PROVIDER TRANSITION INFORMATION

commonwealth care alliance®

MA-Multi-P-5535527a

Table of Contents

CCA + CareSource

- Last year CareSource®, an Ohio-based nonprofit managed care health plan, finalized the acquisition of Commonwealth Care Alliance® (CCA) with the intent to ensure that residents of Massachusetts with complex health needs maintain access to high-quality health care services.

- The affiliation between CareSource and CCA leverages **combined resources** and **expertise** to address the critical needs of members and the broader community. By integrating CareSource's expertise with CCA's specialized programs, members will benefit from **enhanced care coordination**, access to **innovative health solutions,** and a **more robust support network** that prioritizes their unique needs.

- Effective June 28, 2026, Commonwealth Care Alliance® Senior Care Options (HMO D-SNP) and Commonwealth Care Alliance ® One Care (HMO D-SNP) plans will be operationally supported by CareSource.

MEET CARESOURCE®

commonwealth care alliance®

About CareSource

MISSION DRIVEN

CareSource is a nonprofit, nationally recognized managed care organization with more than 35 years of Medicaid managed care experience and over 2.3 million enrollees. Since its founding in 1989, CareSource administers one of the largest Medicaid managed care plans in the U.S., offering Medicaid, Health Insurance Marketplace (Qualified Health Plans), and Medicare products. As a mission-driven organization, CareSource is committed to enrollee-centric care and transforming health care with innovative programs that address social drivers of health and access to care.

HEALTH CARE WITH HEART

As a national leader in managed care, CareSource firmly believes the future of health care will be shaped by those who innovate and drive value for consumers and the states they serve.

Operations Performance

Key Performance Indicator (KPI)	Claims First Pass Accuracy	Financial Accuracy	Claim Average Days to Pay	Prompt Pay Timeliness	Encounters Submitted in 14 Days	Encounter Completeness and Accuracy
Current Rate	**99%**	**99.96%**	**10 Days**	**> 100%**	**> 99.9%**	**> 99.9%**

Corporate Headquarters:
Dayton, Ohio

Locations:
Arkansas, Florida, Georgia, Indiana, Massachusetts, Michigan, Mississippi, Nevada, Ohio, and Wisconsin

Year Established:
1989

4-STAR
CMS Medicare Rating

More than **7,000 employees** in **46 states**

$39 million invested in nonprofits and communities through the CareSource Foundation

A Partnership with Heart

At CareSource and CCA, we recognize a true partnership can only exist when we listen to and understand your needs. We are dedicated to partnering with you to improve member outcomes and make it easier for you to care for our members.

“The CareSource and Commonwealth Care Alliance partnership ensures residents of Massachusetts with complex health needs continue to have access to high-quality health care.”

Erhardt Preitauer, President and CEO of CareSource

What's Not Changing?

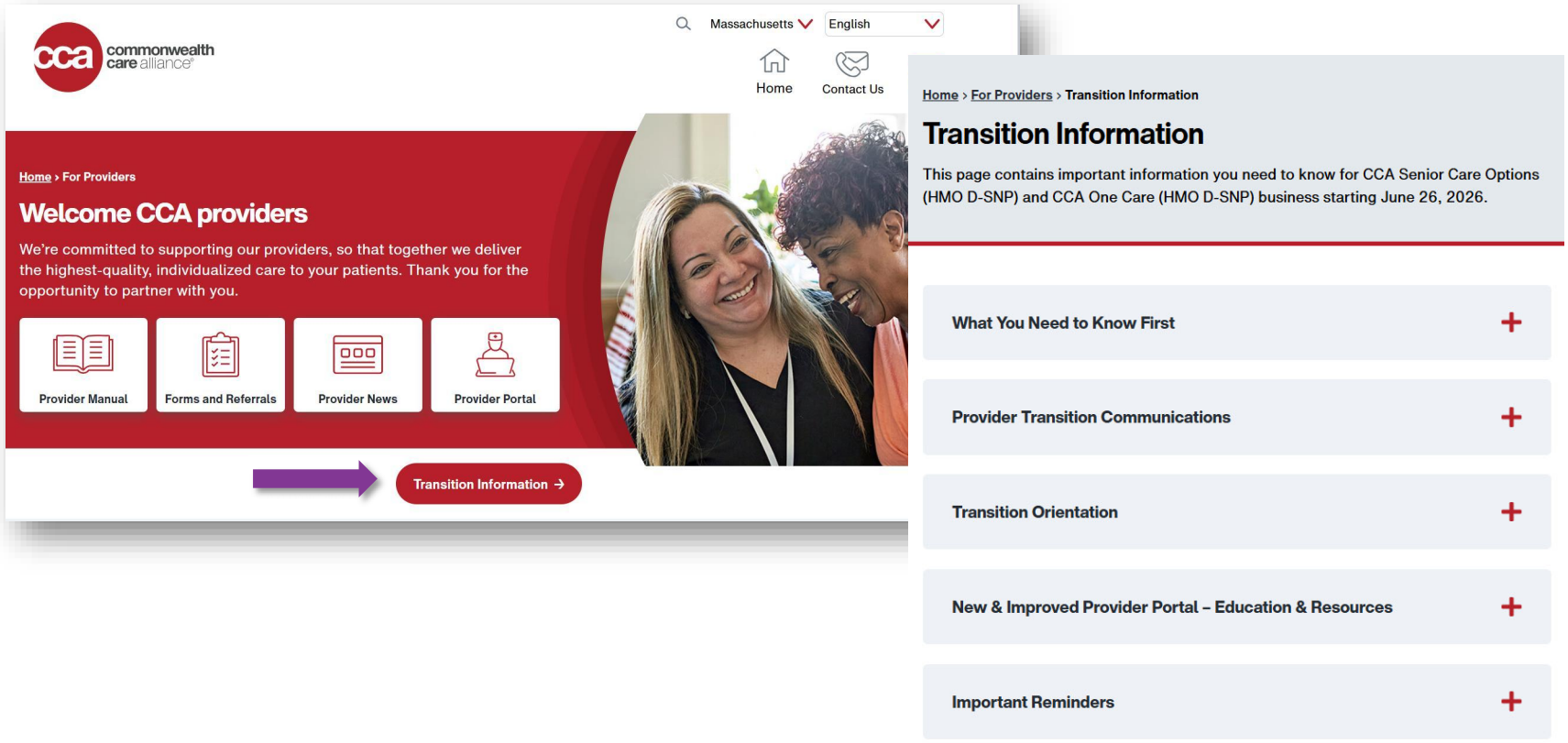
Not everything is new. Some things will remain **exactly the same**.

- Our commitment to our provider partners
- Your Senior Care Options and One Care contract
- Our plans: CCA Senior Care Options, CCA One Care, and associated member benefits
- The CCA Uncommon Care® Model
- Care Management services for all members
- Access to instED mobile acute care services
- Provider Services and Provider Relations — no change to how you reach us
- Provider annual training requirements
- Pharmacy Benefit Manager (PBM) CVS Caremark®
- CCA Senior Care Options and CCA One Care formularies
- Durable Medical Equipment (DME) platform: Tomorrow Health
- Benefit administrators for transportation, routine vision, dental, and hearing

NEW INFORMATION FOR CURRENT CCA PROVIDERS

commonwealth care alliance®

Navigating the CCA Provider Website



Visit the Transition Information webpage on the CCA website.

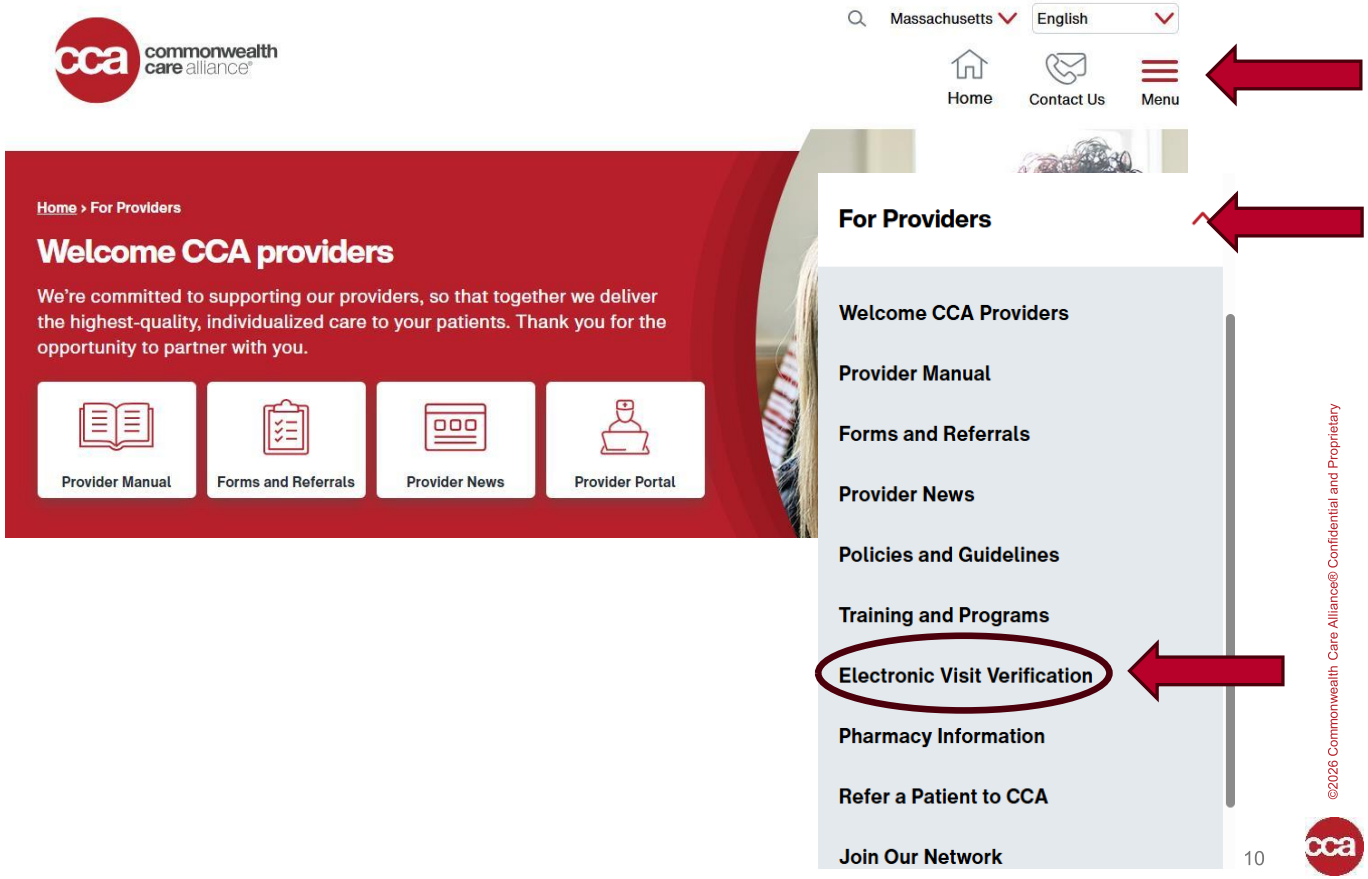
Electronic Visit Verification (EVV)

CMS requires EVV for Personal Care and Home Health services per the 21st Century Cures Act. Accurate data entry is critical to avoid claim denials. CCA is dedicated to helping providers navigate this process successfully.

To Ensure Compliant Claims:

- Enter correct procedure codes, units, and date of service into the aggregator
- Claim data must match what is reflected in the aggregator
- Verify correct provider and member Medicaid IDs in the aggregator
- Confirm the correct payer is listed for the member in the aggregator
- Ensure EVV visit records match submitted claim data

Claims that do not match risk denial.



NEW PROVIDER PORTAL

Provider Portal | **Value**

SAVE TIME AND MONEY

The Provider Portal is a robust, encrypted, and secure online tool available to all providers who serve our members. With our secure online Provider Portal, you can:

Check member eligibility and benefit limits	Submit claims and verify claim status
Submit prior authorization requests	View and update care management and service plans
Check prior authorization status	Verify/update coordination of benefits
View member gap-in-care alerts	And much more!

