates of coverage)
5. Medicare certification; if you are not certified, provide proof of participation
6. IRS W-9

During the credentialing review, we check the following entities:

1. National Practitioner Data Bank (NPDB)
2. Office of Inspector General, Department of Health and Human Services, (OIG) for the list of excluded individuals/entities
3. System for Award Management (SAM) for information on providers debarred from participation or otherwise declared ineligible to participate in federal procurement or nonprocurement programs
4. State Medicaid Debarment

If an illegible and/or incomplete application packet is submitted, or if required attachments are missing, you will be contacted in an attempt to obtain this information. If the information is not received within 30 days, a cover letter detailing the missing or incomplete items, along with the incomplete application packet, is sent back to you.

Occasionally, further clarification of information is needed and you are sent a request for additional information. You have 10 business days to submit the requested information. If the information is not received within the appropriate timeframe for you to be credentialed within 90 days of application submission, the application is withdrawn from processing and you are notified of such via a mailed letter. We consider any previously withdrawn application once all requested information has been received. The date of the application restarts to the date the application deemed complete is received.

When your initial application is approved by the Credentialing Committee, you are sent a welcome letter with a credentialing approval date within 10 business days of the credentialing decision. If the application is denied, a decision letter that includes rights to appeal the committee's decision is sent out to you within 10 business days of the committee meeting.

RECREDENTIALING PROCESS AND REVIEW

You are required to undergo and complete a recredentialing review every 3 years. To qualify for recredentialing, you must maintain the same minimum qualification requirements as for the initial credentialing. A recredentialing notification letter is sent to you at least 3 months ahead of the 3-year anniversary.

There is no action required of you if the Council for Affordable Quality Healthcare (CAQH) application is complete and updated. If you do not have a CAQH application, you can submit a universal application. However, if you fail to respond within 60 days of your 3-year anniversary, it is considered an administrative termination, and a termination letter is sent to you. If you are terminated as a nonresponder, you need to go through the initial credentialing process again, which includes the signing of a new contract.

Recredentialing applications must include the following:

- Signed and dated attestation within 180 days of the recredentialing date
- Current valid professional medical license
- Current DEA and CDS certificate for the practicing state, required for physicians* and if applicable for that state
- For physicians, a letter explaining why a DEA and/or CDS will not be obtained and how prescriptions will be covered should be provided.
- Current board certification or copy of the confirmation of registration to sit for a board certification, if applicable
- Current adequate professional malpractice insurance, a minimum of $1,000,000/$3,000,000
- Explanation of hospital coverage arrangements, if applicable

You are encouraged to maintain up-to-date information of your CAQH or universal application.

Once the recredentialing application is received and all components are verified, your file is "clean" and you remain in the Clover network. If you get denied when presented to the Credentialing Committee for decision making, you are notified in writing within 10 business days of the committee decision. The letter includes reasons for nonapproval and indicates your rights to appeal the committee's decision. The actual termination date is not effective until the appeal process is completed and the original decision upheld. Exceptions to this rule are terminations related to quality-of-care issues where you have caused or may cause harm to members.

DELEGATED ENTITIES

Delegation is a formal process by which a health plan provides a provider group with the authority to perform certain functions on its behalf, such as credentialing. A function may be fully or partially delegated. Full delegation allows all activities of a function to be delegated. Partial delegation allows some of the activities to be delegated.

All participating providers or entities delegated for credentialing/recredentialing are to use the same Clover policies and procedures as defined in the delegated credentialing agreement. Delegated oversight audits, in-person or remotely, are conducted at least annually.

Although Clover can delegate the authority to perform a function, it cannot delegate the ultimate responsibility for fulfilling the service or obligation.

CONFIDENTIALITY

The Credentialing Department is responsible for ensuring the confidentiality of all information received and maintained in the credentialing and recredentialing processes. Information derived from peer-review functions are protected from subpoena and discovery by state immunity laws, except as otherwise provided by law. This includes proceedings, reports, and records of a peer review specialty committee.

NONDISCRIMINATION

Clover does not discriminate in the credentialing or recredentialing process on the basis of your religion, race, color, national origin, age, gender, sexual orientation, height, weight, familial status, marital status, disability, or any other basis prohibited by law. Additionally, Clover does not discriminate in credentialing and recredentialing based upon the types of procedures or the risks of the population that you serve.

REVIEW OF YOUR INFORMATION ON FILE

With the exception of information determined by Clover to be peer-review protected, you have the right to request in writing your file information and to subsequently review and correct any erroneous information obtained by Clover to support its evaluation of your application.

Please send written requests to:

Clover Health
Attn: Credentialing Department—Credentialing Manager
Harborside Financial Center Plaza 10, Suite 803
Jersey City, NJ 07311

ONGOING MONITORING

Clover is responsible for offering its members qualified and competent providers who will be accountable for the delivery of appropriate and medically necessary care and services. Because of this, Clover carries out an ongoing monitoring of your sanctions and limitations. Clover is responsible for regularly informing you of any findings related to performance or practice of care.

The Credentialing Department is responsible for the management of ongoing (monthly) monitoring of:

- Medicare-Medicaid sanctions, which may lead to termination/suspension of Provider Agreement
- State licensure/disciplinary actions, which may lead to termination/suspension of Provider Agreement
- Quality-of-care issues, which may lead to a corrective action plan or termination

Any findings are discussed during the monthly Credentialing Committee meeting. If you get denied inclusion to the network when presented to the Credentialing Committee for decision making, you are notified in writing within 10 business days of the committee decision. The letter includes reasons for denial and indicates your rights to appeal the committee's decision. The actual termination date is not effective until the appeal process is completed and the original decision upheld. Exceptions to this rule are terminations related to quality-of-care issues where you have caused or may cause harm to members.

