**IMPORTANT CONTACT INFORMATION**

**NURSE ADVICE LINE: 1-800-919-8807**
Members may call this number to speak to a nurse 24 hours a day, 7 days a week.

**MAILING ADDRESS:** P.O. Box 31370
Tampa, FL 33631

**BEHAVIORAL HEALTH CRISIS LINE: 1-800-411-6485**
Members may call this number 24 hours a day for a Behavioral Health Crisis. For non-crisis related concerns, please call Member Services.

**CONVENIENT SELF-SERVICE**

WellCare offers robust technology options to save you time. The fastest ways to get what you need are shown below.

**WellCare Secure Provider Portal**

<table>
<thead>
<tr>
<th>Service</th>
<th>Portal</th>
<th>Chat</th>
<th>(IVR) Interactive Voice Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authorization Requirements*</td>
<td>Fastest Result</td>
<td>Available</td>
<td>Available</td>
</tr>
<tr>
<td>Authorization Status*</td>
<td>Fastest Result</td>
<td>Available</td>
<td>Available</td>
</tr>
<tr>
<td>Authorizations Request*</td>
<td>Fastest Result</td>
<td>Available</td>
<td>N/A</td>
</tr>
<tr>
<td>Benefit Information</td>
<td>Fastest Result</td>
<td>Available</td>
<td>Available</td>
</tr>
<tr>
<td>Claims Status</td>
<td>Fastest Result</td>
<td>Available</td>
<td>Available</td>
</tr>
<tr>
<td>Co-payment</td>
<td>Fastest Result</td>
<td>Available</td>
<td>Available</td>
</tr>
<tr>
<td>Eligibility Verification</td>
<td>Fastest Result</td>
<td>Available</td>
<td>Available</td>
</tr>
<tr>
<td>Submit Appeals</td>
<td>Fastest Result</td>
<td>Available</td>
<td>N/A</td>
</tr>
<tr>
<td>Submit Claim Disputes</td>
<td>Fastest Result</td>
<td>Available</td>
<td>N/A</td>
</tr>
<tr>
<td>Submit Claims</td>
<td>Fastest Result</td>
<td>Available</td>
<td>N/A</td>
</tr>
<tr>
<td>Submit Corrected Claims</td>
<td>Fastest Result</td>
<td>Available</td>
<td>N/A</td>
</tr>
</tbody>
</table>

WellCare understands that having access to the right tools can help you and your staff streamline day-to-day administrative tasks. The Provider Portal will help with those routine tasks.

- Provider Portal Registration – [click here](#)
- Provider Portal Training – [click here](#)

*Note: Includes Pharmacy Medical Requests supplied by Physician.
For Pharmacy Benefit-related questions, please see the below Pharmacy page.

**For your convenience, language on this QRG in bold, underlined fonts are hyperlinks to supporting WellCare Provider Job Aids, Resource Guides and forms when the Quick Reference Guide is viewed in an electronic format.**

NOTE: This guide is not intended to be an all-inclusive list of covered services under WellCare Health Plans, Inc., but it substantially provides current referral and prior authorization instructions. Authorization does not guarantee claims payment. All services/procedures are subject to benefit coverage, limitations and exclusions as described in the applicable Plan coverage guidelines. (Revised April 2022)

PRO_94561E State Approved 05/12/2022
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NJ2PROGDE94561E_0000
CARE MANAGEMENT REFERRALS (NON-MLTSS MEMBERS)
Phone: 1-844-901-3781 TTY: 711
Fax: 1-866-287-3286 Hours: M-F 8-7 p.m. Eastern

COMMUNITY CONNECTIONS HELP LINE 1-866-775-2192
MCO CARE COORDINATION (SPECIAL NEEDS MEMBERS) 1-866-635-7045
DSNP PROVIDER SERVICES 1-877-706-9509
RISK MANAGEMENT Fraud, Waste & Abuse Hotline 1-866-685-8664

Prior Authorization Contacts*
To check the status of a prior authorization (medical, behavioral, pharmacy, dental) or changes to a prior authorization, please call Provider Services at 1-888-453-2534 or visit provider.wellcare.com.

For information regarding the status of a prior authorization for LTC (PCA, Medical Day Care, PDN, or HCBS) Please call 1-855-642-6185.

*WellCare’s process for prior authorization acknowledgement includes a response to the request and/or a request for additional information. There is no formal acknowledgement policy in place. However, providers may call Provider Services at 1-888-453-2534 to inquire on prior authorization requests not received within 15 days.