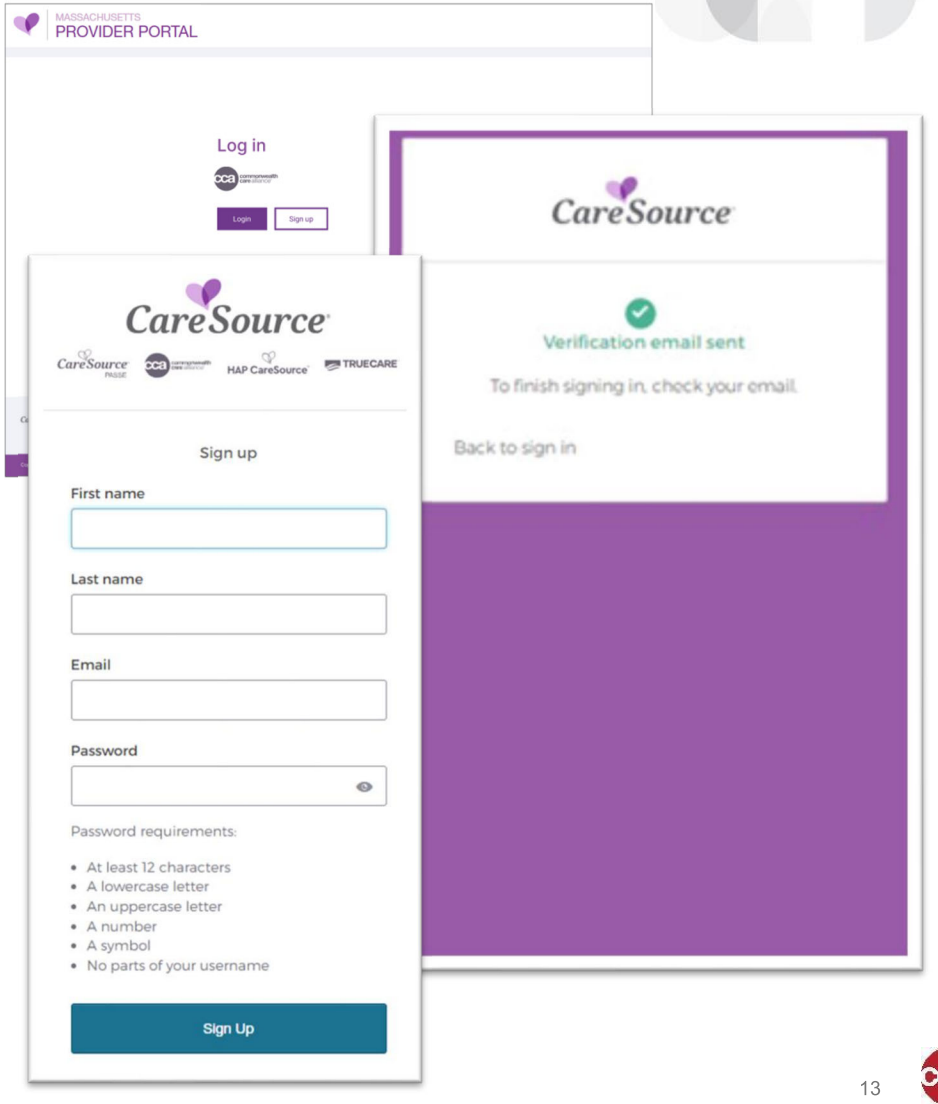
Review the content on the **Transition Information** web page under **New & Improved Provider Portal - Education and Resources**.

Access the Provider Portal 24 hours a day, seven days a week at **ProviderPortal.CareSource.com/GL/User/Login.aspx/**.

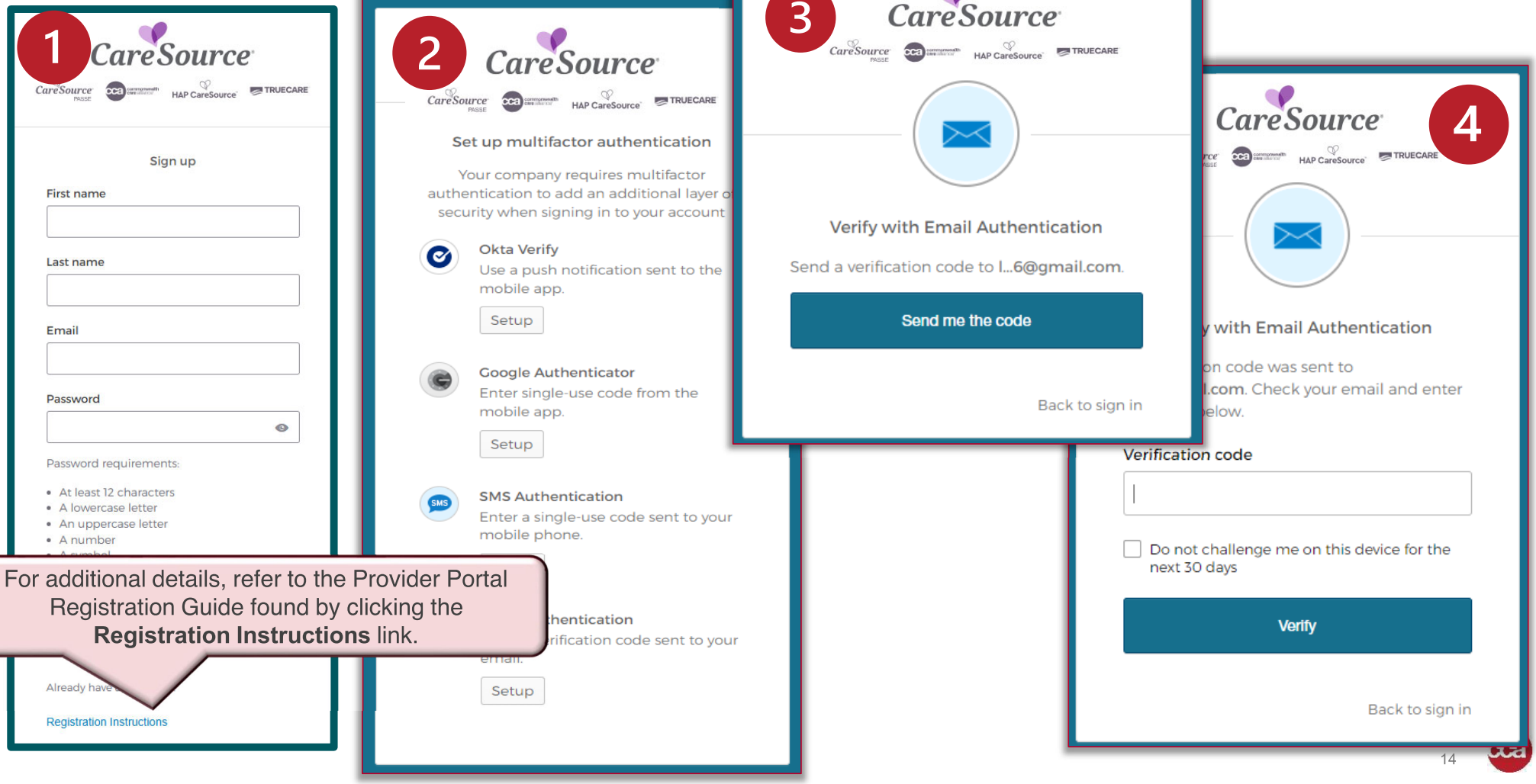
Provider Portal | **Registration**

1. Click the **Sign-up** link on the page.
2. Complete the **Create Account/Sign Up** table and click **Register/Sign Up**.
3. Enter the email address you want to associate with your account. You will use this email to log into the portal.
4. Create a **Password** with a minimum of 12 characters.
    - Contain one lowercase and one capital letter
    - One number, one special character (!, @, $, or %) not part of your username (email).
5. Enter **First** and **Last Name**.
6. Enter the verification code you receive per your selected Multi-Factor Authentication method.
7. To associate your account with a **Billing ID**, select the **Provider Type**, **Practitioner's First Name**, **Practitioner's Last Name**, **Tax ID**, **CareSource Provider ID Number**, **and ZIP Code** to link a provider to your account and then click **Next**.

*Required fields are marked with a red asterisk.

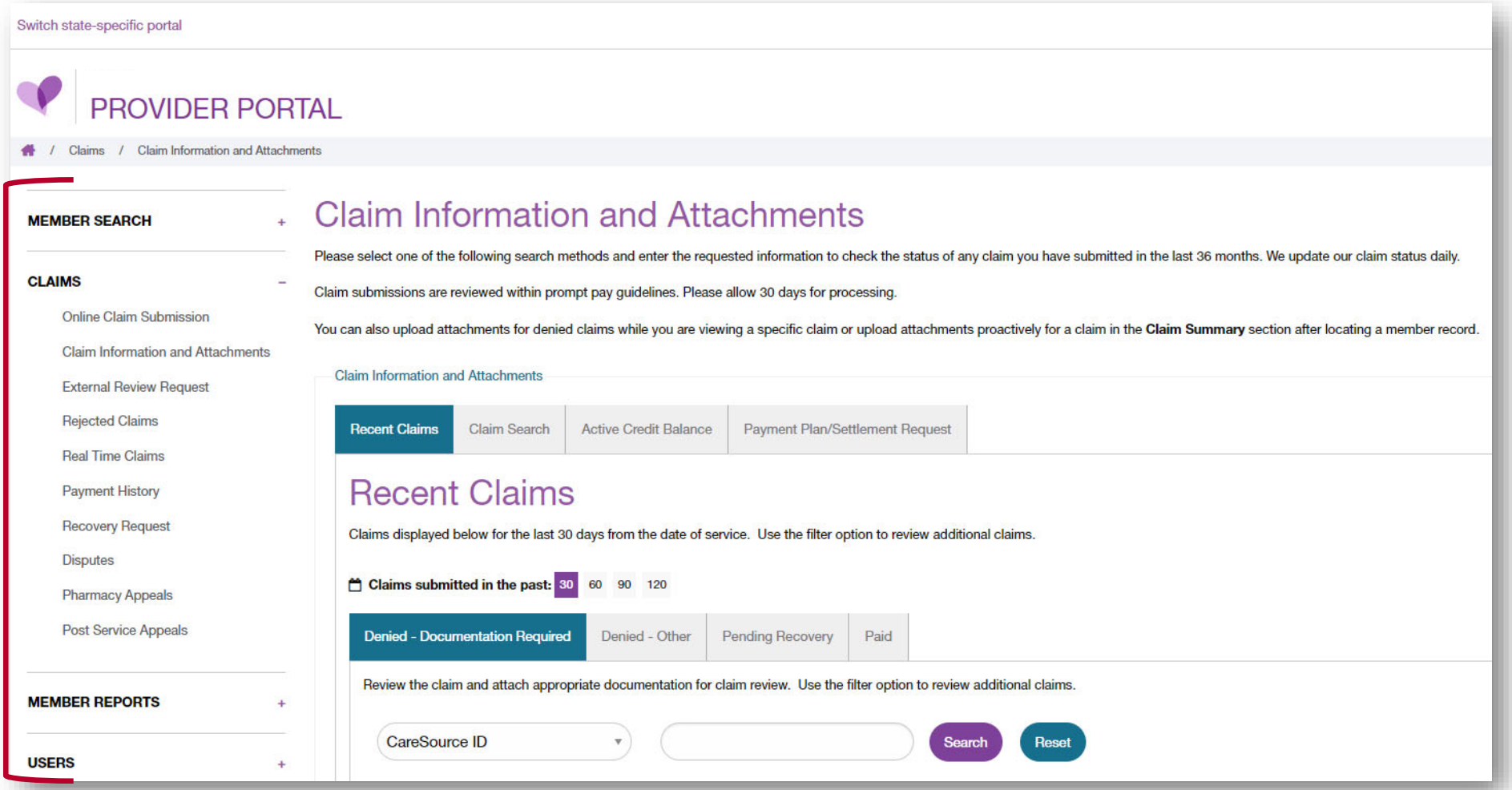


Provider Portal | **MFA Setup**



For additional details, refer to the Provider Portal Registration Guide found by clicking the **Registration Instructions** link.