Provider Termination

While we do everything we can to nurture our partnerships with you, there may be times when the only reasonable resolution is to discontinue working together. This section describes what is involved when a partnership is not serving the best interests of either party.

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CIRCUMSTANCE FOR TERMINATION

There may be certain circumstances in which Clover decides to terminate its relationship with contracted or participating providers. Depending on the cause, Clover may work with you to address the problem, or initiate a termination to take effect immediately.

An immediate termination may be initiated for the following reasons:

- Suspension, revocation, condition, expiration, or other restriction of your licensure, certification, and/or accreditation to perform services contemplated under your Provider Agreement
- Suspension or bar from participation in federal healthcare programs
- Determination that you engaged in or are engaging in fraud
- Noncompliance with the general and professional liability insurance requirements set forth in your Provider Agreement
- State sanctions, indictment, arrest, or conviction, or a felony or any criminal charge
- Clover's reasonable determination that your immediate termination is necessary for the health and safety of members

Clover may also terminate the participation of an individual group provider or may require that an individual group provider cease providing services to members based upon any of the foregoing events, without terminating the Provider Agreement in its entirety.

Certain terminations initiated may also not take effect immediately (terminations for cause, terminations without cause). Please reference your Provider Agreement for details around terminations that may not take effect immediately and the effective time frames.

In the event of a termination, Clover sends a termination notice to you, your ancillary, or your hospital. Clover may require you, your ancillary, or your hospital to provide continuity of care until a safe transition to another provider has been made.

Your Provider Agreement will not be terminated or refused renewal solely because you have:

- Advocated on behalf of a member
- Filed a complaint against Clover
- Appealed a decision made by Clover

Additionally, you may have termination rights of your own. For details about Provider Termination Rights, please reference your Provider Agreement.

Appeal hearing process

When you, your ancillary, or your hospital requests an appeal of a termination decision, an appeals hearing committee is established on an ad-hoc basis by the medical director. The appeals hearing committee consists of no fewer than 3 members, one of which must be your peer and has the same specialty or similar specialty.

Here are the rules and regulations for holding an appeals process:

- Peers can be providers or healthcare professionals outside of the Clover network of providers
- No individuals involved in the investigation of an appeals case may be part of the appeals hearing committee
- The appeals hearing committee voting may be made in person, via phone, or via e-mail
- The medical director appoints a hearing officer who serves as the presiding officer over the hearing
- The presiding officer should:
    - Determine the order and decorum of the hearing and deliberations
    - Assure that all participants have opportunity to present oral and documented evidence
    - Provide guidance to the appeals hearing committee during the hearing and deliberations
- The hearing officer does not have voting privileges

The notice of the final decision of the appeals hearing committee is delivered by certified mail to you, your ancillary, or your hospital 30 days after close of the hearing. The notice includes the final decision, the basis for that decision (affirm, modify, or withdraw the original proposed action), and the Provider Agreement provisions and facts relied upon by Clover during the hearing.

NONRENEWAL OF CONTRACT

Unless otherwise specified, the Provider Agreement Clover executes with you automatically renews on the one-year anniversary of the effective date on your Provider Agreement, unless terminated in accordance with the provisions stated in it. A nonrenewal of your Provider Agreement constitutes a termination and will be treated as final.

CONTINUITY OF CARE

In the event of a termination, whether initiated by you or by Clover, our goal is to ensure that your patients, our members, continue to receive the care they require until they no longer require it or until a safe transition can be made (unless otherwise specified).

In the event that you voluntarily decide to leave the network, or Clover terminates with/without cause (i.e., a termination that does not fit the criteria of "immediate" as defined above), you must agree to continue to provide covered services until it is safe to discontinue or safe alternatives have been confirmed.

During this continuity-of-care period, you agree to:

1. Accept Clover's established reimbursement rates as payment in full
2. Adhere to Clover's quality improvement requirements
3. Provide medical information related to the care
4. Adhere to Clover's policies and procedures

Pre-authorization by the Utilization Management Department is required during any continuity-of-care period.

To ensure Clover stays aligned with its mission to build high-performing, cost-effective provider networks, Clover maintains discretion to select the providers with whom it decides to contract. Clover is able to make changes to these networks at any time during the contract year, as long as you can continue to furnish all Clover-covered services in a nondiscriminatory manner, meet established access and availability standards and timely notice requirements, and ensure continuity of care for members.

Fraud, Waste, and Abuse

We know most of you strive to work ethically to deliver the highest-quality medical care and abide by the proper administrative guidelines. In the rare event you may choose to compromise this integrity, we support the laws put in place to combat fraud, waste, and abuse.

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STATE AND FEDERAL LAWS

Clover recognizes the importance of preventing, detecting, and investigating fraud, waste, and abuse, and is committed to protecting and preserving the integrity and availability of healthcare resources for members. Clover must ensure that First Tier, Downstream, or Related Entities (FDR) receive general compliance training, as well as fraud, waste, and abuse training.

Federal and state fraud and abuse laws that apply to you include the False Claims Act, the Anti-Kickback Statute, and the physician self-referral law (Stark Law). Violations of these laws can result in nonpayment of claims, civil monetary penalties (CMP), exclusion from all federal healthcare programs, and criminal and civil liability.

