



# 2026 Provider Orientation

ATC-03252026-AP-1





wellcare™

# Welcome to Your 2026 Provider Orientation

*Ready. Set. Onboard.*



## *Welcome to Absolute Total Care*

As a key partner in supporting the health of South Carolinians, your onboarding experience is designed to equip you with the clarity, resources and confidence needed to work effectively within our plan. During this orientation, we'll review essential operational processes, key contacts, prior authorization expectations, provider tools, and workflow guidance to support your daily practice. Our goal is to ensure you are set up to deliver efficient, high-quality care while keeping provider interactions simple, timely, and supportive.

# Agenda

## 1 Welcome to Your 2026 Provider Orientation

- Introduction to Absolute Total Care
- Provider Engagement Account Management Support

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- South Carolina Medicaid Overview
  - Medicaid Member Benefits, Covered Services and Incentives
  - Health Insurance Mobile App
  - Provider Enrollment
  - Recordkeeping Requirements
- Dual Special Needs Plan (DSNP) Overview
- Ambetter Overview
- Medicare Advantage Overview
  - Model of Care Overview and Process

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- Provider Secure Web Portal
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  - Availity Essentials
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## 6 Credentialing Rights

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- Interpreter / Translation Services

## 8 Annual Provider Training

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- Claims, Adjustments and Disputes
- Rejections and Denials

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## 12 Quality Improvement

- Partnership for Quality (P4Q)
- CAHPS<sup>®</sup> Consumer Assessment of Healthcare Providers and Systems

## 13 Accessibility and Availability Standards

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# Provider Engagement Account Manager Support



Your dedicated partner for operational and performance success

## Administrative & Operational

- Admin policies & procedures
- Operational questions/issues
- Contract clarification
- Roster questions
- Portal & PaySpan support

## Performance & Education

- Performance monitoring
- Education & training
- Financial analysis
- Demographic updates



Your **Account Manager** is here to help you navigate processes, solve issues, and stay informed.

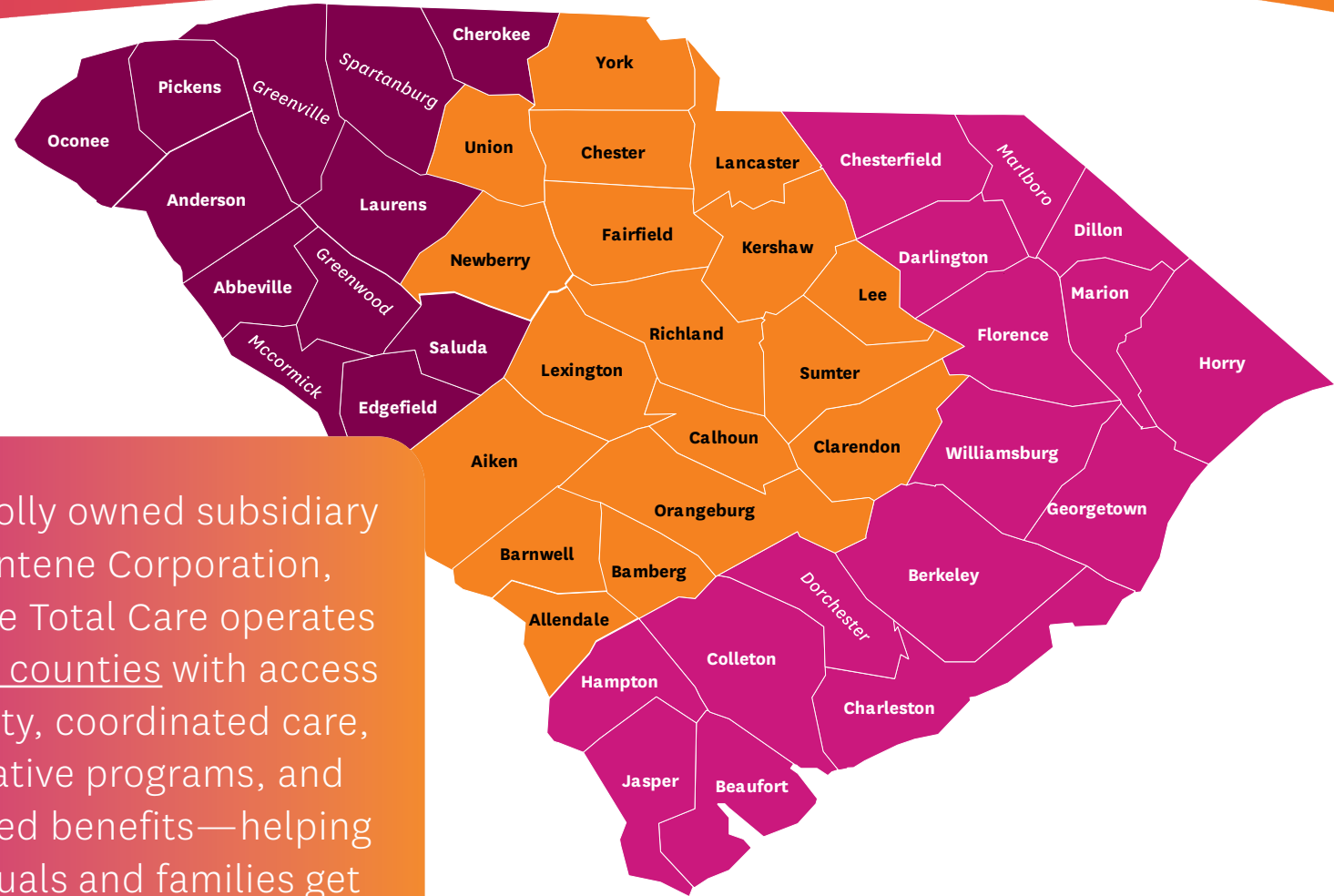
<https://www.absolutetotalcare.com/providers/find-my-provider-engagement-acct-manager.html>