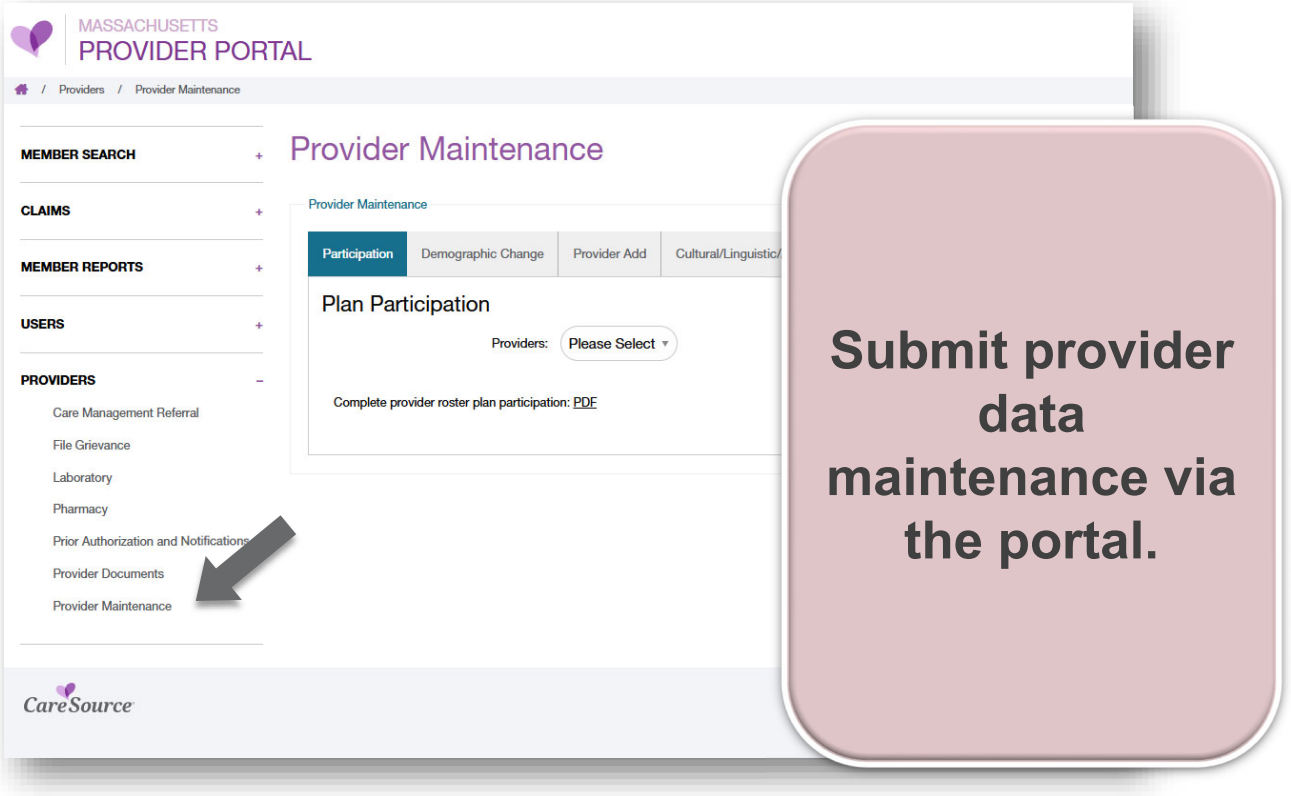
Provider Portal | **Home Page**



Provider Portal | **Provider Data**

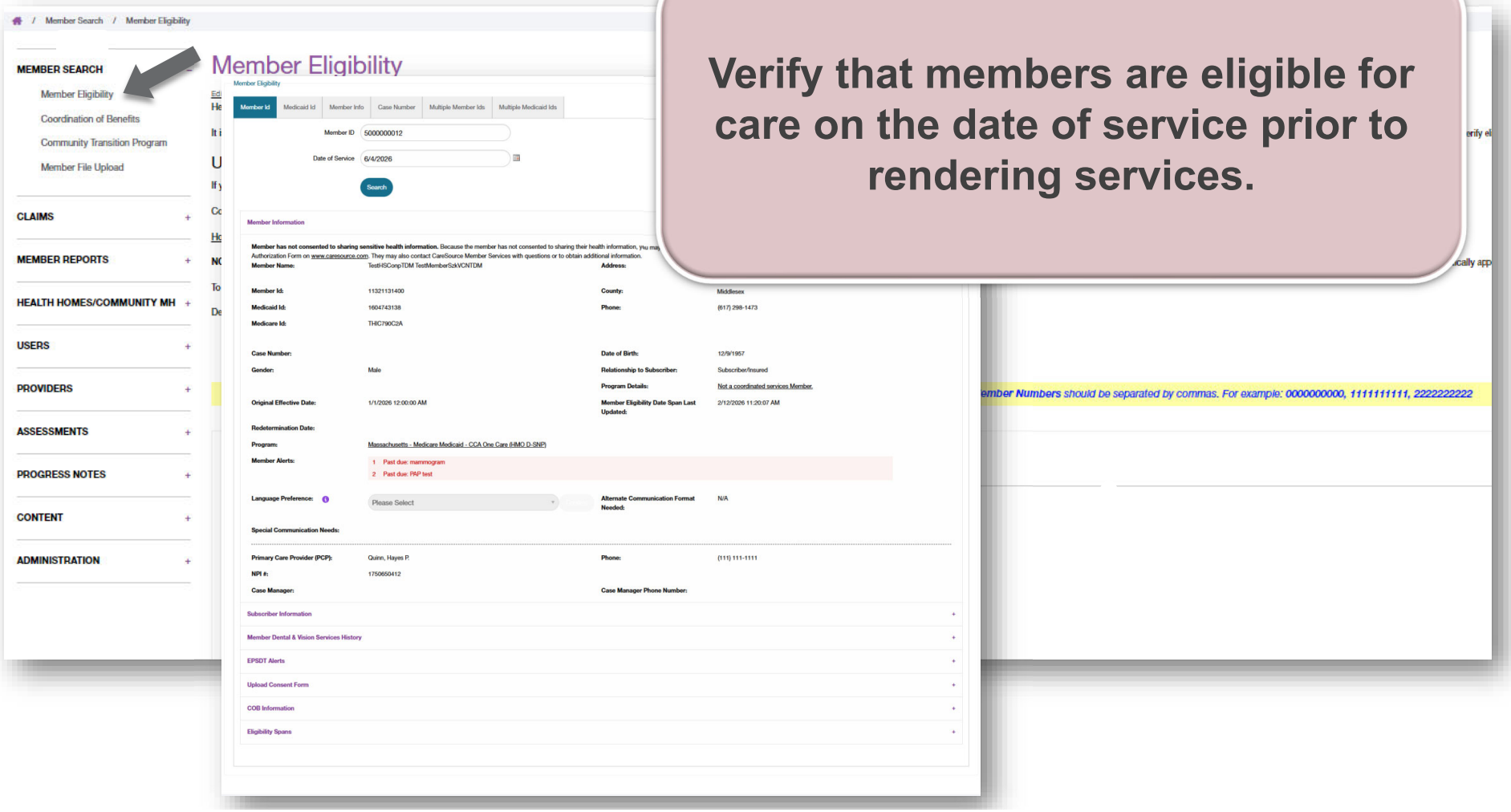
Practitioners, provider groups, and facilities are responsible for notifying CCA of any changes to provider enrollment information.

All requests must be sent to the Provider Data Management (PDM) department via the **Provider Portal** or by email at PNMDepartment@CommonwealthCare.org 45 days prior to the change or update.



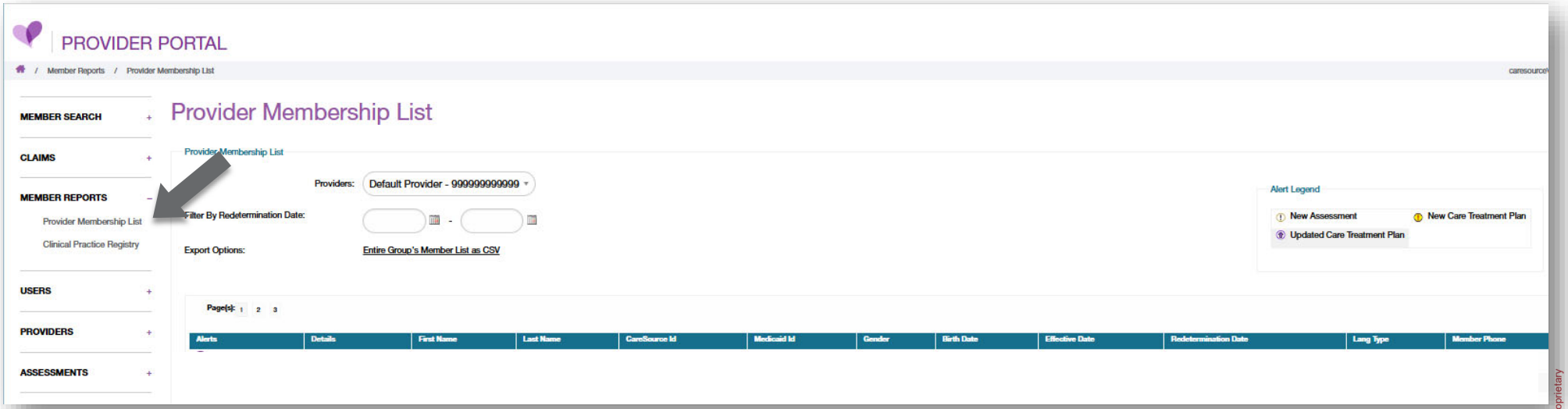
Please refer to CCA's *Provider Enrollment and Credentialing* (Section 15 of the Provider Manual) for more detail.

Provider Portal | **Eligibility Status**



Verify that members are eligible for care on the date of service prior to rendering services.

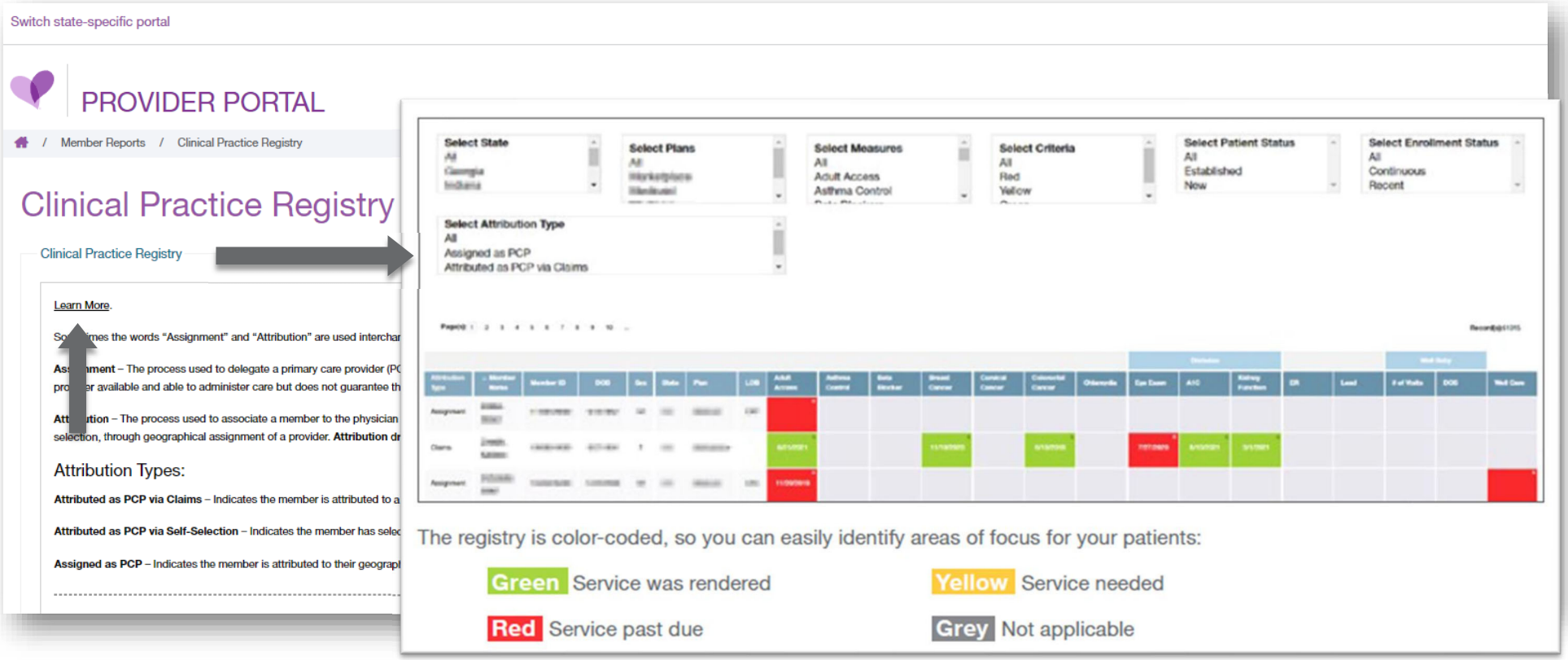
Provider Portal | **Membership List**



To locate member information:

1. Select **Provider Membership List** from the menu.
2. Choose the provider's name associated with the member.
   - Note that providers not associated with a group will only see their name.

Provider Portal | **Clinical Practice Registry (CPR)**



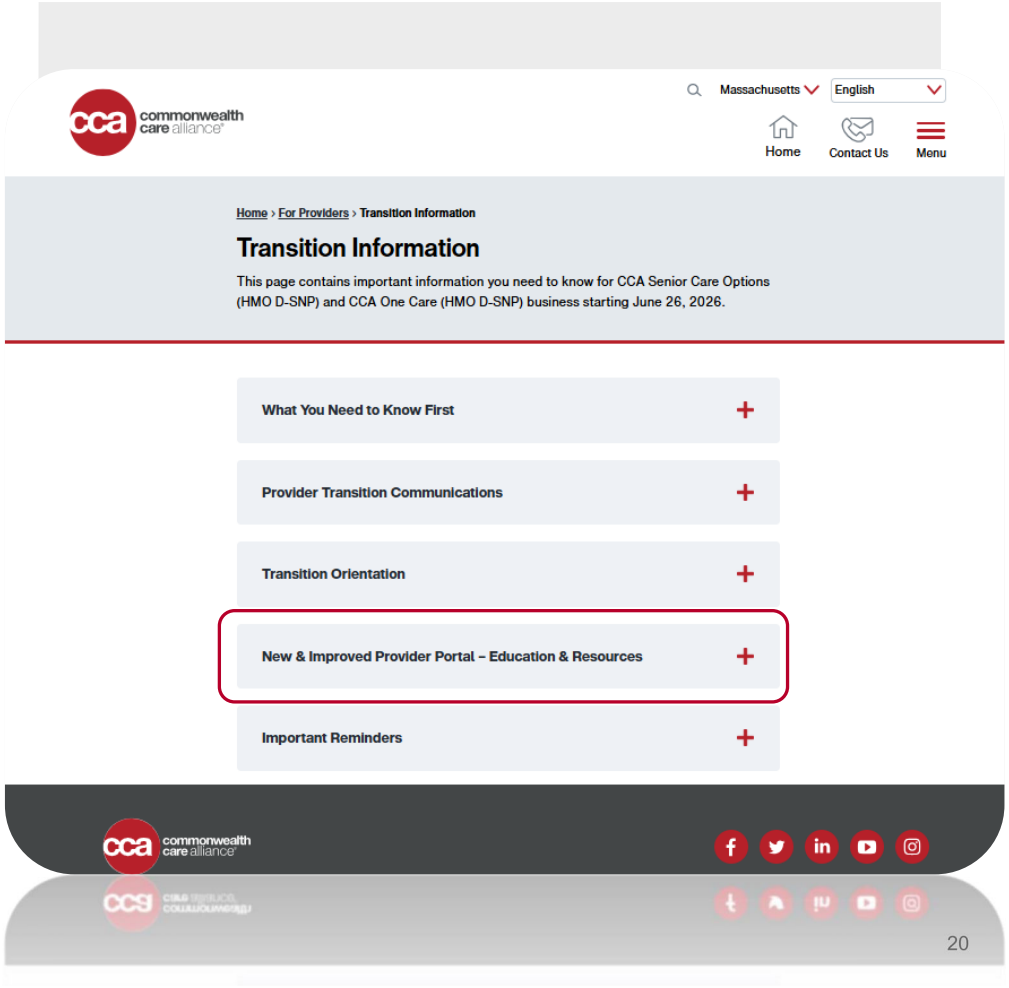
View the CPR flier on our Provider Transition Information page.