Care Management Programs: 1-855-642-6185

MLTSS Care Management:
Nursing Facility Contacts
• For requesting authorization Joan Cosme, Manager, Program Coordination, Joan.Cosme@wellcare.com or Mariel Plasencia, Supervisor, Program Coordination, Mariel.Plasencia@wellcare.com
• For claims, eligibility, enrollment and hospice issues: Providers can call 1-888-453-2534 or visit https://www.wellcarenewjersey.com/contact-us.html

For nursing facility providers to address questions regarding 835 files: #edianalyst@wellcare.com
• For a resident that is auto-assigned or self-selected the MCO and needs a NJ Choice Assessment performed: Teresa Howard, Manager, Prior Authorization & Referrals 1-973-848-7031 teresa.howard@wellcare.com
• For a SNF that has a resident that elects hospice: Teresa Howard, Supervisor Outpatient Care, 1-973-848-7031 or teresa.howard@wellcare.com

Care Management:
• Care Coordination contact for mailing address and fax number to send Provider Correspondence on behalf of Member – to contact WellCare separate from Utilization appeal information: 1-866-635-7045

Maternity Contact
• For prenatal and perinatal services for women, Providers and Members may call: 1-866-635-7045
• For in-network NJ FamilyCare perinatal services/providers (eg, obstetric/midwifery care, centering pregnancy, childbirth education, doula, labor and delivery, breastfeeding, newborn child coverage, dental, SUD, conception): Megan Rock, Care Manager, 1-866-635-7045 or megan.rock@wellcare.com

For your convenience, language on this QRG in bold, underlined fonts are hyperlinks to supporting WellCare Provider Job Aids, Resource Guides and forms when the Quick Reference Guide is viewed in an electronic format.
**FIDE SNP CARE MANAGEMENT**
- Care Coordination contact for mailing address and fax number to send Provider Correspondence on behalf of Member – to contact WellCare separate from Utilization appeal information: 1-866-635-7045
- FIDE SNP MLTSS contact: 1-855-642-6185

**BEHAVIORAL HEALTH SERVICES INCLUDING FIDE SNP**
- For claims, eligibility and enrollment issues: Providers can call 1-888-453-2534 or visit [https://www.wellcarenewjersey.com/contact-us.html](https://www.wellcarenewjersey.com/contact-us.html)
- For participating providers and services as well as authorization process: Lisa Dolmatz, Director, Behavioral Health Services, 1-973-848-3024, lisa.dolmatz@wellcare.com
- For Office Based Addiction Treatment (OBAT) Services: Providers can call 1-888-453-2534 or visit [https://www.wellcarenewjersey.com/contact-us.html](https://www.wellcarenewjersey.com/contact-us.html)

**HOME AND COMMUNITY BASED SERVICES**
- For Chore Services and other non-traditional MLTSS services: Anny Chevlier, Provider Network Specialist, 1-973-985-5283 or anny.chevalier@wellcare.com
- For Hospital Billing Contact
- For hospital billing staff to address questions regarding claim denials: Oscar Morales, Senior Manager, Contracting & Network Development, 1-973-634-2640 or oscar.morales@wellcare.com

**PROVIDER RESOURCE GUIDE CONTINUED**

**JOINING WELLCare’S PROVIDER NETWORK**
To ask whether WellCare is accepting new providers or to check on an existing application:
- Call 1-973-274-2100, option 2
- Email NJPR@wellcare.com

To submit an application for enrollment in WellCare’s provider network:
- Contact Provider Relations:
  1. Call 1-973-274-2100
  3. Send an email inquiry to NJPR@wellcare.com
- Schedule a meeting
- Receive application
- Sign and return application including all up to date credentialing documents. All credentialing documents must not expire within the following 60 days after submission.

To submit application for network consideration:
- For Medical, Behavioral and HCBS – Mail to 550 Broad St. 12th Floor Newark, NJ 07102
- For Dental – Contact Liberty Dental at 1-888-352-7924 to be added to the WellCare panel
- For Vision – Contact Superior Vision at 1-866-819-4298 to be added to the WellCare panel
- For Hearing – Contact HearUSA at 1-800-333-3389 to be added to the WellCare panel

*Completing the online form or sending an email is an inquiry for consideration and not an official registration. WellCare will review the request, and a representative will follow up and provide assistance through the formal application process.
Application process can take up to 90 days.

**WELLcare WEBSITE**
Visit [https://www.wellcarenewjersey.com/providers/medicaid.html](https://www.wellcarenewjersey.com/providers/medicaid.html) to:
- Search for providers by county (includes visibility into open/closed panels) by clicking on “Find a Provider”
- Review the Provider Resource Guide
- Access Claims/Encounter Guides and other Job Aids
- Access the secure Provider Portal

For your convenience, language on this QRG in bold, underlined fonts are hyperlinks to supporting WellCare Provider Job Aids, Resource Guides and forms when the Quick Reference Guide is viewed in an electronic format.
SECURE PROVIDER PORTAL

THE SECURE PROVIDER PORTAL OFFERS 24-HOUR ACCESS TO THE FOLLOWING:

- Submit a claim
- Request an authorization
- Check status of a claim
- Check status of a prior authorization
- Check member eligibility and co-payment information
- Access online training
- Run reports e.g., Member Panel
- Catch up on provider news
- Submit and Check Care Gaps (PCPs)

Log onto the web portal at [https://provider.wellcare.com/](https://provider.wellcare.com/)

To register to use the secure provider portal, an account will need to be created. The following is needed to create a new account:

- Name of Person to Access Account
- Primary Group or Physician address
- Phone Number for the Group or Physician

Additionally, the following actions need to be taken:

- Provider must assign an Administrator whether there is one or many users
- Within 24 hours of registration, an email with a temporary password will be sent. Use this password (within 30 days) to log into the portal and create a permanent password to complete the registration process.
- Once access portal, there are training videos and materials on using it.