REPORTING FRAUD, WASTE, AND ABUSE

If you think you are in a problematic relationship or have been following billing practices and you realize you were wrong:

1. Immediately cease filing the problematic bills
2. Seek knowledgeable legal counsel
3. Determine what money you collected in error and report and return overpayments
4. Undo the problematic association by taking all steps to free yourself
5. Consider using the OIG or CMS self-disclosure protocols

To report suspicious activity, please contact:

OIG Fraud Hotline:
1-800-HHS-TIPS (1-800-447-8477)
TTY 1-800-377-4950
oig.hhs.gov/fraud/report-fraud
stopmedicarefraud.gov

Administrative Procedures and Compliance

We are here to ensure your practice stays aligned with compliance guidelines, our marketing policies, and other industry-standard regulations. In the following section, we provide some helpful links and overviews to make it easy for you or your staff to reference or access them.

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CMS GUIDELINES

You and any persons involved in the administration or delivery of the Medicare program benefits must complete the following required trainings within 90 days of initial hire and annually thereafter:

- CMS Medicare Parts C and D Compliance training
- CMS Medicare Parts C and D Fraud, Waste, and Abuse (FWA) training

CMS has developed a web-based training module that can be used to satisfy the training requirement. It is available on the CMS Medicare Learning Network (MED Learn) **website**.

Clover recommends that you read and understand the guidelines set forth by the Centers for Medicare and Medicaid Services. For additional information visit **cms.gov**.

MARKETING MA PLANS

You may not develop materials that market Clover without Clover's prior written approval, but you may use CMS approved materials supplied directly by Clover. Under Medicare Advantage program rules, Clover and other Medicare Advantage plans must follow CMS marketing guidelines and obtain CMS review and approval for all marketing materials before making such materials available for distribution to eligible individuals.

You may have Clover marketing materials, including brochures, posters, or notifications, available in your office as long as Clover is not exclusively represented. Materials for other Medicare Advantage plans in which you are a participant must be available as well and in the same location. Medicare Advantage marketing materials can only be displayed in common areas and not in private patient exam rooms.

If you are interested in Clover marketing materials to share with members, please contact your Clover representative. If a member has a question regarding Clover, feel free to recommend they contact Clover Member Services at **1-888-778-1478 (TTY 711)**.

AUDIT

Providers must ensure compliance with Medicare laws, regulations, and CMS instructions; agree to audits and inspections by Clover, CMS, and/or its designees; cooperate, assist, and provide information as requested; and maintain records for a minimum of 10 years.

CONFLICT OF INTEREST POLICY

Conflicts of interest are created when an activity or relationship renders you unable or potentially unable to provide impartial assistance or advice, impairs a person's objectivity, or provides a person with an unfair competitive or monetary advantage. Many of the relationships discussed in this document are subject to conflict-of-interest disclosure policies. Even if the relationships are legal, you may have an obligation to disclose their existence.

Become a Clover Participating Provider

Our team of clinicians, social workers, data scientists, and software engineers use patient-centered analytics to identify potential health risks to drive preventive care for our members. We work closely with you to develop quality programs and incentives designed to support increased transparency, improve patient outcomes, and present additional revenue opportunities.

We invite you to become part of the Clover Provider Network. For more information about Clover, please visit our website at cloverhealth.com or contact our Provider Relations Team at **1-877-853-8019.**

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Glossary

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Abuse: Actions that may, directly or indirectly, result in unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

Appeal: Any of the procedures that deal with the review of adverse organization determinations on the healthcare services the member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the healthcare services.

Covered services: Medically necessary healthcare services to which the member is entitled under the terms of the member's benefit agreement.

Fraud: Knowingly and willfully executing or attempting to execute a scheme or artifice to defraud any healthcare benefit program, or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any healthcare benefit program. 18 U.S.C. § 1347.

Grievance: Any complaint or dispute expressing dissatisfaction with the manner in which Clover or one of its delegated entities provides healthcare services, regardless of whether any remedial action can be taken.

Group/group provider: Employees, affiliates, or any individuals contracted with a group to provide covered services to a Clover member.

Healthcare provider: Physicians, healthcare professionals, and/or other providers licensed and/or authorized under the laws of the state in which services are provided who are employed by or contracted by Clover.

Medical necessary services: Services that are necessary for the diagnosis or treatment of disease, illness, or injury, and without which the member can be expected to suffer prolonged, increased, or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort.

Member benefit agreement: The agreement between Clover and the member that details the benefits to which the member is entitled.

Participating provider: A healthcare provider, hospital, healthcare facility, ancillary provider, or any other person or entity who has contracted with Clover to provide covered services to members.

Provider Agreement: A signed agreement between Clover and a provider outlining the obligations of both parties in the delivery of quality care and covered services to members, and the compensation for those services.

Provider Manual: A document that explains Clover's operating policies, standards, and procedures for participating providers including, but not limited to, Clover's requirements for claims submission and payment, credentialing, utilization review, care management, quality improvement, advance directives, members' rights, grievances, and appeals.

Quality Improvement Organization (QIO): An organization comprising practicing doctors and other healthcare experts under contract to the federal government to monitor and improve the care given to Medicare enrollees.

Representative: An individual appointed by an enrollee or other party, or authorized under state or other applicable law, to act on behalf of an enrollee or other party involved in an appeal or grievance.

Waste: Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather by the misuse of resources.

Appendix A: Attachments

Clover
Pre-Authorization Request

Need faster turnaround times?
Go online: **cloverhealth.com/pre-auth**

HOW TO USE THIS FORM:

1. **Complete** all required fields marked with an **asterisk** (*).
   Incomplete forms may be delayed unless all required information is received.
2. **Attach** copies of supporting clinical information.
   Required clinical documentation is listed on our website: **cloverhealth.com/pre-auth-list**
3. **Fax** this form to 1-800-308-1107
4. **Call** us with questions, 1-888-995-1690 to chat with our Utilization Management dept.