Provider Portal | **Training Resources**

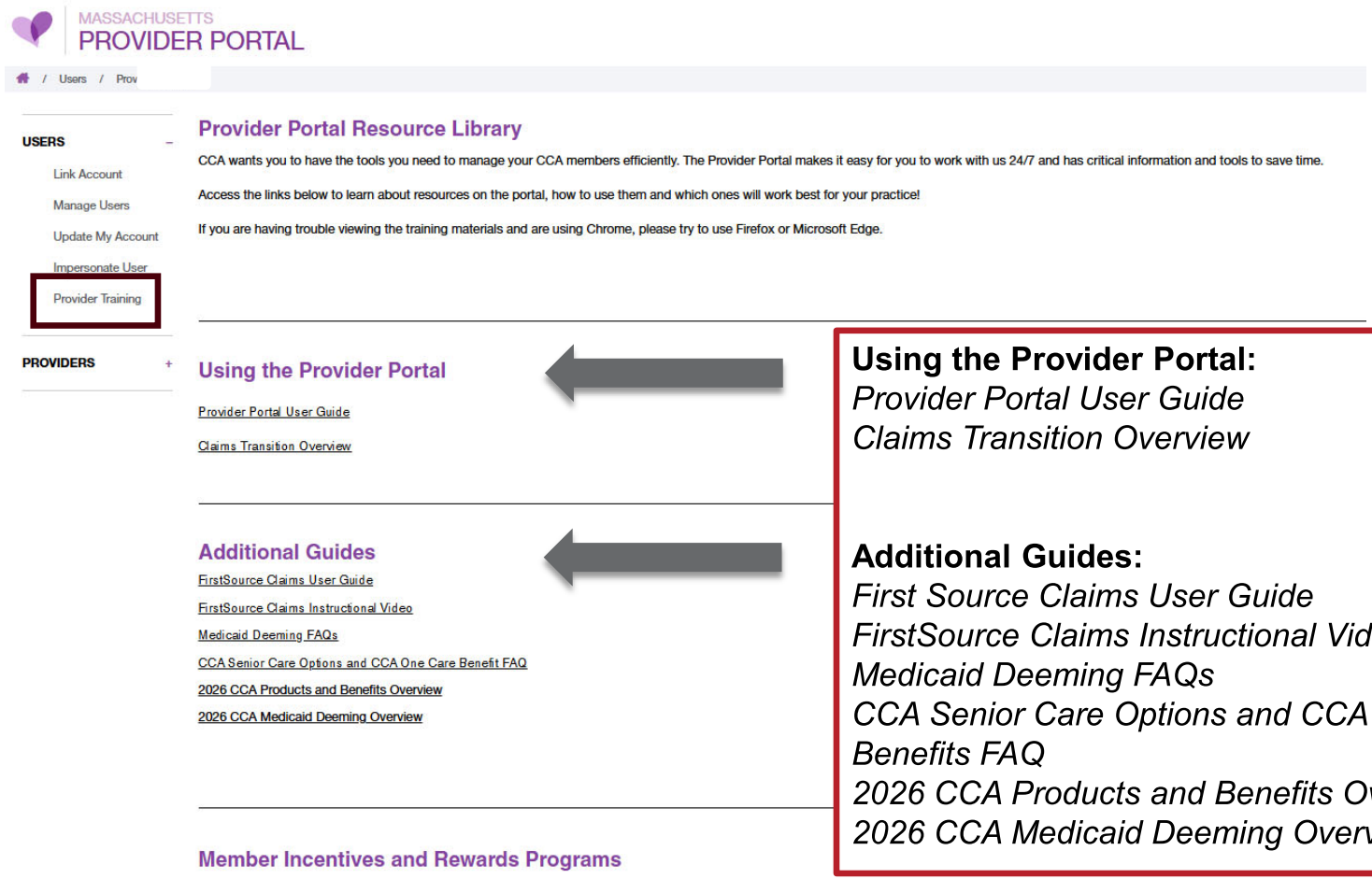
The **new** Provider Portal is a robust, secure, and encrypted online tool available for all providers who serve our members.

- Available Documents
  - Provider Portal Solutions
  - Clinical Practice Registry Flier
  - Provider Portal User Guide
  - Provider Portal Quick Start Guide
  - Provider Portal Registration Guide
  - Provider Portal: Managing User Access
- Available Training Videos
  - Portal Overview
  - Provider Portal: Service Plan Reviews Prior Authorizations
  - Provider Portal: Managing User Access
  - Provider Portal Service Plan Review

Visit the Transition Information page at CCA's website to access these resources.



Provider Portal | **Training**

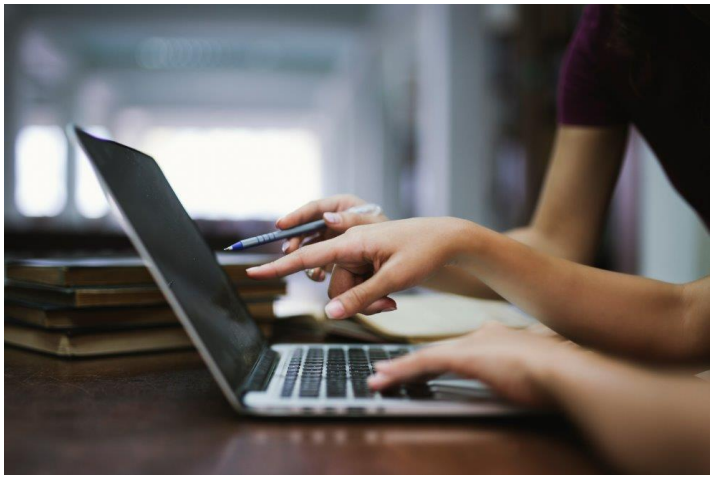


Using the Provider Portal:
Provider Portal User Guide
Claims Transition Overview

Additional Guides:
First Source Claims User Guide
FirstSource Claims Instructional Video
Medicaid Deeming FAQs
CCA Senior Care Options and CCA One Care Benefits FAQ
2026 CCA Products and Benefits Overview
2026 CCA Medicaid Deeming Overview

PRIOR AUTHORIZATION SUBMISSION

Prior Authorization | **Submission Requirements**



All retrospective authorization requests must be submitted within 30 calendar days of the date of service or date of discharge or as specified in a provider contract. The only exception is a Coordination of Benefits (COB) denial. In this case we allow 90 days from the other insurance notification. Providers must submit rationale for retrospective authorizations.

Submit prior authorizations via:

- **New Provider Portal ProviderPortal.CareSource.com/GL/User/Login.aspx/ - preferred method**
- Select **Providers > Prior Authorizations and Notifications**

Alternative methods via:

- Phone: 1-866-420-9332
- Fax: 1-855-341-0720

Please refer to CCA's *Prior Authorization Requirements* (Section 4 of the Provider Manual) for more detail.

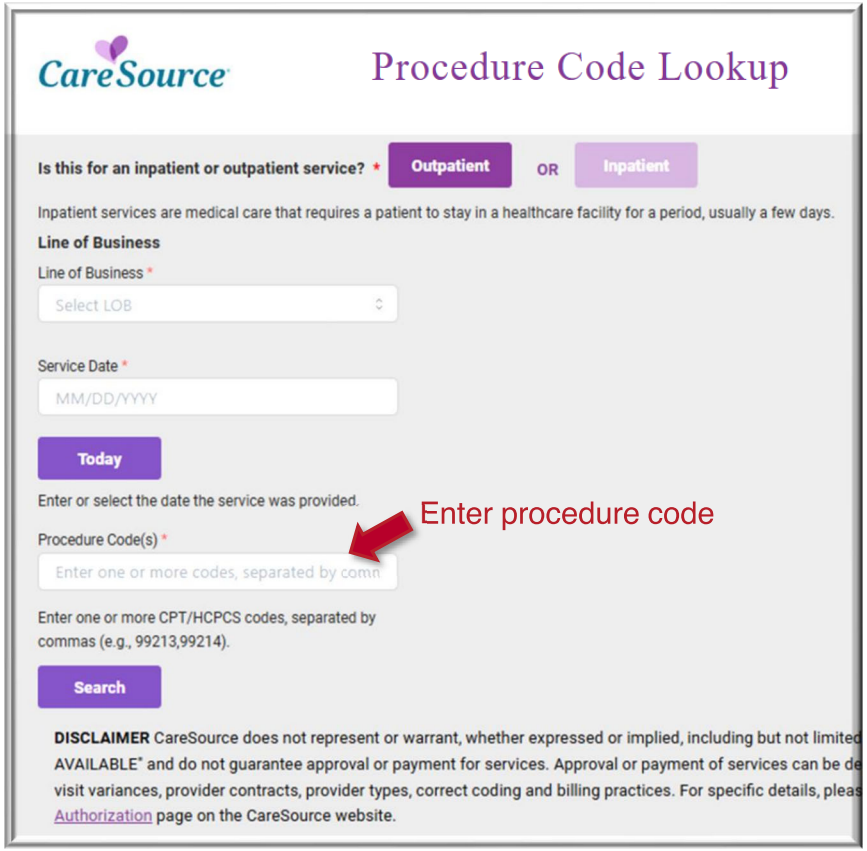
Prior Authorization | **Procedure Code Lookup Tool**

Utilize the **Procedure Code Lookup Tool** to verify prior authorization requirements before entering your request for an outpatient or inpatient procedure.

1. Visit **ProcedureLookUp.CareSource.com**.
2. Select service type
3. Select plan
4. Enter date of service
5. Enter procedure code

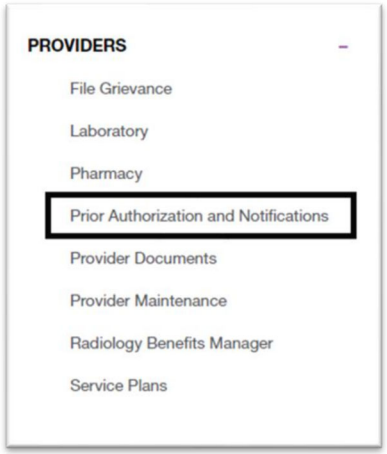
The Procedure Lookup Tool will identify requests that need to be submitted to **TurningPoint**, our Third-Party Administrator (TPA) for Cardiac & Musculoskeletal procedures. It will also identify the codes that need to be submitted to our other UM TPA partners.

If you have any additional questions or would like additional training on prior authorization submission, email **CiteAutoAssistance@CareSource.com**.

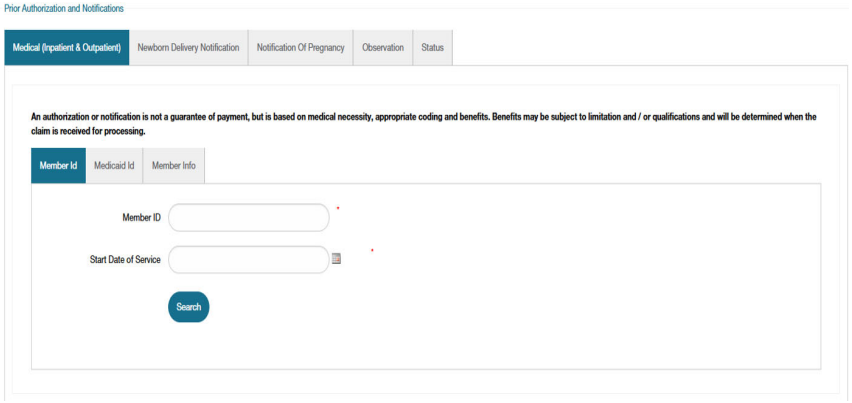


Prior Authorization | **Submission via the Provider Portal**

Select **Providers** > **Prior Authorization and Notifications** from the left-hand navigation menu.