CLAIM SUBMISSION INFORMATION

**SUBMISSION INQUIRIES:**
**Provider Services: 1-888-453-2534**
For inquiries related to your electronic submissions to WellCare, please contact our EDI team at EDI-Master@wellcare.com

**ELECTRONIC FUNDS TRANSFER AND ELECTRONIC REMITTANCE ADVICE:**
Register online using the simplified, enhanced provider registration process: PaySpan.com or call 1-877-331-7154. For more details on PaySpan, please refer to your Provider Manual.

**CLEARINGHOUSE CONNECTIVITY SETUP & CONNECTION SUPPORT:**
WellCare has partnered with Change Healthcare as our preferred EDI Clearinghouse. You may connect directly to Change Healthcare or in some cases your existing clearinghouse, billing service, or trading partner may maintain 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 want to consider contacting Change Healthcare to establish free connectivity to WellCare for your EDI transactions.

Change Healthcare offers Submitter/client Connectivity Services at 1-877-411-7271. All Clearinghouses, Practice Management Vendors or Billing Services may call Change Healthcare, at 1-800-527-8133 for connectivity services.

**CHANGE HEALTHCARE CPIDS:**
If your billing system is connected to Change Healthcare and requires a 4-digit Change Healthcare payer ID, please use the following according to the file type (Fee-For-Service or Encounters):

<table>
<thead>
<tr>
<th>Claim Type</th>
<th>Fee-for-Service (CH - Chargeable) Submissions</th>
<th>Encounter (RF - Reporting only) Submissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional</td>
<td>1844</td>
<td>3211</td>
</tr>
<tr>
<td>Institutional</td>
<td>8551</td>
<td>4949</td>
</tr>
</tbody>
</table>

**WELLCARE PAYER IDs** – If your clearinghouse or billing system is not connected to Change Healthcare and requires a five-digit Payer ID, please use the following according to the file type (Fee-For-Service or Encounters):

- Fee For Service (FFS) is defined in the Transaction Type Code BHT06 as CH, which means Chargeable, expecting adjudication.
- Encounters (ENC) is defined in the Transaction Type Code BHT06 as RP, which means Reportable only, NOT expecting adjudication.

<table>
<thead>
<tr>
<th>Claim Type</th>
<th>Fee For Service (CH - Chargeable) Submissions</th>
<th>Encounter (RF - Reporting only) Submissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional</td>
<td>14163</td>
<td>59354</td>
</tr>
<tr>
<td>Institutional</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**FREE DIRECT DATA ENTRY (DDE) AND SMALL BATCH FILE SOLUTIONS (USE SAME WELLCARE PAYER IDS DEFINED ABOVE):**
AdminisTEP offers a web browser for single submission direct data entry (DDE) or batch upload for professional
and institutional submissions, claim status and reporting 
and inquiry functions at no cost to you. To sign up, go to 
http://www.administep.com/Signup.aspx or call 
1-888-751-3271.

ConnectCenter™ for physicians offers a web browser 
for direct data entry (DDE) or batch upload capability 
at no cost to you. To sign up, go to: https://physician. 
connectcenter.changehealthcare.com.

For registry questions, submitter/clients may contact Payer 
Connectivity Services at 1-877-411-7271. Direct questions 
regarding functionality of ConnectCenter to the Change 
HealthCare at 1-800-527-8133, opt 2.

- Providers will be required to enter a credit card upon 
  initial enrollment to verify them as a valid submitter.
- Only WellCare submissions are free of charge. Please 
  ensure you use vendor code 212750 when you register.

WellCare follows the Centers for Medicare and Medicaid 
Services’ (CMS) guidelines for paper claim submissions. 
Since Oct. 28, 2010, WellCare accepts only the original 
“red claim” form for claim and encounter submissions. 
WellCare does not accept handwritten, faxed or replicated 
claim forms. To download claim forms and guidelines and 
to check the status of an initial claim submission and/or 
adjusted and appealed claims, visit www.wellcare.com/
New-Jersey/Providers/Medicaid/Claims.

Paper claims (new and corrected) are verified by the 
provider portal.

MAIL PAPER CLAIM SUBMISSIONS TO:
WellCare Health Plans 
Claims Department 
P.O. Box 31224 
Tampa, FL 33631-3224

CLAIM PAYMENT DISPUTES

The claim payment dispute process is designed to address claim denials for issues related to untimely filing, unlisted 
procedure codes and noncovered codes, etc. Claim payment disputes must be submitted in writing to WellCare within 
90 days of the date on the EOP.

Submit all claims payment disputes with supporting documentation at https://provider.wellcare.com/

MAIL CLAIM PAYMENT DISPUTES WITH 
SUPPORTING DOCUMENTATION TO:
WellCare Health Plans 
Attn: Claim Payment Disputes 
P.O. Box 31370 
Tampa, FL 33631-3370

Note: Any appeals related to a claim denial for lack of prior authorization, services exceeding the authorization, 
insufficient supporting documentation or late notification must be sent to the Appeals (Medical) address in the 
section below. Examples include Explanation of Payment Codes DN001, DN004, DN0038, DN039, VSTEX, DMNNE, 
HRM16, and KYREC, however, this is not an all-encompassing list of Appeals codes. Anything else related to 
authorization, or medical necessity that is in question should be sent to the Appeals PO Box with all substantiating 
information like a summary of the appeal, relevant medical records and member specific information.