MEMBER INFORMATION (please print clearly)

Member Name*	**Member ID***	**Date of Birth***
	___ ___ ___ ___ ___ ___ ___ ___ ___	____/____/_____ (MM / DD / YYYY)

REQUESTING PROVIDER / FACILITY INFORMATION

Requesting NPI (Provider or Facility)*			Requesting Contact Name	
___ ___ ___ ___ ___ ___ ___ ___ ___ ___				
Requesting MD/Facility Name*			Title/Dept.	
Address*			Email	
City*	**State***	**ZIP code***	Phone	Fax

SERVICING PROVIDER / FACILITY INFORMATION

Servicing NPI (Provider or Facility)* ☐ Same as requesting Provider or Facility			Servicing Contact Name	
___ ___ ___ ___ ___ ___ ___ ___ ___ ___				
Servicing MD/Facility Name*	**Specialty***		Title/Dept.	
Address*			Email	
City*	**State***	**ZIP code***	Phone	Fax

AUTHORIZATION REQUEST (please attach copies of required clinical documentation)*

Service Type*	**Place of Service***	**Start Date or Admission Date***	End Date or Discharge Date
☐ Inpatient ☐ Outpatient	☐ MD Office ☐ Home Health ☐ DME ☐ Amg Surg. ☐ Other _____	____/____/_____	____/____/_____

Primary Procedure Code (CPT/HCPCS)	Unit(s)	Modifier	**Diagnosis Code (ICD 10)***	Service Description
Additional Procedure Code(s) (CPT/HCPCS)	Unit(s)	Modifier	Diagnosis Code (ICD 10)	Service Description

URGENT REQUEST (If applicable, explain medical need to expedite*)

Routine requests are processed on a 14 calendar day timeframe, but does not mean we will take the full 14 days as we will process according to the member's needs and no later than 72 hours if the physician documents that would place the member's health in danger.

Total Pages:

Clover Health
Provider Update Request

Email: providers@cloverhealth.com
Fax: Provider Services (908) 450 2059

Required Information: (please print clearly)	**Contact person handling the requested change:**
Provider Name:	Name:
Provider NPI: __ __ __ __ __ __ __ __ __ __	Phone #: (__ __ __) __ __ __ - __ __ __ __
Tax ID: __ __ - __ __ __ __ __ __ __	Fax #: (__ __ __) __ __ __ - __ __ __ __
Practice Name:	Email:

Adding Address:		
New primary address? ☐ Yes ☐ No	Billing address? ☐ Yes ☐ No	Office location? ☐ Yes ☐ No
Street Address:		Suite Number:
City:		State: / Zip:
Phone:		Fax:
Email:		Effective Date of Change:

Changing Address: (use this field to update office contact information)		
Old Address		
Street Address:		
City:		State: / Zip:
Phone:	Fax:	Email:

New Address:		
New primary address? ☐ Yes ☐ No	Billing address? ☐ Yes ☐ No	Office location? ☐ Yes ☐ No
Street Address:		Suite #:
City:		State: / Zip:
Phone:		Fax:
Email:		Effective Date of Change:

Termination of Address Location:	
Street Address:	Suite #:
City:	State: / Zip:
Phone:	Fax:
Email:	Effective Date of Change:

Signature:	**Title:**	**Date:**

Clover Health
Provider Tax ID Update Form

*Required Attachment: W-9

Required Information: (please print clearly)	**Contact person handling the requested change:**
Practice Name:	Name:
Tax ID: __ __ - __ __ __ __ __ __ __	Phone #: (__ __ __) __ __ __ - __ __ __ __
Is this Tax ID contracted with Clover? ☐ Yes ☐ No	Fax #: (__ __ __) __ __ __ - __ __ __ __
Effective date:	Email:

Provider Information: (Individuals only)
Last Name:
First Name:
National Provider Identifier (NPI): __ __ __ __ __ __ __ __ __ __

Provider Information: (Groups only)	
Group Name:	Group NPI:
Does this update apply to all providers under this Tax ID? ☐ Yes ☐ No (Please list all applicable NPIs below) *Attach separate roster if there are not enough fields to complete the form.	
Provider Name:	NPI: __ __ __ __ __ __ __ __ __ __
Provider Name:	NPI: __ __ __ __ __ __ __ __ __ __
Provider Name:	NPI: __ __ __ __ __ __ __ __ __ __

Primary Office Address: (If more than one, attach a separate list of all office addresses)			
Street Address:		Suite #:	
City:		State:	Zip:
Phone:	Fax:	Email:	

Billing Address:			
Same as primary address? ☐ Yes ☐ No			
Street Address:		Suite #:	
City:		State:	Zip:
Phone:	Fax:	Email:	

Signature:	**Title:**	**Date:**

Form **W-9**
(Rev. December 2014)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See **Specific Instructions** on page 2.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification; check only **one** of the following seven boxes:

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____

Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Social security number

			–		–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here **Signature of U.S. person** ▶ **Date** ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at *www.irs.gov/fw9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding?* on page 2.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

Clover

Form for Requesting an Appeal of a Clover Health Denial

Because Clover Health (or one of our delegates) denied your request for coverage of (or payment for) medical benefits, you have the right to ask us for an appeal of our decision. You have 60 days from the date of our denial notice to ask us for an appeal. This form may be sent to us by mail or fax:

Clover Health
Attention: Appeals and Grievances
Harborside Financial Center
Plaza 10, Suite 803
Jersey City, NJ 07311
Fax: (732) 412-9706

Expedited appeal requests can be made by phone at 1-888-657-1207. Speech and Hearing Impaired call 711.