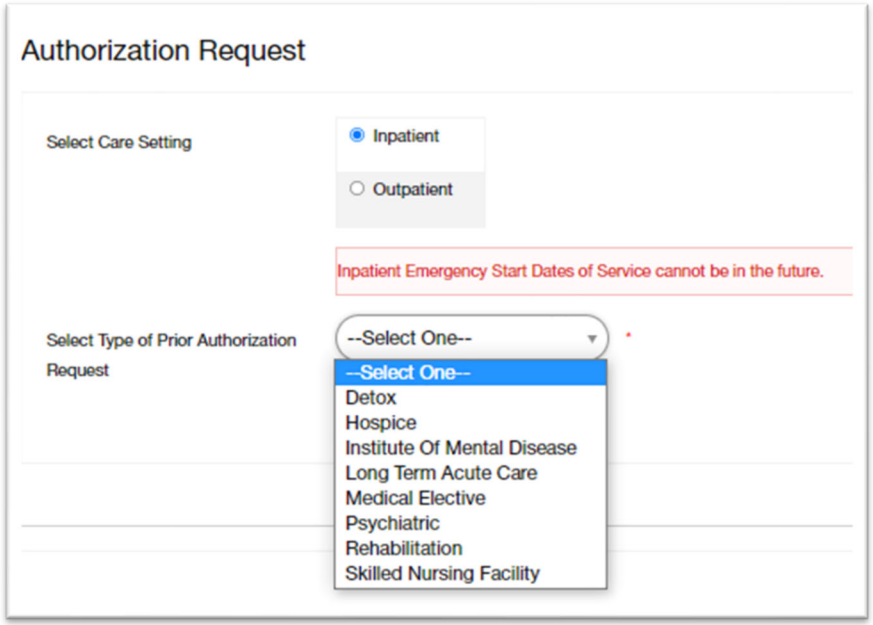


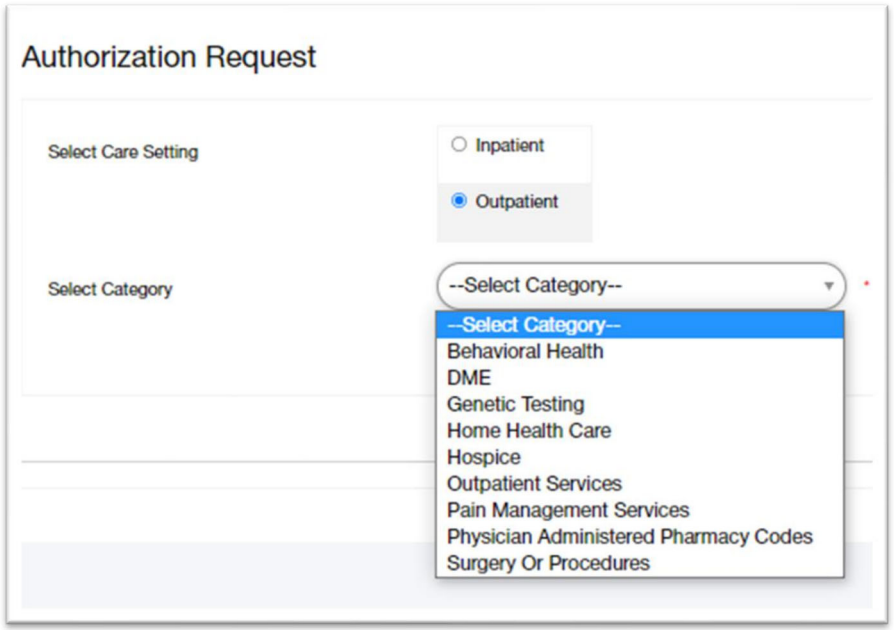
Enter the member's CCA ID and start date of service in the fields provided. Click **Search**. Confirm eligibility and click **Verified**.



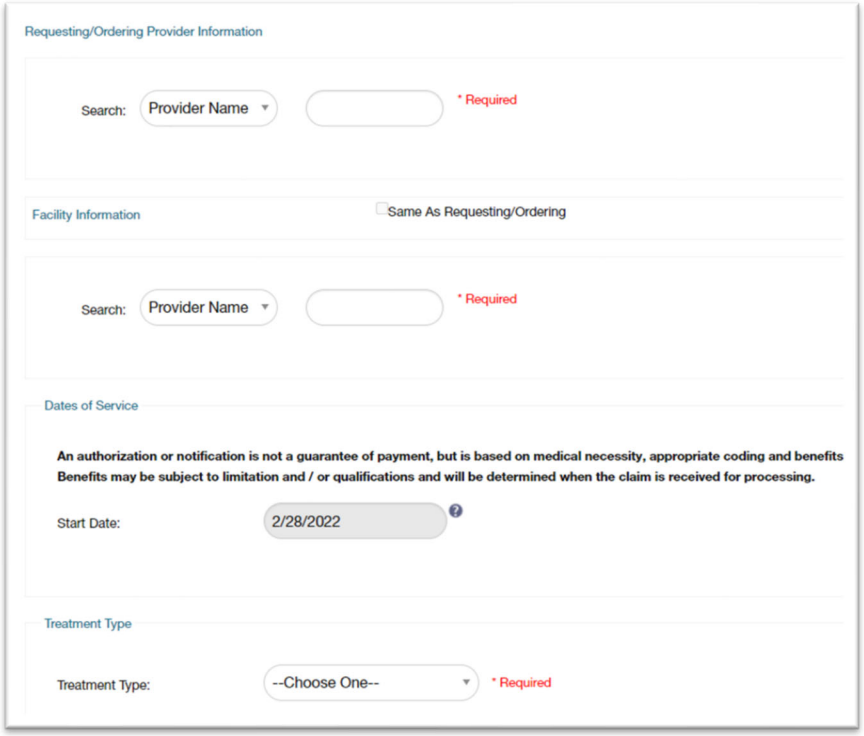
Prior Authorization | **Select the Care Setting**

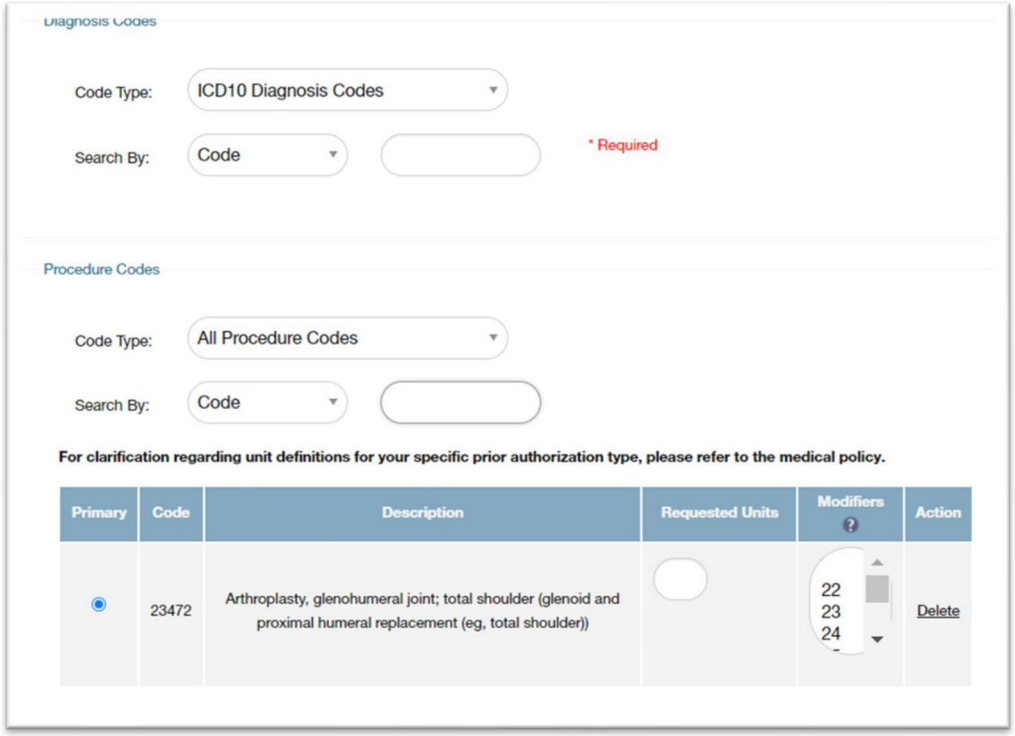
Select the Care Setting and enter the authorization details based on the type of request.





Prior Authorization | **Complete the Required Fields**





Prior Authorization | **Choose File**

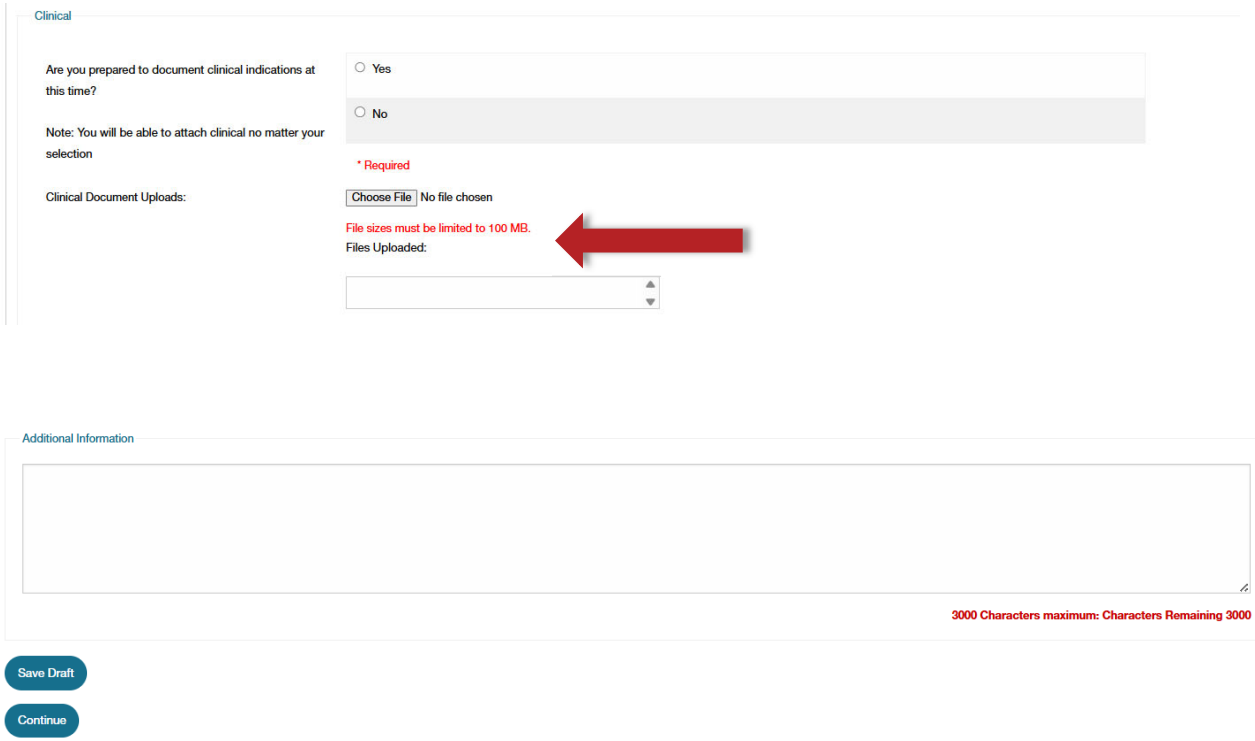
Click **Choose File** to locate document.

Click **Upload** to attach to case and close.

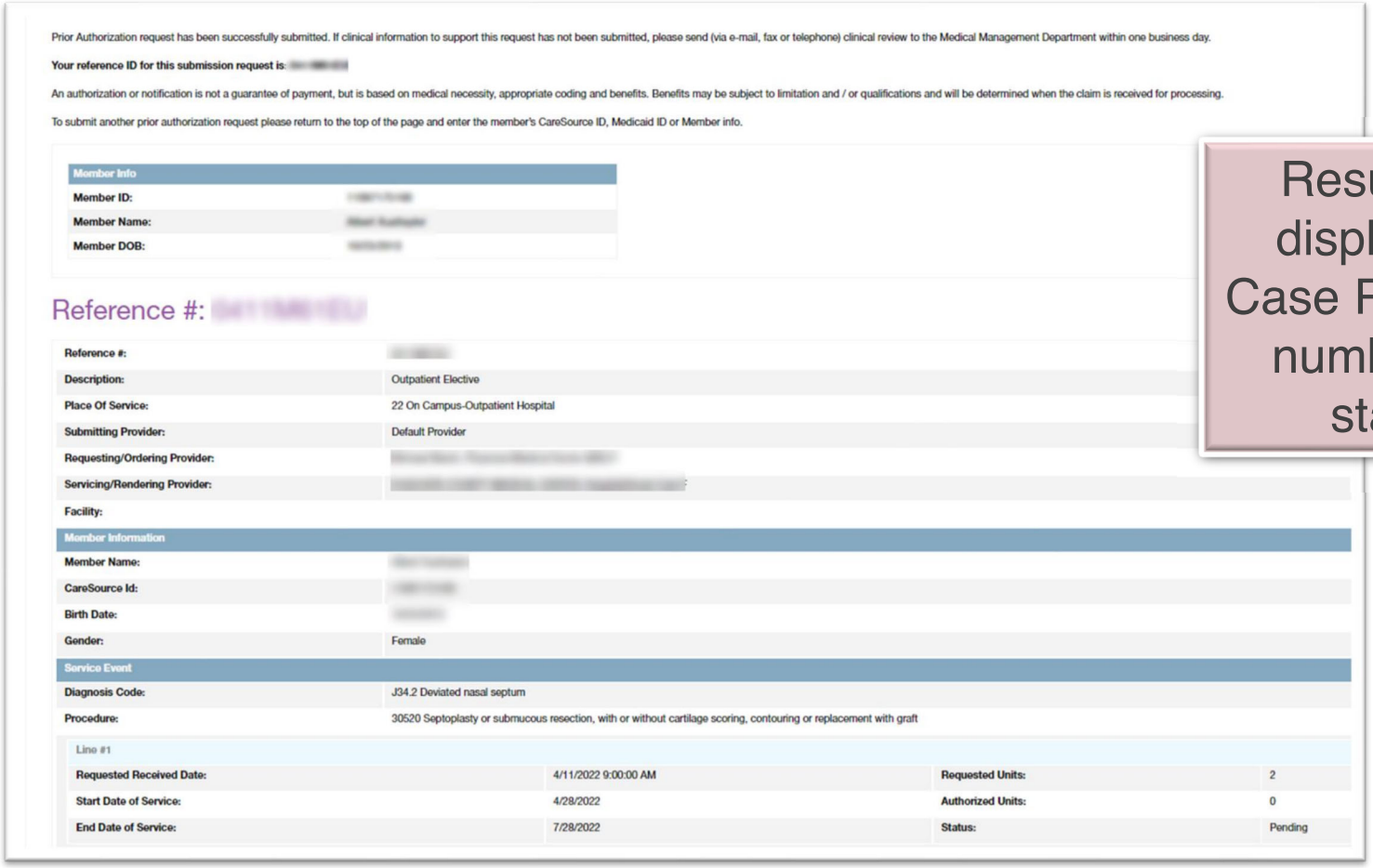
File Name will show.