For your convenience, language on this QRG in bold, underlined fonts are hyperlinks to supporting WellCare Provider Job 
Aids, Resource Guides and forms when the Quick Reference Guide is viewed in an electronic format.
CLAIM PAYMENT POLICY DISPUTES

The Claims Payment Policy Department has created a new mailbox for provider issues related strictly to payment policy issues. Disputes for payment policy related issues must be submitted to WellCare in writing within 90 days of the date of denial on the EOP. Please provide all relevant documentation, which may include medical records, in order to facilitate the review. Submit all Claims Payment Policy Disputes related to Explanation of Payment Codes beginning with IH###, CE###, CV### (Medical records required) or PD### at https://provider.wellcare.com/

MAIL ALL DISPUTES RELATED TO EXPLANATION OF PAYMENT CODES BEGINNING WITH IH###, CE###, CV### (MEDICAL RECORDS REQUIRED) OR PD### TO:

WellCare Health Plans
Payment Policy Disputes Department
P.O. Box 31426
Tampa, FL 33631-3426

MAIL ALL MEDICAL RECORDS AND INITIAL REVIEWS AND 1ST LEVEL APPEALS RELATED TO EXPLANATION OF PAYMENT CODES BEGINNING WITH CPI##:

BY MAIL (U.S. POSTAL SERVICE)
Phone: 1-844-458-6739
Fax: 1-267-687-0994
OPTUM
P.O. Box 52846
Philadelphia, PA 19115

BY DELIVERY SERVICES (FEDEX, UPS)
OPTUM
458 Pike Road
Huntingdon Valley, PA 19006

BY SECURE INTERNET UPLOAD
Refer to Optum’s Medical Record Request letter for further instructions

MAIL ALL DISPUTES RELATED TO EXPLANATION OF PAYMENT CODES LT###, RVLT# AND CPI## 2ND LEVEL APPEALS:

WellCare Health Plans
CCR
P.O. Box 31394
Tampa, FL 33631-3394

MAIL ALL DISPUTES RELATED TO EXPLANATION OF PAYMENT CODES RVPI#:

PICRA
P.O. Box 31416
Tampa, FL 33631-3416

MAIL ALL DISPUTES RELATED TO EXPLANATION OF PAYMENT CODES RVPI#:

PICRA
P.O. Box 31416
Tampa, FL 33631-3416

RECOVERY/COST CONTAINMENT UNIT (CCU)

If you do not agree with this proposed WellCare overpayment notification related to adjustments RVXX (Except RV059 that should refer to the Claim Payment Disputes section above), you may request an Administrative Review by submitting your request in writing within 45 days of the date of this letter. Your request should detail why you disagree with these findings and must include any supporting evidence/documentation you believe is pertinent to your position.

REFUND(S) in response to a WellCare overpayment notification should include a copy of the overpayment notification as well as a copy of attachment(s) and sent to:

WELLCARE – COMPREHENSIVE HEALTH MANAGEMENT
Atten: Recovery/Cost Containment Unit (CCU)
PO Box 947945
Atlanta, GA 30394-7945

MAIL OR FAX YOUR ADMINISTRATIVE REVIEW REQUEST TO:
Fax: 1-813-283-3284
WellCare Health Plans
Attn: CCU Recovery
P.O. Box 31658
Tampa, FL 33631-3658

Additional documentation received after your initial Administrative Review request will not be considered. A Final Determination will be rendered within 30 days of the date of WellCare’s receipt of your request. If you do not object or render payment within such time period, we will take action to recover the above listed amount as allowed by law, or applicable, the contract between you and WellCare.

For your convenience, language on this QRG in bold, underlined fonts are hyperlinks to supporting WellCare Provider Job Aids, Resource Guides and forms when the Quick Reference Guide is viewed in an electronic format.
Providers may file an appeal on behalf of the member with the member’s written consent. Providers may also seek an appeal through the Appeals department within **90 calendar days** of a claims denial for lack of prior authorization, services exceeding the authorization, insufficient supporting documentation or late notification. Examples include Explanation of Payment Codes DN001, DN004, DN0038, DN039, VSTEX, DMNNE, HRM16, and KYREC. However, this is not an all-encompassing list of Appeals codes. Anything else related to authorization, or medical necessity that is in question should be sent to the Appeals P.O. Box with all substantiating information like a summary of the appeal, relevant medical records and member specific information.

**MAIL OR FAX MEDICAL APPEALS WITH SUPPORTING DOCUMENTATION TO:**
Fax: 1-866-201-0657  
WellCare Health Plans  
Attn: Appeals Department  
P.O. Box 31368  
Tampa, FL 33631-3368

WellCare does not send an acknowledgement letter upon receipt of a provider appeal. However, a written resolution letter is sent to the provider.

**GRIEVANCES**

Member grievances may be filed verbally by contacting Customer Service or submitted via fax or mail. Providers may also file a grievance on behalf of the member with the member’s written consent.