Who May Make a Request: Your physician may ask us for an appeal on your behalf. If you want another individual (such as a family member or friend) to request an appeal for you, that individual must be your representative (see information on how to add a representative below). Contact Customer Service at 1-888-657-1207 if you have any questions. TTY users should call 711. We are open 8 a.m. - 8 p.m. EST, 7 days a week. From February 15 through September 30, alternate technologies (for example, voicemail) will be used on the weekends and holidays.

Member Information

Member Name _____ Date of Birth _____

Member Address _____

City _____ State _____ Zip Code _____

Phone _____

Member Plan ID Number _____

Complete the following section ONLY if the person making this request is not the member:

Requestor's Name _____

Requestor's Relationship to Member _____

Address _____

City _____ State _____ Zip Code _____

Phone _____

Representation documentation for appeal requests made by someone other than member or the member's physician: If representation documentation was not submitted with the request for the organization determination, attach documentation showing the authority to represent the member (a completed Appointment of Representative (AOR) Form or other legal documentation that demonstrates representation per State law (e.g., a court appointed guardian, an individual who has Durable Power of Attorney, or a health care proxy, or a person designated under a health care consent statute). For more information on appointing a representative and how to obtain an AOR Form, please contact Customer Service at 1-888-657-1207. TTY users should call 711. You may also contact Medicare at 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048.

Important Note: Expedited Decisions
If you or your physician believes that waiting 30 days for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your physician indicates that waiting 30 days could seriously harm your health, we will automatically give you a decision within 72 hours. If you do not obtain your physician's support for an expedited appeal, we will decide if your case requires a fast decision.

☐ **CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION WITHIN 72 HOURS. If you have a supporting statement from your physician, attach it to this request.**

Please explain your reasons for appealing. Attach additional pages, if necessary. Attach any additional information you believe may help your case, such as a statement from your physician and relevant medical records. You may want to refer to the explanation we provided in the denial notice you were issued.

Signature of person requesting the appeal (the member, or the member's physician or representative:

_____

Date: _____

Clover Health is a Preferred Provider Organization (PPO) with a Medicare contract. Enrollment in Clover Health depends on Contract Renewal.

Clover Health

Request for Redetermination of Medicare Prescription Drug Denial

Because we, Clover Health, denied your request for coverage of (or payment for) a prescription drug, you have the right to ask us for a redetermination (appeal) of our decision. You have 60 days from the date of our Notice of Denial of Medicare Prescription Drug Coverage to ask us for a redetermination.

Send form by mail or fax:	**Who may make a request**: Your prescriber may ask us for an appeal on your behalf. If you want another individual (such as a family member or friend) to request an appeal for you, that individual must be your representative. Contact us to learn how to name a representative. **Appeal through our website:** www.cloverhealth.com **Call for expedited appeal requests:** (855) 479-3657
Address: CVS Caremark Part D MC109; P.O. Box 52000 Phoenix, AZ 85072-2000 **Fax #:** (855) 633-7673	

Enrollee's Information:		
Name:		
Street Address:		
City:	**State:**	**Zipcode:**
Phone Number: (_ _ _) _ _ _ - _ _ _ _	**Birth Date:**	
Enrollee's Plan ID #:		

Complete the following section ONLY if the person making this request is not the enrollee:		
Requestor's name:		
Relationship to the Enrollee:		
Street Address:		
City:	**State:**	**Zipcode:**
Phone Number: (_ _ _) _ _ _ - _ _ _ _		

Representation documentation for appeal requests made by someone other than enrollee or the enrollee's prescriber: Attach documentation showing the authority to represent the enrollee (a completed Authorization of Representation Form CMS-1696 or a written equivalent) if it was not submitted at the coverage determination level. For more information on appointing a representative, contact your plan or 1-800-Medicare.

Prescription drug you are requesting:		
Name of Drug:	Strength/quantity/dose:	
Have you purchased the drug pending appeal?	☐ Yes	☐ No
If "yes", please provide the following information:		
Date purchased:	Amount paid: $ (attach copy of receipt)	
Pharmacy:	Pharmacy Telephone:	

Prescriber's Information:		
Name:		
Street Address:		
City:	State:	Zipcode:
Office Phone:	Fax:	
Office Contact Person:		

Important Note: Expedited Decisions

If you or your prescriber believe that waiting seven days for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescriber indicates that waiting seven days could seriously harm your health, we will automatically give you a decision within 72 hours. If you do not obtain your prescriber's support for an expedited appeal, we will decide if your case requires a fast decision. You cannot request an expedited appeal if you are asking us to pay you back for a drug you already received.

☐ CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION IN 72 HOURS

If you have a supporting statement from your prescriber, attach it to this request.

Please explain your reasons for appealing. Attach additional pages, if necessary. Attach any additional information you believe may help your case, such as a statement from your prescriber and relevant medical records. You may want to refer to the explanation we provided in the Notice of Denial of Medicare Prescription Drug Coverage.

Signature of Person Requesting Appeal: (the enrollee, or the enrollee's prescriber or representative):	**Date:**

New Jersey Department of Banking and Insurance

Health Care Provider Application to Appeal a Claims Determination

A Health Care Provider has the right to appeal a Carrier's claims determination(s).[1] A Health Care Provider also has the right to appeal an apparent lack of activity on a submitted claim.

