Bright HealthCare™

BRIGHT HEALTHCARE REMAINING OPERATIONS - PROVIDER FAQ'S

2/7/24

This document is intended to provide instruction to former contract Providers of Bright Healthcare. These instructions are the remaining operations as we wind down the business around Bright Healthcare insurance plans.

Providers in the state of Texas should visit this site for instruction *https://brighthealthcaretxsdr.com/*, the instructions in this document may not apply to providers contracted in Texas.

Claims

The timely filing period for most services has passed. Initial claims must be filed within 180 days of service. Refer to your contract for your specific submission timeline.

Unpaid claims

If you have submit ed a claim that has yet to be paid, please be assured we're still reviewing claims and will do so until all have a decision. There has been much work done to resolve claims as quickly as possible. We do have agreements in place to set le batches of claims with provider groups who have contracted with Bright Healthcare.

Set lements in progress – Bright Healthcare has reached set lements or is in the process of negotiating set lements with many provider practices and medical groups. It's advised that you check through your internal leadership to check if this has impacted or is impacting your claims.

If you still feel that you have a claim that should be filed, please follow the instructions on this page:

Claims and Payment https://brighthealthcare.com/provider/claims-and-payment

Disputes and Appeals

The approved timeframe for submitting a dispute or appeal has passed for most situations. In most circumstances, a dispute or appeal must be filed within 180 days of the date a decision was made for the claim. If you are within those time frames and do need to file a dispute or appeal, please see the instructions below.

Provider Disputes

Provider dispute resolution: For issues that do not involve routine inquiries resolved in a timely fashion through informal processes, we offer a provider dispute process for administrative, payment, or other disputes that you may have. Dispute categories include:

- Payment disputes
- Contractual denials
- Allowable rate disputes
- Medical necessity denials
- Missing prior authorization

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Access the dispute form through this link:
https://providerinquiries.brighthealthcare.com/?_ga=2.141065969.239491180.1707148409-1164323799.1706891347

By using our provider dispute form, you avoid delays and receive an acknowledgment with a case number. For more information regarding federal and state mandated arbitration and mediation please see here (https://brighthealthcare.com/provider/out-of-network-regulated-disputes).

Please refer to your provider manual with any questions.

Appeals

Please keep in mind that most appeals must be submit ed within 180 days of the claim denial. It is your right to at empt an appeal for any claim decision. Please follow the instructions below.

The request for an appeal must include*:*

- The patient's name and their member ID (located on their member ID card)
- If post-service, the date(s) of the medical service(s) and the provider's name
- A description of the adverse determination, including what was denied
- The reason the member disagrees with the adverse determination
- Any documentation, including medical records, or other writ en information to support the member's position
- If the adverse determination is based on a contractual exclusion, the member may want to submit evidence from a medical professional indicating that there is a reasonable medical basis for the exclusion not to apply

Submit Appeals to:

IF enrolled in a policy through CA, GA, UT, or VA:

Fax #: (877) 471-0295

OR

Bright Health P.O. Box 1519 Portland, ME 04104

IF enrolled in a policy through AL, AZ, CO, FL, IL, OK, NC, NE, SC, or TN:

Fax #: (888) 965-1815

OR

Bright Health P.O. Box 16275 Reading, PA 19612

Utilization Management

The ability to request an authorization has passed. Please see below for instructions as it relates to claims decisions that have been impacted by lack of authorization.

- Timely filing for retrospective authorizations is 180 days from the date of service.
- If authorization is needed for the processing of a claim, file a provider's dispute on the denied claim and submit the supporting medical and/or clinical information to be reviewed for medical necessity.
- The request will be reviewed for medical necessity and will be either denied, partially approved, or approved.
- If the authorization is denied or partially approved due to the request not meeting medical necessity, Providers and/or member have the right to appeal. Please follow the appeal process as described previously in this document.
    - Prior Authorization List for 2022: 2022 IFP_SG PA List 20221001_Provider facing.xlsx (brighthealthplan.com)