**MAIL OR FAX ALL MEMBER GRIEVANCES TO:**
Fax: 1-866-388-1769  
WellCare Health Plans  
Attn: Grievance Department  
P.O. Box 31384  
Tampa, FL 33631-3384

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**eviCore**

*eviCore* is our in-network vendor for the following programs and clinical criteria can be accessed through the corresponding program links: **Lab Management** and **Sleep, Diagnostics**.

Contact eviCore for all **authorization-related** submissions for the services listed above rendered in outpatient places of service (including the home setting). Please click on the hyperlinks above for a list of the specific services and related criteria included in the eviCore programs.

Web submissions are faster and if the procedure requested meets clinical criteria, the web provides an immediate approval that can be printed for easy reference. Member eligibility and authorization requests may be submitted via the **eviCore Provider Web Portal**. A searchable **Authorization Lookup and Eligibility Tool** is also available online and criteria can be accessed through the program links above.

**Urgent Authorizations and Provider Services:** 1-888-333-8641

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**NIA aka National Imaging Associates**

*NIA* (National Imaging Associates) is our in-network vendor for the following programs and clinical criteria can be accessed through the corresponding program links: **Advanced Radiology**, **Advanced Cardiology**, **Pain Management**, **Physical**, **Occupational**, and **Speech Therapy**.

Contact NIA for all **authorization-related** submissions for the services listed above rendered in outpatient places of service (including the home setting*). Please click on the hyperlinks above for a listing of the specific services and related criteria included in the NIA program. Web submissions are faster and if the procedure requested meets clinical criteria, the web provides immediate approval that can be printed for easy reference. Member eligibility and authorization requests may be submitted via the **NIA Provider Web Portal**. A searchable **Authorization Lookup tool** is also available online and criteria can be accessed through the program links above.

**Urgent Authorizations and Provider Services:** 1-866-249-1583

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**HealthHelp**

*HealthHelp* is our in-network vendor for the following programs and provider resources, The vendor can be accessed through the corresponding program links: **Radiation Therapy and Medical Oncology**.

Contact HealthHelp for all **authorization-related** submissions for the services listed above rendered in all outpatient places of service. Please click on the links above for a listing of the specific services and related resources included in the HealthHelp programs.

Member eligibility and authorization request materials may be accessed via the **HealthHelp Portal**. A searchable **Authorization Lookup** is also available online to check the status of your authorization request and criteria can be accessed through the program links above.

**Urgent Authorizations and Provider Services:** 1-888-210-3736

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**Contracted Networks**

<table>
<thead>
<tr>
<th>VISION</th>
<th>HEARING</th>
<th>TRANSPORTATION</th>
</tr>
</thead>
</table>
| Superior Vision (Includes FIDE SNP)  
Provider Services: 1-866-819-4298 | HearUSA (Includes FIDE SNP)  
Phone: 1-800-333-3389 | Phone: 1-888-453-2534  
*Please confirm benefit coverage and limitations at member’s plan level.* |

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**Dental Services**

**LIBERTY DENTAL PLAN**

Dental Provider Services (Liberty Dental Plan): 1-888-352-7924 (Both FIDE SNP/Medicaid)

Fax: 1-800-268-0154

Email (Provider Relations Inquiry): prinquiries@libertydentalplan.com

Website Address and Link to Liberty Provider Manual:

https://www.libertydentalplan.com/Providers/Provider-Resource-Library.aspx


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NJ FAMILYCARE DENTAL SERVICES CLINICAL CRITERIA POLICY/GRID:
The NJFC program has established a clinical criteria policy for dental services. Please see the link below for a full description of the clinical criteria policy/guidelines and grid. [https://www.libertydentalplan.com/Providers/Provider-Resource-Library.aspx](https://www.libertydentalplan.com/Providers/Provider-Resource-Library.aspx)

TREATMENT FOR DENTAL EMERGENCIES (TO INCLUDE ORAL-FACIAL TRAUMA)
- Claims received for reimbursement are date stamped on arrival.
- Matched with authorizations, logged into system.

SUMMARY OF PROCEDURES REGARDING APPROVAL AND/OR CLAIMS PAYMENT FOR OUT OF STATE AND OUT OF NETWORK PROVIDERS
In order for a claim to be accepted and adjudicated, the claim must be received by Liberty within 90 days after the date of service for contracted providers and within 180 days after the date of service for non-contracted providers. In order for a claim to be considered a “complete claim,” it must contain, at a minimum, all the attachments and supplemental information or documentation needed to provide “reasonably relevant information” and “information necessary to determine payer liability” and the following information:

- Provider name and license number
- Provider facility address
- Member name, date of birth, and social security number
- Date(s) of service
- ADA/CDT 9 codes
- Billed charges for each services
- Provider tax ID number or social security number

The “complete claim” may be submitted electronically, via paper, or other agreed upon method. The attachments or supplemental information/documentation needed varies by provider type and service but must provide the minimum information to properly adjudicate the claim and determine payer liability. Although emergency services or out-of-area urgently needed services do not require authorization in order to be considered a “complete claim,” the claim must include documentation, including X-rays, that is immediately identifiable as emergent or out-of-area urgent.

