NEW FOR 2021:
WellCare PPO Plans

WellCare of New Jersey is launching Preferred Provider Organization plans (local PPOs or LPPOs) in select counties: Atlantic, Bergen, Burlington, Camden, Cumberland, Essex, Gloucester, Hudson, Mercer, Middlesex, Monmouth, Morris, Ocean, Passaic, Somerset and Union.

Like many Medicare Advantage plans, LPPOs give members Part A, B and D coverage, and cover ancillary benefits not covered by Original Medicare such as dental, vision and hearing.

PPO plans give members additional flexibility to get health care services from providers who are outside of the plan's network. Like HMO plans, PPOs reimburse providers for all plan-covered, medically necessary services at **100% of the Medicare allowable rate**, but out-of-pocket costs for members are usually higher when they get services outside of the WellCare network.

Please also note these important points about LPPOs:

- Providers who do not contract with WellCare are under no obligation to treat our members, except in emergency situations.
- Providers must be eligible to participate in Medicare.
- Members do not need referrals or authorizations to see out-of-network providers.
- Members should ask the out-of-network provider to bill the plan first. However, if the member has already paid, WellCare will reimburse the member for our share of the cost for covered services.
- Although referrals and pre-service authorizations for out-of-network providers are not required, they are highly encouraged.

Quality care is a team effort.
Thank you for playing a starring role!

WellCare®
Beyond Healthcare. A Better You.

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Frequently Asked Questions About Preferred Provider Organizations

1. **How does an out-of-network provider file a pre-service evaluation request?**
   - Obtain a pre-service evaluation form (prior authorization request) at **www.wellcare.com**. From there, select > *Providers,* > *Forms,* and under > *Authorizations* select the appropriate form. Then submit by fax: **1-877-899-2044**.
   - Pre-service requests should be submitted prior to the planned service.
   - Providers will be notified of the decision by mail.
2. **How is medical necessity determined for out-of-network claims?**
   - The plan may request clinical documentation after claims submission to show that services or supplies are medically necessary for the prevention, diagnosis or treatment of the member's medical condition and meet accepted standards of medical practice.
   - For a list of services that require medical necessity evaluation, go to **www.wellcare.com**. From there, select > *Providers,* > *Authorization Lookup,* > *Resources* and > *Medicare Quick Reference Guide.*
3. **How does an out-of-network provider file a claim for Medicare-covered services?**

   WellCare has partnered with Change Healthcare, our preferred EDI Clearinghouse, to process your EDI transactions as efficiently as possible. You may connect directly to Change Healthcare. In some cases, your existing clearinghouse, billing service or trading partner may have existing reciprocal agreements with Change Healthcare. We encourage you to contact your claims vendor and determine if they have connectivity to Change Healthcare. If not, you may contact Change Healthcare at **1-866-855-4723** to establish **FREE** connectivity to WellCare for your EDI transactions. Clearinghouses, practice management vendors or billing services may call **1-800-527-8133** for help with EDI transactions.

If your clearinghouse or billing system is not connected to Change Healthcare and requires a 5-digit Payer ID, please use the following according to the file type (Fee-For-Service or Encounters).

WellCare Payer IDs

14163 Fee-For-Service - Professional or Institutional	59354 Encounters - Professional or Institutional

If your clearinghouse or billing system is connected to Change Healthcare and uses their 4-digit CPID, please use the following according to the file type (Fee-For-Service or Encounters).

Change Healthcare CPIDs

1844 Fee-For-Service - Professional	3211 Encounters - Professional
8551 Fee-For-Service - Institutional	4949 Encounters - Institutional

Although WellCare encourages electronic (EDI) claim submissions, we also accept paper CMS-1500 and UB-04 claim forms. Paper claims should only be submitted on original (red ink on white paper) claim forms.

Please refer to the Medicare Provider Manual on the WellCare web site for complete details about paper submission guidelines:
www.wellcare.com/New-Jersey/Providers/Medicare

Mail paper claim submissions to:

WellCare Claims
PO Box 31372
Tampa, FL 33631-3372

Please note that claims filed by providers who are not part of the network must be filed no later than 12 months after the date the services were furnished.

Become a WellCare Provider

We support our provider partners with quality incentive programs, quicker claims payments and dedicated local market support. To join the WellCare provider network, visit the WellCare website and complete the Become a Provider form. Go to **www.wellcare.com** and select your state. Under the > Provider tab, click on > *Join Our Network*.

4. **How does an out-of-network provider file a claim for supplemental benefits beyond Medicare-covered services?**

   Supplemental services vary by market and may include dental, hearing and vision benefits.

   - Call WellCare Provider Services at **1-855-538-0454** for more information.

5. **How can I help members with questions about benefits and covered services?**

   - As with any plan, the member's Evidence of Coverage (EOC) is the best resource to explain what benefits and/or services are available. Members can find their EOC and formulary information at **www.wellcare.com**. From there, the member should select the plan type > (*Medicare*), enter his or her ZIP code and click on > *Go to my plan details*.
   - Members may also call WellCare Customer Service at **1-833-444-9088**.