Health Care Providers:

- Must submit your internal payment appeal to the Carrier. **DO NOT** submit your internal payment to the New Jersey Department of Banking and Insurance.
- May use either this form, or the Carrier's branded *Health Care Provider Application to Appeal a Claims Determination* (which the Carrier may allow to be submitted online). The Carrier will accept either form.

DO NOT submit a *Health Care Provider Application to Appeal a Claims Determination* IF:

- The Carrier's determination indicates that it considered the health care services for which the claim was submitted not medically necessary, experimental or investigational, cosmetic rather than medically necessary or dental rather than medical. INSTEAD, you may submit a request for a **Stage I UM Appeal Review**. [2]
- The Carrier's determination indicates that it considered the person to whom health care services for which the claim was submitted to be ineligible for coverage because the health care services were not covered under the terms of the relevant health benefits plan, or because the person is not the Carrier's member. INSTEAD, you may submit a complaint. For more information, contact the Carrier's Provider Relations Department.
- The Carrier has provided you with notice that it is investigating the claim (and related ones, if any) for possible fraud.

You MAY submit a *Health Care Provider Application to Appeal a Claims Determination* IF the Carrier's determination:

- Resulted in the claim not being paid at all for reasons other than a UM determination or a determination of ineligibility, coordination of benefits or fraud investigation
- Resulted in the claim being paid at a rate you did not expect based upon the payment agreement between you and the Carrier
- Resulted in the claim being paid at a rate you did not expect because of differences in the Carrier's treatment of the codes in the claim from what you believe is appropriate
- Indicated the Carrier required additional substantiating documentation to support the claim and you believe that the required information is inconsistent with the Carrier's stated claims handling policies and procedures, or is not relevant to the claim

You also MAY submit a *Health Care Provider Application to Appeal a Claims Determination* IF:

- You believe the Carrier failed to adjudicate the claim, or an uncontested portion of the claim, in a timely manner consistent with law, and the terms of the contract between you and the Carrier, if any
- The Carrier's determination indicates it will not pay because of lack of appropriate authorization, but you believe you obtained appropriate authorization from another Carrier for the services
- You believe the Carrier failed to appropriately pay interest on the claim
- You believe the Carrier's statement that it overpaid you on one or more claims is erroneous, or that the amount it calculated as overpaid is erroneous
- You believe the Carrier has attempted to offset an inappropriate amount against a claim because of an effort to recoup for an overpayment on prior claims (essentially, that the Carrier has under-priced the current claim)

If you do not know how to file a claims appeal with the Carrier, and you are a network provider, review your Provider Manual for instructions on how to file a Claims Appeal. If you are a not a network provider, you can find general contact information Licensed Insurance Carriers or Managed Care Entities on our website. Contact the Carrier for more specific instructions.

[1] A carrier's contractors (organized delivery systems and other vendors) are subject to the same standards as the carrier when performing claim payment and processing functions (including overpayment requests) on behalf of the carrier. Use of the word Carrier includes the carrier and its relevant contractors.

[2] For more information: review your Provider Manual, or contact the Carrier's Utilization Management department or Provider Relations Department, or visit the New Jersey Department of Banking and Insurance's website at: How to File a Utilization Management Appeal

Provider Name: _____ Contact Number:_____

Member Name :_____ DOS:_____

You may provide additional information in an attachment to explain w hy you are disputing Our handling of the claim. You must be specific about billing codes and reason for dispute.

The following should be submitted with your appeal (copies only):

- The relevant claim form
- The relevant Explanation(s) of Benefits or Remittance Advice
- A statement specifying the line items that you are appealing
- Copies of any overpayment requests or A/R notice
- Information We previously requested that you have not yet submitted, if available
- Itemization of your provider contract provisions you believe We are not complying with, including a copy of the pertinent section of your contract
- Pertinent correspondence between you and Us on this matter
- A description of pertinent communications between you and Us on this matter that were not in writing
- Relevant sections of the National Corre ct Coding Initiative (NCCI) or other coding support you relied upon IF the dispute concerns the disposition of billing codes
- Other documents you may believe support your position in this dispute (this may include medical records)

Attachments: ☐ **Yes** ☐ **No**

Signature:_____ Date: ____/____/____

Important to Note

In order to ensure your Internal Payment Appeal is eligible to meet processing requirements for the External Binding Arbitration Program

- **The Internal Appeal Form must be sent to the address posted on the carrier's website;**
- **The Internal Appeal Form must have a complete signature (first and last name);**
- **The Internal Appeal Form Must be Dated;**
- **There is a signed and dated Consent to Representation in Appeals of UM Determinations and Authorization for release of Medical records in UM Appeals and Independent Arbitration of Claims Form**