Repeat process to add additional files.

Click **Continue** to submit form.



Prior Authorization | **Results Screen**



Prior Authorization request has been successfully submitted. If clinical information to support this request has not been submitted, please send (via e-mail, fax or telephone) clinical review to the Medical Management Department within one business day.

Your reference ID for this submission request is: [redacted]

An authorization or notification is not a guarantee of payment, but is based on medical necessity, appropriate coding and benefits. Benefits may be subject to limitation and / or qualifications and will be determined when the claim is received for processing.

To submit another prior authorization request please return to the top of the page and enter the member's CareSource ID, Medicaid ID or Member info.

Member Info	
Member ID:	[redacted]
Member Name:	[redacted]
Member DOB:	[redacted]

Reference #: [redacted]

Reference #:	[redacted]
Description:	Outpatient Elective
Place Of Service:	22 On Campus-Outpatient Hospital
Submitting Provider:	Default Provider
Requesting/Ordering Provider:	[redacted]
Servicing/Rendering Provider:	[redacted]
Facility:	
Member Information	
Member Name:	[redacted]
CareSource Id:	[redacted]
Birth Date:	[redacted]
Gender:	Female
Service Event	
Diagnosis Code:	J34.2 Deviated nasal septum
Procedure:	30520 Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft

Line #1			
Requested Received Date:	4/11/2022 9:00:00 AM	**Requested Units:**	2
Start Date of Service:	4/28/2022	**Authorized Units:**	0
End Date of Service:	7/28/2022	**Status:**	Pending

Results will display with Case Reference number and status.

Prior Authorization | **Checking Status**

Select **Prior Authorization and Notifications**.

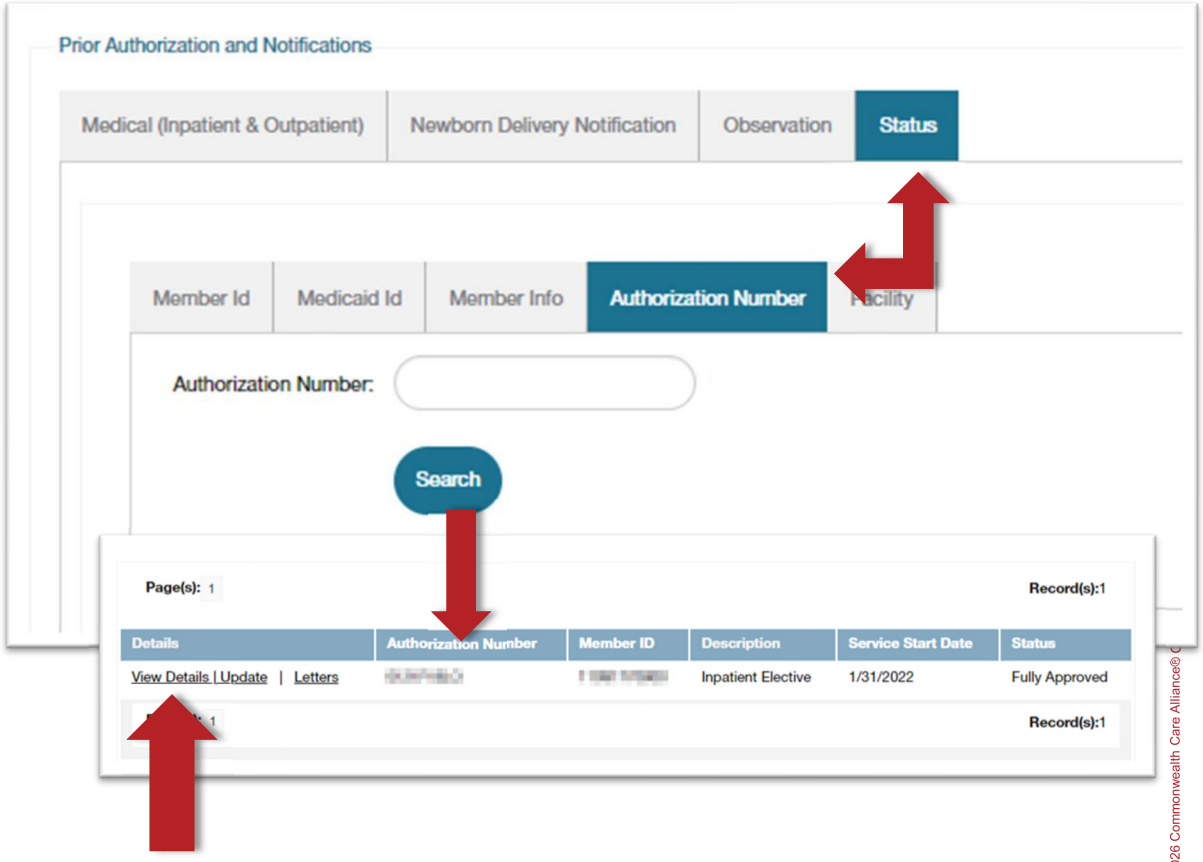
Click **Status** tab, then select the **Authorization Number**. Click **Search**.

Case will display at bottom of screen.

Click **View Details | Update** to review case information.

You may also search Prior Authorization status by facility.

1. Under the **Status** tab, select **Facility**.
2. Use the drop-down menu to **Select the Facility**.
3. Choose your **Start** and **End Dates**, and all prior authorizations that are associated with the facility during the given date range will populate.

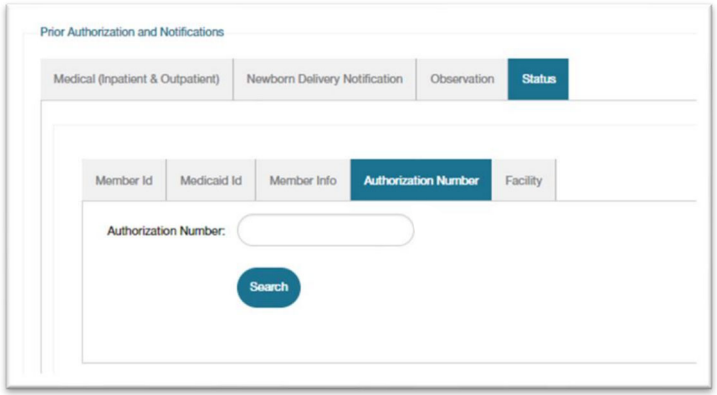


Prior Authorization | **Request for Change or Update**

Select **Prior Authorization and Notifications**.

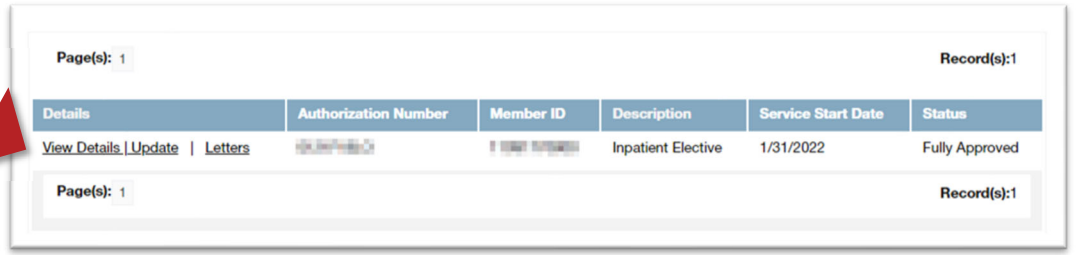
Click **Status** tab, then select the **Authorization Number**. Click **Search**.

Case will display at bottom of screen.

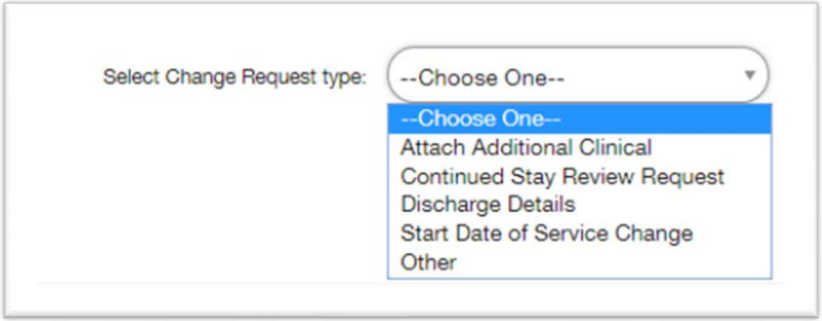


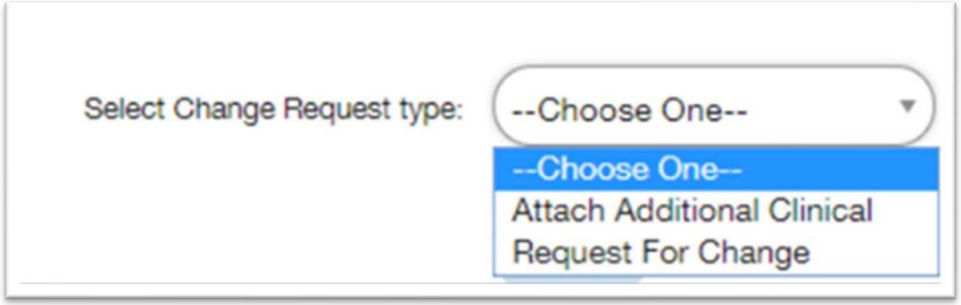
Click **View Details | Update**.

Access is restricted to those authorizations affiliated with each tax ID number.



Prior Authorization | **Change Details**





- Use the dropdown to select **Change Details**.
- Complete changes and required fields. Click the dropdown to select the type of attachment.
- Choose **File** and locate the electronic saved copy. (There's no limit on the number of attachments).
- Click **Submit**. The request will be sent to the Utilization Management (UM) team to review the case and complete the process.

Change requests for approved authorizations are accepted when the service intent is the same/similar and does not require a new medical necessity review.

Note: if the case status is Denied or Voided, you will be unable to update the case.
You must submit a new case.

Prior Authorization | **When to Contact the Care Manager or Submit by Fax**

Some services follow a different authorization process.

Certain HCBS, LTSS, and related services cannot be submitted through the Provider Portal Prior Authorizations and Notifications page yet.

Use the correct process based on service type.

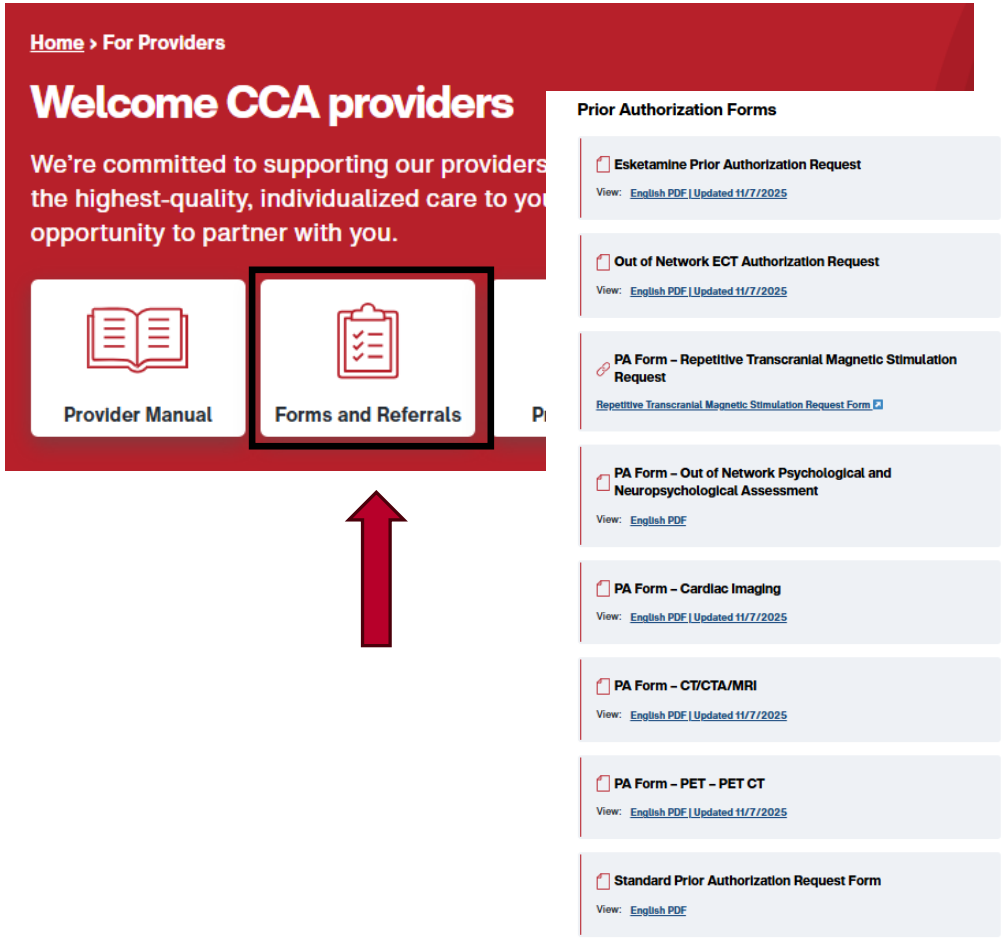
CONTACT MEMBER'S ASSIGNED CARE MANAGER	CONTINUE TO SUBMIT VIA FAX
Chore Companion Personal Care Agency (PC) Homemaker Grocery Shopping and Delivery Home Delivered Meals (HDM) Supportive Home Care Aide (SHCA)	Adult Day Health (ADH) Day Habilitation Personal Care Attendant (PCA) Adult Foster Care (AFC) Group Adult Foster Care (GAFC)

Prior Authorization | **Standard Prior Authorization Forms**

Prior authorization requests require a completed Standard Prior Authorization Request form and supporting clinical documentation in accordance with relevant Medical Necessity Guidelines.