# Introduction to Absolute Total Care

## About Absolute Total Care

Absolute Total Care is a managed care organization (MCO) licensed by the South Carolina Department of Insurance and contracted with the South Carolina Department of Health and Human Services (SCDHHS). Headquartered in Columbia, SC, we have more than 18 years of experience serving low-income and underserved populations statewide.

As a wholly owned subsidiary of Centene Corporation, Absolute Total Care operates in all 46 counties with access to quality, coordinated care, innovative programs, and expanded benefits—helping individuals and families get well, stay well, and be well.



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# Products and Services

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# Absolute Total Care Healthy Connections Medicaid

# South Carolina Medicaid: Healthy Connections

South Carolina's Medicaid program, Healthy Connections, provides health coverage to eligible low-income residents across the state. Individuals may apply online at [apply.scdhhs.gov](https://apply.scdhhs.gov).

## Medicaid Overview

- Joint federal and state program administered by [South Carolina Department of Health and Human Services \(SCDHHS\)](#)
- Serves children, pregnant women, families, seniors, and individuals with disabilities
- Care is delivered primarily through [Managed Care Organizations \(MCOs\)](#)
- South Carolina has participated in Medicaid since [1968](#)
- Eligibility is determined through applications at [apply.scdhhs.gov](https://apply.scdhhs.gov)

## Medicaid Eligibility

Eligibility is based on income and asset guidelines. Individuals who may qualify include:

- Children
- Parents and caretaker relatives
- Pregnant women
- Adults age 65 and older
- Individuals with disabilities
- Children with developmental delays
- Breast and cervical cancer patients

# Member Benefits


## Provider Quick Reference



Earn My Health Pays rewards when you complete healthy activities like a yearly wellness exam, annual screenings, tests and other ways to protect your health.

Use your **myhealthpays**<sup>™</sup> rewards to help pay for:

- Utilities
- Transportation
- Phone and Internet Services
- Childcare Services
- Education
- Rent

Or you can use your rewards to shop at **Walmart**  for everyday items\*



**Rewards  
for Healthy  
Activities**

*\*This card may not be used to buy alcohol, tobacco, or firearms products.*

## Healthy Activities Eligible for

### Flu Vaccines

- **\$15** annual flu shot (ages 2–64)
- **\$15** initial flu vaccines (children 6–24 months)

### Well-Care Visits

- **\$20** child well-care visits (birth–24 months; up to 9 visits)
- **\$10** annual adult well-care visit (ages 3–64)

### Diabetes Care (ages 18–64)

- **\$20** HbA1c test
- **\$20** diabetic eye exam

### Preventive Screenings

- **\$10** cervical cancer screening (ages 18–64)
- **\$20** breast cancer screening (ages 50–64)
- **\$10** chlamydia screening

### Adolescent Immunizations

- **HPV, Tdap, Meningococcal** (age-specific)

### For Pregnant and New Moms

- **\$50** prenatal visit *First trimester or within 42 days of enrollment*
- **\$50** postpartum visit *7–84 days after delivery*

# Member Enhanced Benefits

## Provider Quick Reference

### Clinical & Educational Support

#### 24-Hour Nurse Advice Line

24/7 access to a registered nurse for health questions and guidance.