Appendix B: HEDIS and Clinical Guidelines for Providers

Clover

HEDIS Guidelines for Primary Care Providers

Measure Description	Guidelines for Medical Record Documentation	Applicable Codes
Adult BMI Assessment (ABA) Patients 18–74 years of age who had an outpatient visit need to have their body mass index (BMI) documented.	Documentation in the medical record must include the weight and the calculated Body mass index (BMI) value.	Z68.1 BMI 19 or less Z68.20 to Z68.44 BMI 20.0 to BMI 69.9 Z68.45 BMI 70 or greater
Breast Cancer Screening (BCS) Women 50–74 years of age need a mammogram to screen for breast cancer every 2 years 2016 -2017. Exclusion: Bilateral Mastectomy any time during the Patients history through 12/31/2017.	**Mammogram**: Documentation in the medical record must include the date when the mammogram was performed. **Bilateral Mastectomy**: Documentation in the medical record must indicate if the mastectomy was bilateral or unilateral and the date(s) of the procedure.	**Mastectomy** Z90.12: Acquired absence of left breast and nipple Z90.11: Acquired absence of right breast and nipple Z90.13: Acquired absence of bilateral breasts and nipples
Controlling High Blood Pressure (CBP) Patients 18–85 years of age who have a diagnosis of hypertension (HTN) need their latest 2017 BP reading be less than 140/90 mm Hg. Exclusion: • Evidence of end-stage renal disease, kidney transplant any time during the patient's history through 12/31/2017 • A diagnosis of pregnancy in 2017 • A nonacute inpatient admission in 2017	**Hypertension Diagnosis:** Documentation in the medical record must include the diagnosis of hypertension. The diagnosis can be documented anytime in the member's history through 6/30/2017 and confirmed by one of the following: Hypertension, HTN, High BP (HBP), Elevated BP (BP), Borderline HTN, Intermittent HTN, History of HTN, Hypertensive vascular disease (HVD), Hyperpiesia, Hyperpiesis. **Compliant Blood Pressure (BP) Reading**: The BP must be taken during an outpatient visit in 2017 that occured after the date when the diagnosis of hypertension was confirmed. The BP reading must be taken during an outpatient visit that did not include a diagnostic test or procedure that requires a change in diet or medication regimen on or one day before the day of the test or procedure, with the exception of fasting blood tests. The BP reading must be less than 140/90 mm Hg.	N/A, medical claims do not meet the compliance guidelines.

Measure Description	Guidelines for Medical Record Documentation	Applicable Codes
Colorectal Cancer Screening (COL) Patients 51–75 years of age need to have one or more of the following screening for colorectal cancer in the appropriate timeframe. • FOBT 2017 • FIT-DNA test 2015–2017 • CT Colonongraphy 2013–2017 • Flexible sigmoidoscopy 2013–2017 • Colonoscopy 2008–2017 Exclusion: Colon Cancer or Total Colectomy any time during the Patients history through 12/31/2017	Documentation in the medical record must include the date when the colorectal cancer screening was performed. A result is not required if the documentation is clearly part of the member reported "medical history" section of the record. Documentation in the medical record must include notation of a diagnosis of Colon Cancer or notation of a Total Colectomy anytime in the member's history. Digital rectal exams (DRE), FOBT tests performed in an office setting or performed on a sample collected via DRE do not meet the requirements.	**Colon Cancer** Z85.038: Personal history of other malignant neoplasm of large intestine Z85.048: Personal history of other malignant neoplasm of rectum, rectosigmoid junction, and anus
Comprehensive Diabetes Care (CDC) **Eye Exam (retinal) performed** Patients 18–75 years of age with diabetes need to have an annual retinal eye exam. • A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in 2017 • A negative retinal or dilated exam (negative for retinopathy) by an eye care professional (optometrist or ophthalmologist) in 2016	Documentation in the medical record must indicate that an ophthalmoscopic exam was completed by an eye care professional (optometrist or ophthalmologist), the date when the procedure was performed and the results. Documentation does not specifically have to state "no diabetic retinopathy" to be considered negative for retinopathy; however, it must be clear that the patient had a dilated or retinal eye exam by an eye care professional (optometrist or ophthalmologist) and that retinopathy was not present. Notation limited to a statement that indicates "diabetes without complications" does not meet criteria.	**Retinal or dilated eye exam reported by a PCP** CPT II 3072F: Low risk for retinopathy (no evidence of retinopathy in 2016) CPT II 2022F: Dilated retinal eye exam interpreted by ophthalmologist/optometrist documented/reviewed CPT II 2024F: Seven standard filed stereoscopic photos w/interpretation by eye professional documented/reviewed CPT II 2026F: Eye imaging validated to match diagnosis from seven standardd stereoscopic photos results documented/reviewed

Measure Description	Guidelines for Medical Record Documentation	Applicable Codes
Comprehensive Diabetes Care (CDC) **Medical Attention for Nephropathy** Patients 18–75 years of age with diabetes need to have an annual nephropathy screening or monitoring test or evidence of nephropathy in 2017 as evidence by the following; • Urine Protein Tests • Evidence of treatment for nephropathy or ACE/ ARB therapy • Evidence of stage 4 chronic kidney disease • Evidence of ESRD • Evidence of kidney transplant • At least one ACE inhibitor or ARB dispensing event	Documentation in the medical record must include date of urine microalbumin test and result. Documentation in the medical record must include date and type of nephropathy treatment or evidence of nephropathy.	**Urine Protein Tests** 81000–81003, 81005, 82042–82044, 84156, 3060F–3062F **Nephropathy Treatment** 3066F: Documentation of treatment for nephropathy (e.g. dialysis, ESRD, CRF, ARF, or renal insufficiency) 4010F: ACE/ARP therapy prescribed or currently being taken
Comprehensive Diabetes Care (CDC) **HbA1c Control** Patients 18-75 years of age with diabetes need an annual HbA1c test with a result <=9.0%. The value from the most recent A1c test performed in 2017 is used to determine controlled status.	Documentation in the medical record must include the date of HbA1c test and the result.	**HgbA1c Test** 83036, 83067 **HgbA1c Result** 3044F: HbA1c level Less Than 7.0 < 7/0% 3045F: HbA1c level 7.0–9.0 3046F: HbA1c level > 9.0
Comprehensive Diabetes Care (CDC) **Blood Pressure Control** Patients 18–75 years of age with diabetes need their blood pressure reading to be <140/90 mm Hg	Documentation in the medical record must include a Blood Pressure reading. **For compliance, the BP reading:** Must be taken during the latest outpatient in 2017 Must be taken during an outpatient visit that did not include a a diagnostic test or procedure that requires a change in diet or medication regimen on or one day before the day of the test or procedure, with the exception of fasting blood tests Must be less than 140/90 mm Hg	**Systolic Reading** 3074F: Systolic blood pressure <130 mm Hg 3075F: Systolic blood pressure 130-139 mm Hg 3077F: Systolic blood pressure >=140 mm Hg **Diastolic Reading** 3078F: Diastolic blood pressure <80 mm Hg 3079F: Diastolic blood pressure 80–89 mm Hg 3080F: Diastolic blood pressure >=90 mm Hg