DENTAL DIRECTORIES:
The following directories can be found on our website at [https://www.wellcare.com/en/New-Jersey/Members/Medicaid-Plans/NJ-FamilyCare](https://www.wellcare.com/en/New-Jersey/Members/Medicaid-Plans/NJ-FamilyCare)
- The NJFC Directory of Dentists Treating Children under the Age of 6
- Directory of Dentists Treating Members with Intellectual and Developmental Disabilities - Adults and Children) and listing of all dental providers to include specialists

All providers, including specialists, can be found in our - Find a Provider/Pharmacy tool: [https://www.wellcare.com/new-jersey/Find-a-Provider?coverage=Medicaid#/Results](https://www.wellcare.com/new-jersey/Find-a-Provider?coverage=Medicaid#/Results)

All the directories are also on our vendor’s website at: [Liberty Dental Plan|Wellcare Find a Dentist](https://www.wellcare.com/new-jersey/Find-a-Provider?coverage=Medicaid#/Results)

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ACARIAHEALTH™

AcariaHealth is a national comprehensive specialty pharmacy focused on improving care and outcomes for patients living with complex and chronic conditions. AcariaHealth is comprised of dedicated healthcare professionals who work closely with physician's offices, including support with referral and prior authorization processes. This collaboration allows our patients to receive the medicine they need as fast as possible.

Representatives are available from Monday–Thursday, 8 a.m. to 7 p.m., and Friday, 8 a.m. to 6 p.m. ET.

*Effective on or about July 2021

MAIL SERVICES PHARMACY
CVS/Caremark® Mail Service

Phone: 1-866-808-7471
TTY: 1-866-236-1069
Fax: 1-866-892-8194

Website: www.acariahealth.com

MEDICATION APPEALS:

Mail medication appeals forms with supporting documentation to:

WellCare Health Plans
Attn: Pharmacy Appeals Department
P.O. Box 31398
Tampa, FL 33631-3398

Medication appeals may also be initiated verbally by contacting Provider Services. Please note that all appeals filed verbally also require a signed, written appeal.

PDL INCLUSIONS:

To request consideration for inclusion of a drug to WellCare of New Jersey’s PDL, providers may submit medical justification to WellCare in writing to:

WellCare Health Plans
Director of Formulary Services
Pharmacy & Therapeutics Committee
P.O. Box 31577
Tampa, FL 33631-3577

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For full list of Prior Authorizations requirements access www.wellcare.com/en/New-Jersey/Providers/Authorization-Lookup

PRIOR AUTHORIZATION (PA) REQUIREMENTS

This WellCare Prior Authorization list supersedes any lists that have been distributed to our providers. Please ensure that older lists are replaced with this updated version. Authorization changes are denoted by a symbol for easy identification. Requirements that have been edited for clarification only are denoted with a symbol.

WellCare supports the concept of the PCP as the “medical home” for its members. PCPs may refer members to network specialists when services will be rendered at an office, clinic or free-standing facility. A written or faxed script to the specialist is required. The reason for the referral and the name of the specialist must be documented in the medical record. The specialist must document receipt of the request for a consultation and the reason for the referral in the medical record. No communication with the plan is necessary. Specialists may not refer members directly to other specialists.

To check the status of a prior authorization (medical, behavioral, pharmacy, dental) or changes to a prior authorization, please call: Provider Services at 1-888-453-2534 or visit provider.wellcare.com

For information regarding the status of a prior authorization for LTC (PCA, Medical Day Care, PDN, or HCBS), please call 1-855-642-6185.

Urgent Authorization Requests and Admission Notifications – Call 1-888-453-2534 for Medical, Behavioral, SUD, PCS, MLTSS, Pharmacy

- Web submissions are faster, and if the procedure requested meets the clinical criteria, the Web provides an approval that can be printed for easy reference
- Notify the plan of unplanned inpatient hospital admissions within 24 hours of admission (except normal maternity delivery admissions). Telephone authorizations must be followed by a fax submission of clinical information to 1-855-776-9464 – by the next business day.
- Outpatient authorizations for urgent and time sensitive services may be requested by phone when warranted by the member’s condition. Please include CPT and ICD-10 codes with your authorization request. Standard authorization requests may be submitted online or via fax using the numbers listed below if you are unable to access the portal with your secure login at https://provider.wellcare.com.
- Obtaining authorization does not guarantee payment, but rather only confirms whether a service meets WellCare’s determination criteria at the time of the request. WellCare retains the right to review benefit limitations and exclusions, beneficiary eligibility on the date of service, the medical necessity of services, and correct coding and billing practices.

For Urgent and Inpatient Hospitalization Authorizations and Provider Services Phone: 1-888-453-2534

Please log in to submit your Outpatient Authorization Requests & Inpatient Clinical only (not Authorization) Submissions. To fax a request, please access our forms here

Web-based information: www.wellcare.com/New-Jersey/Providers/Medicaid/Behavioral-Health

- Emergency behavioral services do not require prior authorization. In order to obtain authorization, notification of an Inpatient admission is required on the next business day following admission.
- Inpatient concurrent review is generally done by telephone, but a fax option is available and the forms and fax numbers can be found here. Psychological testing is done telephonically or via fax. All other levels of care requiring authorization including outpatient services can be submitted online.
- For Behavioral Health Crisis call 1-888-453-2534
- For more information on Authorization Requirements click here and select the “Prior Authorization Grid” PDF under Helpful Documents
- Please submit your request for more sessions at least two weeks prior to the completion of the current authorized session(s). Behavioral Health Services are performed by WellCare network providers.