As part of the transition, the **Servicing Provider TIN is now required** on all prior authorization request forms. The **Referring Provider TIN is not required**. Please ensure you fill out all required fields in the form.

If any required information is missing, we will continue processing your request and will contact you for the additional information.



Please refer to CCA's *Prior Authorization Requirements* (Section 4 of the Provider Manual) for more detail.

Prior Authorizations | **Cardiac & Musculoskeletal Surgery**

CCA utilizes **TurningPoint** to implement cardiac and musculoskeletal surgical procedures.

TurningPoint Authorization	Turnaround Times	Required Information
Phone: 1-304-603-4673 1-855-578-7350 Fax Intake Form: 1-304-553-7061 1-844-472-0481 TurningPoint Portal	• Standard non-urgent = seven calendar days • Expedited Requests = 72 hours • Retrospective requests = 30 calendar days from the date on which the vendor received the authorization request	• Provider information • Facility information • Anticipated surgery date • Health plan information • Member demographics • Requested procedures/diagnosis • Clinical Information
Turning Point Customer Service Phone: 1-866-422-0800 Email: ProviderSupport@tpshealth.com		

See CCA and TurningPoint announcement for additional information.

Please contact CCA directly for appeals and claims

CLAIM SUBMISSION

Claims | **Billing Overview**

CCA accepts claim submissions through the electronic data interchange (EDI), Provider Portal, or via paper claim submissions.

- Electronic billing is preferred. Use Payer ID **A2793.**
- Mail paper claims to: **Commonwealth Care Alliance**
  Attn: Claims Department
  P.O. Box 1127
  Dayton, OH 45401-1127
- Contracted providers must file claims no later than 90 days from date of service unless the filing limit is otherwise stipulated in their contract.

Provider shall not seek or accept payment from a CCA member for any covered service if the member is wholly enrolled and eligible for both Medicare and MassHealth.

Please refer to *CCA's Claims and Billing Procedures* (Section 7 of the Provider Manual) for detail.

Claims | **Submissions**

ELECTRONIC CLAIM SUBMISSIONS

- It is encouraged to use electronic claim submission as the primary submission method.

Portal Submission

- Providers can submit claims through our **NEW** secure, online Provider Portal at CCA Provider Homepage | Commonwealth Care Alliance MA > Provider Portal. Here, providers can submit claims along with any documentation, track payments, and more.

CLEARINGHOUSES

- For EDI transactions, CareSource accepts electronic claims through our clearinghouse, Availity. Providers can also use their existing clearinghouse if they are configured to accept the CCA Payer ID (A2793). Providers can find a list of EDI vendors online at: availity.com/ediclearinghouse.

Please refer to *CCA's Claims and Billing Procedures* (Section 7 of the Provider Manual) for more detail.

Claims | **Electronic Funds Transfer (EFT)**

ECHO Health offers three payment options:

1. EFT – preferred
2. [Default] Virtual Card Payment (QuicRemit) – Standard bank and card issuer fees apply*
3. Paper Checks

We partner with ECHO Health for electronic funds transfer (EFT). You must enroll with ECHO Health to participate.

Sign up for ECHO Health online at enrollments.echohealthinc.com/EFTERADirect/CareSource to complete your enrollment in EFT with your tax ID, bank information, ECHO payment draft number, and payment amount. For questions, call ECHO Support at: 1-888-485-6233.

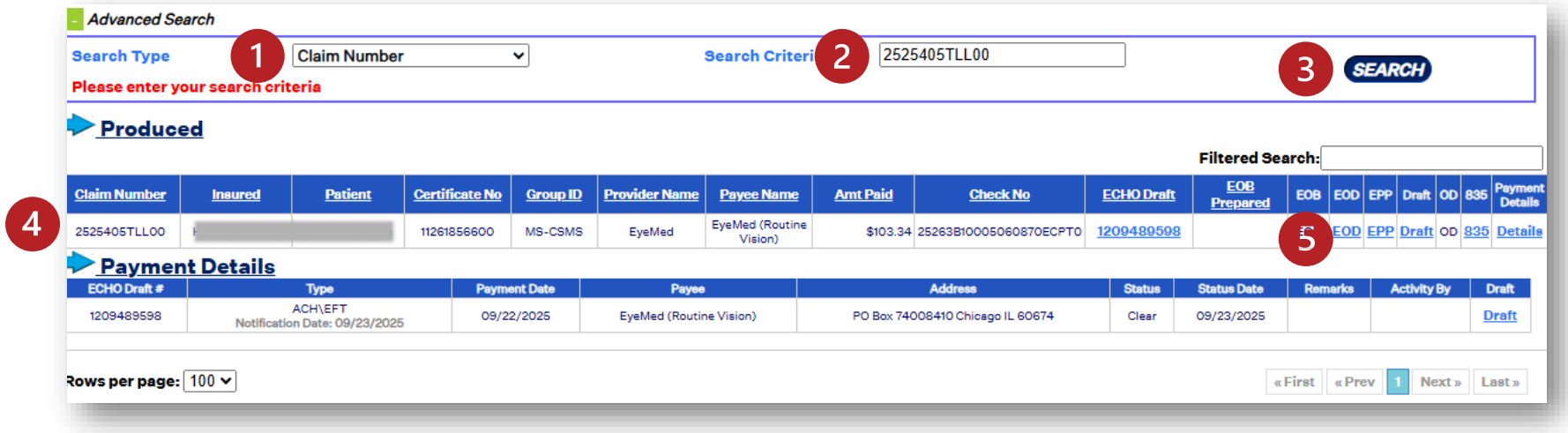
*Payment processing fees are what you pay your bank and credit card processor for use of a payment terminal to process payments via credit card.

Providers who elect to receive EFT payment can also choose to receive an EDI 835 (Electronic Remittance Advice) through a designated clearinghouse. Providers can download the PDF version of the Explanation of Provider Payment (EPP) from the Provider Portal.

Notice: Email notifications are not sent when a deposit/payment is made. Deposits/payments are made twice weekly.

EPP | ECHO

1. Click the **Search Type** drop-down list and choose appropriate search criteria.
   - The below search options may provide the best results:
     - **ECHO Draft Number**: this is the payment check number on the Remittance tab on the claim.
     - **Provider ID**: the provider's tax ID number.
     - **Claim Number**: CareSource's claim number.
2. Input the appropriate information in the **Search Criteria** field.
3. Click **Search**.
4. Locate the appropriate payment.
5. Click **EPP**.



Claims | **Explanation of Payment (EOP)**

The new CCA EOP will display Medicare and Medicaid adjudication results separately, giving you clearer visibility into coordination of benefits. You will also see Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) broken out for each payer.

Past CCA EOP

Claim Identifier:	MA	**Provider Name:**	LG NEWCORP INC
Claim#:	260170206700	**Provider ID:**	1033936810
DRG:			
Patient Name:	[redacted]	**Insured Name:**	[redacted]
Patient Account #:		**Insured ID:**	

Service Date From - To	Procedure Code	Service Code	Modifier(s)	Total Charge	Excluded Amount	Reason Codes	Allowed Amount	Other Carrier Amount	Deductible Amount	Copay Amount	Coinsurance Amount	Payment Amount
11/19/25 - 11/25/25	0124			$8,088.00	$0.00	94, 253	$12,724.29	$0.00	$0.00	$0.00	$0.00	$12,724.29
11/19/25 - 11/25/25	0259			$1,620.46	$1,620.46	M15, N1, M15, N1, 97	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
11/19/25 - 11/25/25	0301			$357.00	$3							
11/19/25 - 11/25/25	0307			$28.00	$2							
11/19/25 - 11/25/25	0450			$2,154.00	$2,							
			Patient Responsibility									
			Totals	$12,247.46								
			Claim Interest	$0.00								

Claim Identifier:	MA		
Claim#:	260170206800		
DRG:	885		
Patient Name:	[redacted]		
Patient Account #:			

Service Date From - To	Procedure Code	Service Code	Modifier(s)	Total Charge	E
10/31/25 - 11/13/25	0124			$18,226.00	$5,
10/31/25 - 11/13/25	0259			$2,803.58	$2,
10/31/25 - 11/13/25	0301			$1,843.00	$1,

New CCA EOP

Patient: [redacted] **Insured:** [redacted] **Payor Claim #:** 2605702YGN00
Patient Acct #: [redacted] **Product Name:** CareSource MyCare Ohio (HMO D-SNP)
Rendering Provider: 1 [redacted]

Line of Business	Line Number	Service Date	Procedures (Modifiers)	Units	Total Charge	Allowed Amount	Provider Discount (Disallowed)	Other Plan Payment (COB)	Other Adjustment	Patient Obligation	Net Payment Amount	Adjustment Reason	Remark
MCR	1	1/3/2026 - 1/3/2026	71045(26)	1	$79.00	$0.00	$79.00	$0.00	$0.00	$0.00	$0.00	CO39	
MED	1	1/3/2026 - 1/3/2026	71045(26)	1	$79.00	$0.00	$79.00	$0.00	$0.00	$0.00	$0.00	CO45	N219
			Total:		$158.00	$0.00	$158.00	$0.00	$0.00	$0.00	$0.00		

Patient: [redacted] **Insured:** [redacted] **Payor Claim #:** 260570332H00
Patient Acct #: [redacted] **Product Name:** CareSource MyCare Ohio (HMO D-SNP)
Rendering Provider [redacted]

Line of Business	Line Number	Service Date	Procedures (Modifiers)	Units	Total Charge	Allowed Amount	Provider Discount (Disallowed)	Other Plan Payment (COB)	Other Adjustment	Patient Obligation	Net Payment Amount	Adjustment Reason	Remark
MCR	1	1/10/2026 - 1/10/2026	71260(26)	1	$510.00	$0.00	$510.00	$0.00	$0.00	$0.00	$0.00	CO198	N640
MED	1	1/10/2026 - 1/10/2026	71260(26)	1	$510.00	$0.00	$510.00	$0.00	$0.00	$0.00	$0.00	CO109	N36
			Total:		$1,020.00	$0.00	$1,020.00	$0.00	$0.00	$0.00	$0.00		

Patient: [redacted] **Insured:** [redacted] **Payor Claim #:** 26057033HJ00
Patient Acct [redacted] **Product Name:** CareSource MyCare Ohio (HMO D-SNP)
Rendering Provider: 1 [redacted]

Line of	Line	Service	Procedures	Units	Total	Allowed	Provider Discount (Disallowed)	Other Plan	Other	Patient	Net Payment	Adjustment	Remark

Claims | **Corrected Claims**

To modify a paid or denied claim, providers must submit a corrected claim electronically or on paper.

- If the correction requires changes to the original data, the new claim can be sent via the EDI/clearinghouse.
- If the correction requires additional information (e.g., invoice, prescription, Medicaid records, or primary carrier explanation of benefit) the corrected claim can be submitted on paper or in the **Provider Portal**.

Corrected submissions should include:

- Original claim number for the claim you are correcting (most recent claim iteration available)
- Any necessary modifications from the original claim
- Any required supporting documentation

Mailing address for corrected and rejected paper claims: **Commonwealth Care Alliance**
P.O. Box 1127
Dayton, OH 45401-1127

Please refer to *CCA's Claims and Billing Procedures* (Section 7 of the Provider Manual) for more detail.

Claims | **Claim Appeals and Disputes**

ALL CLAIM APPEALS MUST BE:

- Must be submitted within **60 calendar days** of the original adjudication date
  - Coordination of Benefit (COB) denials must be submitted within 60 days of the COB denial date (retro-authorization policy still applies)
- Non-contracted providers must include a signed Waiver of Liability form holding the member harmless regarding the outcome of the appeal.
- Submitted via one of these methods:
  - Provider Portal (preferred method)
  - Mail: Commonwealth Care Alliance
    P.O. Box 1127
    Dayton, Ohio 45401-1127
  - Fax: 857-453-4517

CLAIM DISPUTES

- Used for payment-related issues (e.g., incorrect adjustments, timely filing denials, overpayment recovery)
- Must be submitted in writing within 90 days of the payment or denial date (per EOP)
- Must include supporting documentation and Request for Claim Review form
- Submit via portal, fax or the address above

NOTE: If you are responding to a denied authorization that required medical necessity review, please submit an appeal.