Measure Description	Guidelines for Medical Record Documentation	Applicable Codes
Medication Reconciliation Post-Discharge (MRP) Patients 18 years of age and older with a inpatient discharge need to have their disharge medications reconciled with their current medications in an outpatient medical record. The visit must occur within 30 days of discharge, including the discharge date (31 total days). The medication reconciliation must be conducted by a prescribing practitioner, clinical pharmacist, or registered nurse. Documentation of the encounter must be in the outpatient chart, but an outpatient visit is not required. A telephonic encounter meets the requirement.	Documentation in the medical record must include evidence of medication reconciliation and the date when it was performed. Any of the following meets criteria: • Documentation that the provider reconciled the current and discharge medications • Documentation of the current medications with a notation that references the discharge medications (e.g., no changes in medications since discharge, same medications at discharge, discontinue all discharge medications) • Documentation of the member's current medications with a notation that the discharge medications were reviewed • Documentation of a current medication list, a discharge medication list and notation that both lists were reviewed on the same date of service • Evidence that the member was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review • Documentation in the discharge summary that the discharge medications were reconciled with the current medications. There must be evidence that the discharge summary was filed in the outpatient chart on the date of discharge through 30 days after discharge (31 total days) • Notation that no medications were prescribed or ordered upon discharge	**Medication Reconciliation** 1111F: Discharge medications reconciled with the current medication list in outpatient medical record **Transitional Care Management Services** 99496: communication (direct contact, telephone, or electronic) with the patient and/or caregiver within 2 business days of discharge; a face-to-face visit within 7 calendar days of discharge; and medical decision-making of at least high complexity during the service period. 99495: communication (direct contact, phone, or electronic) with the patient and/or caregiver within 2 business days of discharge; a face-to-face visit within 14 calendar days of discharge; and medical decision-making of at least moderate complexity during the service period.

Measure Description	Guidelines for Medical Record Documentation	Applicable Codes
Osteoporosis Management in Women Who Had a Fracture (OMW) Women 67–85 years of age who suffered a fracture need to have either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis within 180 days (6 months) of the fracture. Exclusion: • Women who had a BMD test during the 730 days (24 months) prior to the fracture • Women who received osteoporosis therapy or dispensed prescription or had an active prescription to treat osteoporosis during the 365 days (12 months) prior to the fracture; Biphosphonates, Other agents (Calcitonin, Denosumab, Raloxifene, Teriparatide)	**Osteoporosis medication**: Documentation in the medical record must include the generic name, strength/dose, route and date when the medication was dispensed to the member. Generic documentation in the medical record (e.g., that a patient "was prescribed" or "is taking" a medication) that does not include drug name, strength/dose and dispense date does not meet criteria. **Bone Density Test:** Documentation in the medical record must include the date of the test. The documentation must clearly indicate that the test was performed and not merely ordered	**Osteoporosis Therapies** Biphosphonates: *Alendronate, Risedronate, Alendronate-cholecalciferol, Zoledronic acid, Ibandronate* Other agents: *Calcitonin, Raloxifene, Denosumab, Teriparatide* **Osteoporosis Therapies Medical Claim** J0630, J0897, J1740, J3110, J3487, J3488, J3489, Q2051 **Bone Mineral Density Test** G0130, 76977, 77078, 77080-77082, 77085
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART) Patients who were diagnosed with rheumatoid arthritis need to have dispensed at least one ambulatory prescription for a disease-modifying anti-rheumatic drug (DMARD) In 2017 Exclusion: • A diagnosis of HIV any time during the member's history through 12/31/2017 • A diagnosis of pregnancy any time in 2017	**DMARD:** Documentation in the medical record must include the generic name, strength/dose, route and date when the medication was dispensed to the member. Generic documentation in the medical record (e.g., that a patient "was prescribed" or "is taking" a medication) that does not include drug name, strength/dose and dispense date does not meet criteria.	**DMARD Medical claim** J0129, J0135, J0717, J1438, J1600, J1602, J1745, J3262, J7502, J7515-J7518, J9250, J9260, J9310 **DMARDs** **5-Aminosalicylates:** *Sulfasalazine* **Alkylating agents:** *Cyclophosphamide* **Aminoquinolines:** *Hydroxychloroquine* *Anti-rheumatics: Auranofin, Auranofin, Leflunomide, Methotrexate, Penicillamine* **Immunomodulators:** *Abatacept, Adalimumab, Anakinra, Certolizumab, Certolizumab Pegol, Etanercept, Golimumab, Infliximab, Rituximab, Tocilizumab* **Immunosuppressive Agents:** *Azathioprine, Cyclosporine, Mycophenolate* **Janus Kinase (JAK) Inhibitor:** *Tofacitinib* **Tetracyclines:** *Minocycline*

Clinical Guidelines

To review the latest Clover Clinical Guidelines for inpatient hospital stays and outpatient procedures for select conditions, please visit the Clover Health website.