For your convenience, language on this QRG in bold, underlined fonts are hyperlinks to supporting WellCare Provider Job Aids, Resource Guides and forms when the Quick Reference Guide is viewed in an electronic format.
### EMERGENCY SERVICES

<table>
<thead>
<tr>
<th>Procedures and Services</th>
<th>Authorization Required</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Behavioral Health Services</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Non-contracted (non-participating)</td>
<td>Yes</td>
<td>All services from non-participating providers require authorization.</td>
</tr>
<tr>
<td>Provider Services</td>
<td>See Comments</td>
<td>The list of authorizations on the Quick Reference Guide is not the complete list. Please refer to the Prior Authorization Grid under Helpful Documents for a complete list of authorization requirements.</td>
</tr>
<tr>
<td>Behavioral Services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### INPATIENT SERVICES & DISCHARGE PLANNING

**Wellcare Secure Provider Portal**

Please [log in](#) to submit your Outpatient Authorization Requests & Inpatient Hospitalization Clinical only (not Authorization) Submissions.

For non-participating providers please use our form [here](#)

Discharge planning requests for Home Health and DME should be submitted separately using one of the methods outlined above.

<table>
<thead>
<tr>
<th>Procedures and Services</th>
<th>Authorization Required</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective Inpatient Procedures</td>
<td>Yes</td>
<td>Clinical updates required for continued length of stay.</td>
</tr>
<tr>
<td>Inpatient Admissions</td>
<td>Yes</td>
<td>Clinical updates required for continued length of stay. *Excludes Normal Newborn Deliveries</td>
</tr>
<tr>
<td>Long Term Acute Care Hospital (LTACH) Admissions</td>
<td>Yes</td>
<td>Clinical updates required for continued length of stay.</td>
</tr>
<tr>
<td>NICU/Sick Baby Admissions</td>
<td>Yes</td>
<td>Notification to the plan is required within 24 hours following admission. Contact <a href="#">ProgenyHealth</a> at fax 1-844-395-0842 to submit clinical updates for initial and continued length of stay.</td>
</tr>
<tr>
<td>Normal Newborn Deliveries</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

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<table>
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<tr>
<th>Procedures and Services</th>
<th>Authorization Required</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observations (22)*</td>
<td>See Comments</td>
<td>①Elective procedures that convert to an Observation stay are subject to Outpatient authorization requirements. Authorization Lookup Tool Services performed during an urgent or emergent Observation stay, such as Advanced Radiology or Cardiology, do not require authorization. Clinical updates required for continued length of stay.</td>
</tr>
<tr>
<td>Rehabilitation Facility Admissions</td>
<td>Yes</td>
<td>Clinical updates required for continued length of stay.</td>
</tr>
<tr>
<td>Skilled Nursing Facility Admissions</td>
<td>Yes</td>
<td>Clinical updates required for continued length of stay.</td>
</tr>
</tbody>
</table>

### OUTPATIENT SERVICES & DISCHARGE PLANNING

**WELLCARE SECURE PROVIDER PORTAL**

**MLTSS members:** All Outpatient services  Fax: 1-855-573-2346  
**Non MLTSS members:** Please log in to submit your Outpatient Authorization Requests & Inpatient Hospitalization Clinical only (not Authorization) Submissions. For non-participating providers please use our form here  
Pharmacy Medical Requests  Fax: 1-888-481-7703  
Discharge planning requests for Home Health and DME should be submitted separately using one of the methods outlined above.

<table>
<thead>
<tr>
<th>Procedures and Services</th>
<th>Authorization Required</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Select Outpatient Procedures</td>
<td>Yes – See Comments</td>
<td>Please refer to the Authorization Lookup Tool for prior authorization requirements.</td>
</tr>
<tr>
<td>Dialysis and End Stage Renal Disease Services</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Procedures and Services</td>
<td>Authorization Required</td>
<td>Comments</td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
<td>------------------------</td>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Durable Medical Equipment purchases and rentals</td>
<td>Yes – See Comments</td>
<td>All DME rentals require authorization. DME purchase items reimbursed at OR below $500 per line item do NOT require authorization. DME contact: Darlene Yard, Durable Medical Equipment Coordinator, 1-973-848-3076 or <a href="mailto:darlene.yard@wellcare.com">darlene.yard@wellcare.com</a>. *For Home Infusion/Enteral Services please refer to the Pharmacy Section above for the preferred provider if the authorization is required.</td>
</tr>
<tr>
<td>Home and Community Based Services – Benefit for MLTSS Members Only</td>
<td>Yes</td>
<td>Refer to <strong>Clinical Coverage Guidelines</strong></td>
</tr>
<tr>
<td>Hospice Care Services</td>
<td>Yes</td>
<td>Refer to <strong>Clinical Coverage Guidelines</strong></td>
</tr>
<tr>
<td>Investigational &amp; Experimental Procedures and Treatment</td>
<td>Yes – See Comments</td>
<td>Refer to <strong>Clinical Coverage Guidelines</strong></td>
</tr>
<tr>
<td>Laboratory Management (Certain Molecular and Genetic Tests)</td>
<td>Yes – See Comments</td>
<td>Contact eviCore for authorization: eviCore Provider Web Portal Phone Number: 1-888-333-8641 <a href="#">WellCare Lab Management Criteria</a> Molecular and Genetic Testing Quick Reference Guide</td>
</tr>
<tr>
<td>Non-contracted (nonparticipating) Provider Services</td>
<td>Yes</td>
<td>All services from nonparticipating providers require authorization.</td>
</tr>
<tr>
<td>Orthotics and Prosthetics</td>
<td>Yes – See Comments</td>
<td>Purchase items reimbursed at OR below $500 per line item do NOT require authorization.</td>
</tr>
</tbody>
</table>