Call: 1-866-433-6041 (TTY: 711)

#### GED Testing

No-cost GED testing for members age 16+ who are not enrolled in high school or did not graduate.

### Rewards, Wellness & Youth Programs

#### Over-the-Counter (OTC) Benefit

- Up to \$60 annually per household for eligible OTC items
- Includes \$15 quarterly allowance (funds do not roll over)

#### Youth Education & Activities\*

For members ages 5–18:

- Reading support (Pre-K–5)
- Sports activity fee up to \$50 per year
- One sports physical per year

#### Start Smart for Your Baby® (SSFB) Program

Education, tips, and resources to support members during pregnancy and early childhood.

\* *Eligibility and benefit limits apply.*

### Pregnancy & Infant Support

#### Pregnancy Support Items

One car seat, stroller, or playpen after six prenatal visits.

*Limit one per pregnancy.*

#### Diaper Rewards Program

One package of diapers and wipes after the 6-week postpartum visit and infant well visits at 1, 2, 4, 6, and 12 months.

#### Breastfeeding Support

Electric breast pump available if:

- Due within 12 weeks
- Delivered within 30 days
- NICU baby within 90 days

#### Postpartum Meals

14 free home-delivered meals for eligible birthing parents after a qualifying delivery.

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# Health Insurance Portal Mobile App

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# Stay Connected — Health Insurance Portal Mobile App

## Health Insurance Portal Mobile App Features:

### Search for Care

Find doctors and urgent care near you, update your primary care provider, and more.

### View Your Benefits

See your available benefits and services.

### Access Your Member ID Card

View and share your digital ID card or save it to your mobile wallet.

### Take a Health Quiz

Share your health needs so we can better support you.

### Let us Know You're Pregnant

Get connected to programs and services for a healthy pregnancy.



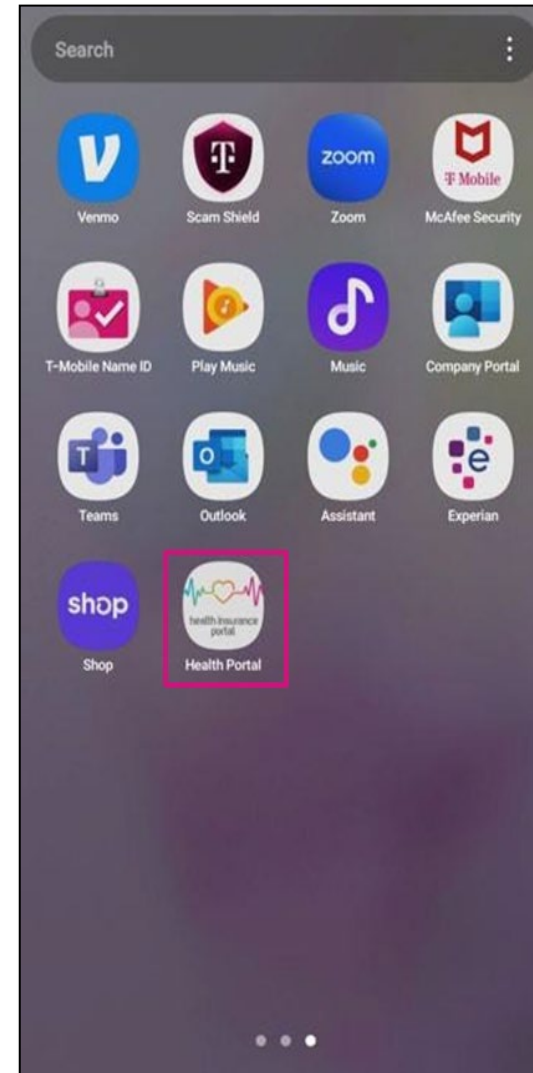


# Member Mobile App User Guide

Follow these Steps to Use the Absolute Total Care Medicaid **Health Insurance Portal** App

## 1 OPEN

Open the mobile app by clicking on the “**Health Insurance Portal**” icon.