- The Provider Portal is the most efficient method of submission to ensure timely receipt and resolution of the appeal.
- As a CCA provider, you may submit a dispute or appeal for a member.
- Providers must obtain a member's written consent to appeal an adverse benefit determination on their behalf.
- We may contact you to obtain documentation when a member has filed a request for one of these. CCA does not retaliate or discriminate against any member or provider for utilizing the grievance and appeals process.

Claims | **Payment Disputes**

Contracted providers may file a payment dispute for CCA's reconsideration if they disagree with CCA's decision of denial or reimbursement of a claim.

- Disputes must be submitted via fax, portal or mail. Disputes should be sent to:
  - Mail:

    Commonwealth Care Alliance
    Attn: Appeals Department
    P.O. Box 1947
    Dayton, OH 45401-1947

    Fax: 857-453-4517

  - Payment dispute requests will be considered when received within 90 days from the original payment or denial date, as indicated on the EPP, with supporting documentation and the *Request for Claim Review* form.

Contracted providers may file a dispute for CCA's reconsideration if they believe CCA is paying an amount different than contractually agreed upon.

For additional questions on provider Payment Disputes or Appeals, please contact CCA Provider Services at 1-866-420-9332 on Mondays, Tuesdays, Wednesdays, and Fridays from 8 a.m. to 5 p.m. Eastern Time (ET) and on Thursdays from 8:30 a.m. to 5 p.m. ET.

Please refer to *CCA's Claims and Billing Procedures* (Section 7 of the Provider Manual) for detail.

Claims | **Contact & Billing Support**

Provider Claims, Billing Support, and EDI Support
CCA Provider Services at 1-866-420-9332 Weekdays, excluding Thursday, 8 a.m. to 5 p.m., ET and Thursdays, 8:30 a.m. to 5 p.m., ET
EDI Support by Availity Client Services at 1-800-282-4548 Monday through Friday, 8 a.m. to 8 p.m. ET
Availity Essentials Provider Portal To register, click on “Get Started” in the upper right corner and follow the instructions

Please refer to *CCA’s Claims and Billing Procedures* (Section 7 of the Provider Manual) for detail.

Claims | **Transition Impact**

Transition Impacts

- EPP format
- Accessing EOPs/835/EPP
- Portal Submission Options
- Recovery Letter Format
- Claims/Payment Policy Updates
- Application of CMS Claim Standards
  - *Be sure to follow CMS submission guidelines to ensure no interruption in claim processing*
- Mailing Addresses

Not Impacted

- Member IDs
- Deeming
- Benefits
- Opt-Out/Medicaid Run Out
- Payor ID
- Wholesale Policy
- Accessing Payment Policies Online

Find more Claims Transition Information training at commonwealthcarealliance.org/ma/providers/transition-information/.

KEY CCA CONTACTS AND UPDATES

commonwealth care alliance®

Key CCA Contacts

Member Services: 1-866-610-2273 (TTY: 711) MemberServices@CommonwealthCare.org

- April 1 to Sept 30: Monday through Friday, 8 a.m. to 8 p.m., ET; Saturday and Sunday from 8 a.m. to 6 p.m.
- Interpretation services are available

Provider Services: 1-866-420-9332 ProviderServices@CommonwealthCare.org

- Monday, Tuesday, Wednesday, and Friday, 8 a.m. to 5 p.m., ET and Thursday, 8:30 a.m. to 5 p.m., ET
- Providers can call with inquiries about covered services, authorization status, service denials, claims, and benefits

Provider Relations: ProviderRelations@CommonwealthCare.org

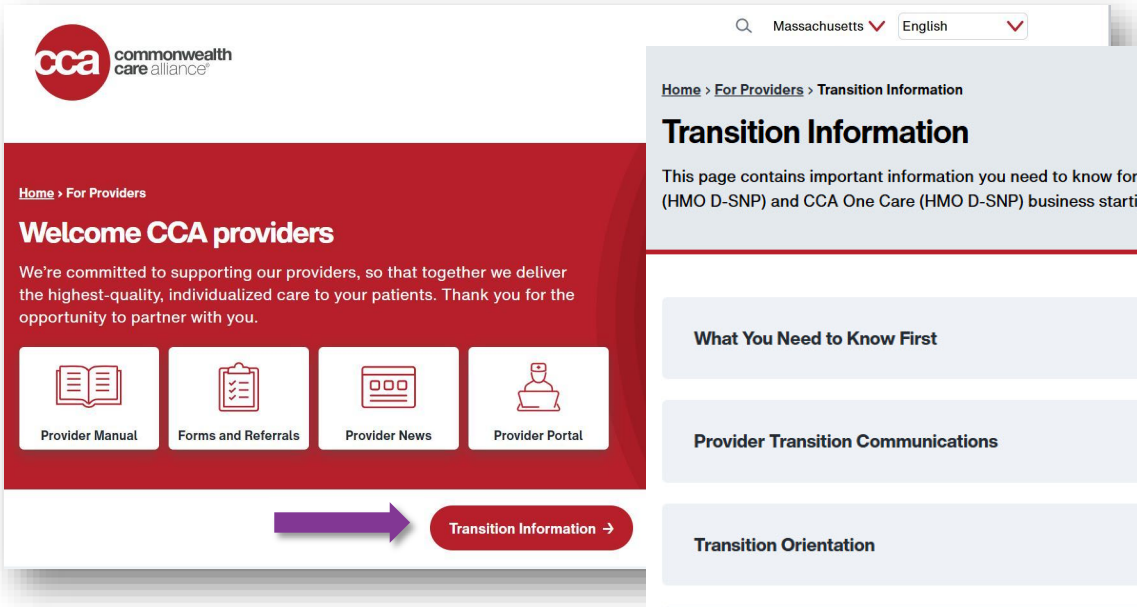
- Email us with questions and inquiries
- Send us an email to be added to the Provider News

Contracting: CCAContracting@CommonwealthCare.org

- Providers can email with inquires and questions related to their contract

Reminder: Provider Resources Available Online

Bookmark this page as your hub for transition materials, trainings, communications, and key reminders.



What You Need to Know First
Transition Guide
Quick Start Guide

Provider Transition Communications
What to Expect Letter
Transition Welcome Letter

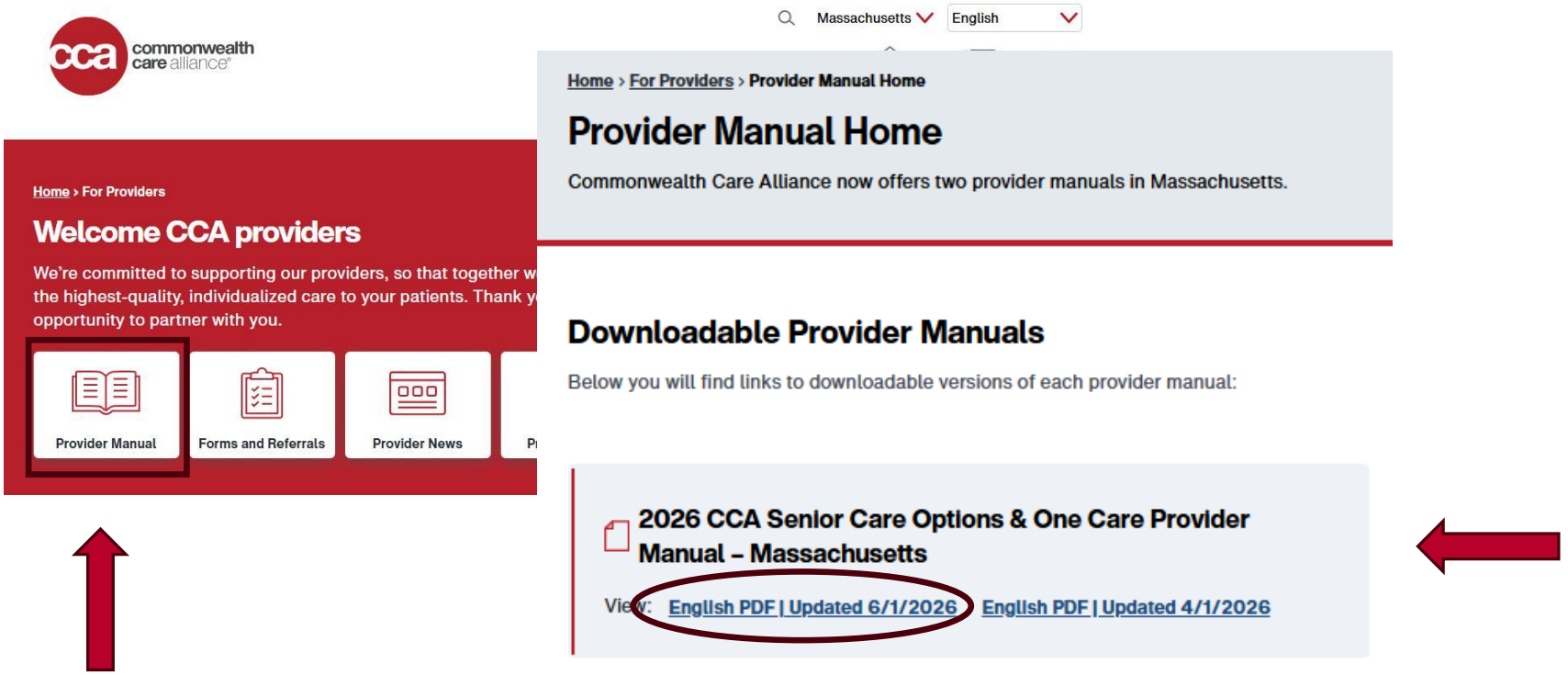
Transition Orientation
Network Notice for Orientation
Register for an Orientation Session
Transition Orientation Presentation

Provider Portal - Education & Resources
Provider Education Series: Portal Overview
Provider Education Series: Prior Authorizations
Provider Education Series: Provider Portal Service Plan Review

Bookmark the Transition Information webpage on the CCA Website for resources, trainings, and important updates.

Provider Manual

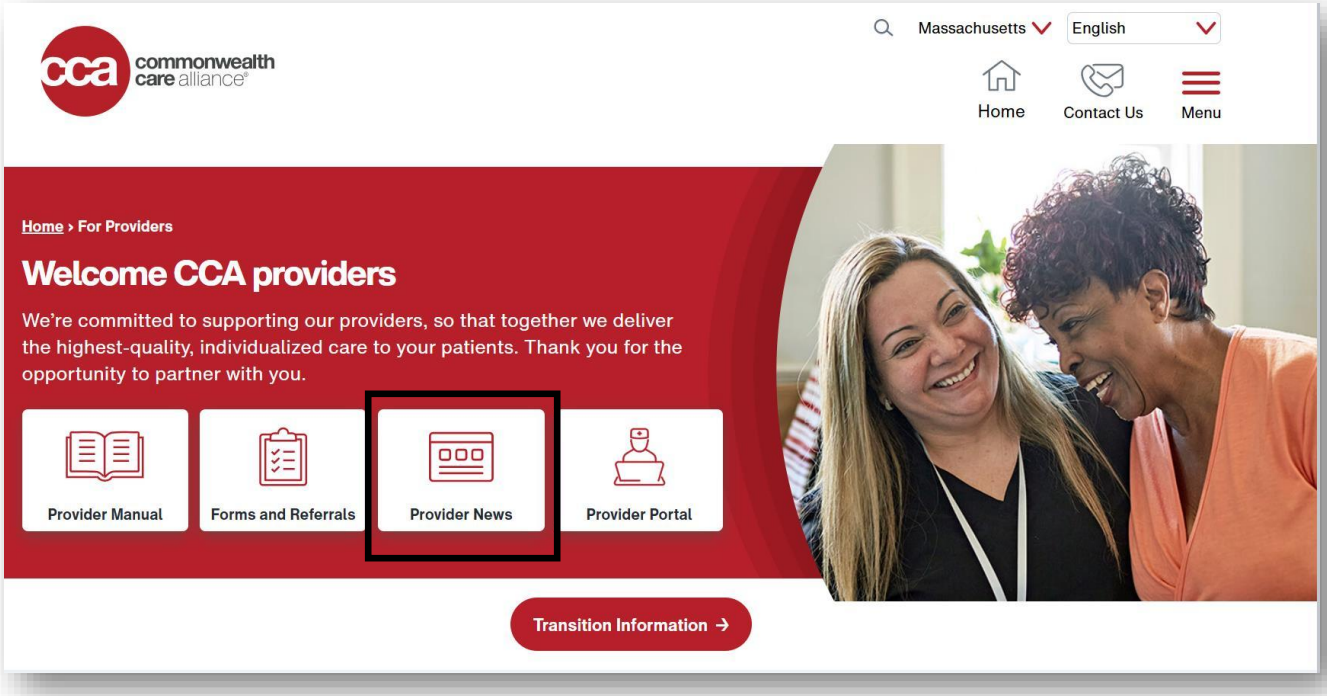
The CCA Provider Manual serves as the primary source of information for participating providers, offering guidance on claims, prior authorization, billing, operational requirements, and provider responsibilities throughout the transition and beyond.



Provider News and Updates

CCA communicates with providers through *Provider News* and *Provider Updates* to highlight the unique role our organization, network team, and providers play in delivering quality care. We also use these tools to communicate about key policy changes, program updates, operational guidance, and time-sensitive announcements that may require action.

View current and archived news and sign up for email distribution preferences at the CCA Provider Homepage.



Thank you!