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<tr>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Phone: 1-866-249-1585</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Radiation Therapy Management</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Program Criteria</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Radiation Therapy Worksheets</td>
</tr>
<tr>
<td>Radiation Therapy Management</td>
<td>Yes – See Comments</td>
<td>Contact HealthHelp for authorization: HealthHelp Portal</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Phone Number: 1-888-210-3736</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Radiation Therapy Management</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Program Resources</td>
</tr>
<tr>
<td>Sleep Diagnostics (11, 12, 22 &amp; 49)*</td>
<td>Yes – See Comments</td>
<td>Contact eviCore for authorization: eviCore Provider Web Portal</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Phone Number: 1-888-333-8641</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sleep Diagnostics Program Criteria</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sleep Management Worksheets</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Phone: 1-866-249-1585</td>
</tr>
<tr>
<td>Transportation (Nonmedical) – Benefit for MLTSS Members Only</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

**PERSONAL CARE SERVICES**

**WELLCARE SECURE PROVIDER PORTAL**

Personal Care Service Requests  Fax 1-855-573-2346

For any Electronic Visit Verification (EVV)-related question or support, please email HHAeXchange at NJsupport@hhaexchange.com

<table>
<thead>
<tr>
<th>Procedures and Services</th>
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<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Care Assistants</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Medical Day Care</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

**TRANSLANT SERVICES**

**WELLCARE SECURE PROVIDER PORTAL**

Please log in to submit your Outpatient Authorization Requests & Inpatient Hospitalization Clinical only (not Authorization) Submissions. For non-participating providers please use our form here.

<table>
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<tr>
<th>Procedures and Services</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Transplant Services</td>
<td>Yes</td>
<td>Please submit clinical records for prior authorization for all transplant phases</td>
</tr>
</tbody>
</table>

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COORDINATION OF BENEFITS (COB) FREQUENTLY ASKED QUESTIONS

1. **Q:** What is the contact number and/or email address for questions related to COB?
   **A:** Providers can call 1-888-453-2534 or visit https://www.wellcarenewjersey.com/contact-us.html

2. **Q:** If a member is dually eligible or has a TPL policy how often does the provider have to submit a denial from Medicare and/or the TPL insurer?
   **A:** The Provider will have to submit a denial from Medicare and/or the TPL, annually as long as the Member is covered under the plan or until the coverage is termed.

3. **Q:** Does the Provider submit the denial from the Medicare and/or Commercial Insurance provider electronically or hard copy?
   **A:** The submission can be submitted both paper and electronic.

4. **Q:** If the EOB denial can be submitted in hard copy what is the address for submission?
   **A:** WellCare Health Plans
   Attn: Claim Payment Department
   P.O. Box 31224
   Tampa, FL 33631-3224

5. **Q:** How do providers track progress of paper copies of the EOB for individual members?
   **A:** Provider will have to register to PaySpanHealth.com. PaySpan Health offers providers a complete solution for claims payment management. Providers can manage multiple payers, choose from among common and proprietary formats for ERAs, easily reconcile payments with claims, and take advantage of claim and remittance retrieval and reporting. Providers can contact PaySpan Health by calling 1-877-331-7154 or providersupport@payspanhealth.com.

6. **Q:** What is required for Providers to submit to WellCare if Member has Medicare and/or Commercial Insurance and the Provider does not participate in the Medicare and/or Commercial Network?
   **A:** The Provider will have to submit to the Primary Insurance Carrier first even if the Provider does not participate in the Medicare and/or Commercial Network. If the Member has a primary insurance carrier, WellCare requires a copy of the explanation of payment from the other carrier before paying as primary.

7. **Q:** Who do providers contact for technical assistance regarding claims submission and coordination of benefits for dually eligible members and members with Commercial Insurance?
   **A:** Providers can contact Provider Services at 1-888-453-2534 for questions related to claim submissions. For inquiries related to your electronic submissions to WellCare, please contact our EDI team at EDI-Master@wellcare.com. Claim forms and guidelines are found online at www.wellcare.com/New-Jersey/Providers/Medicaid/Claims.