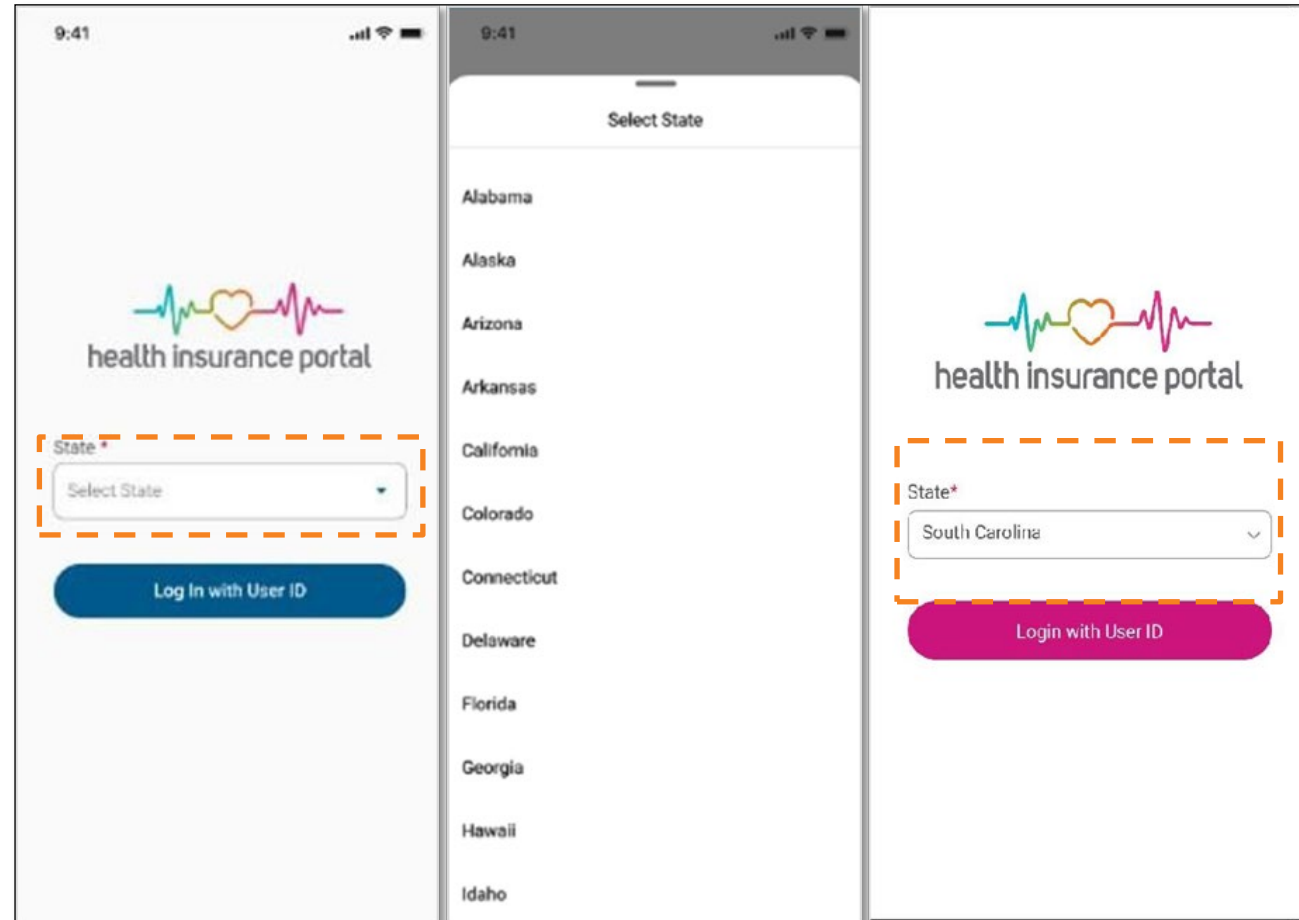




# Member Mobile App User Guide

## 2 LOG IN

Click on the dropdown arrow to search for your **“State”** (South Carolina). Once you have selected **“South Carolina”** as your State, click on **“Log In with User ID.”**

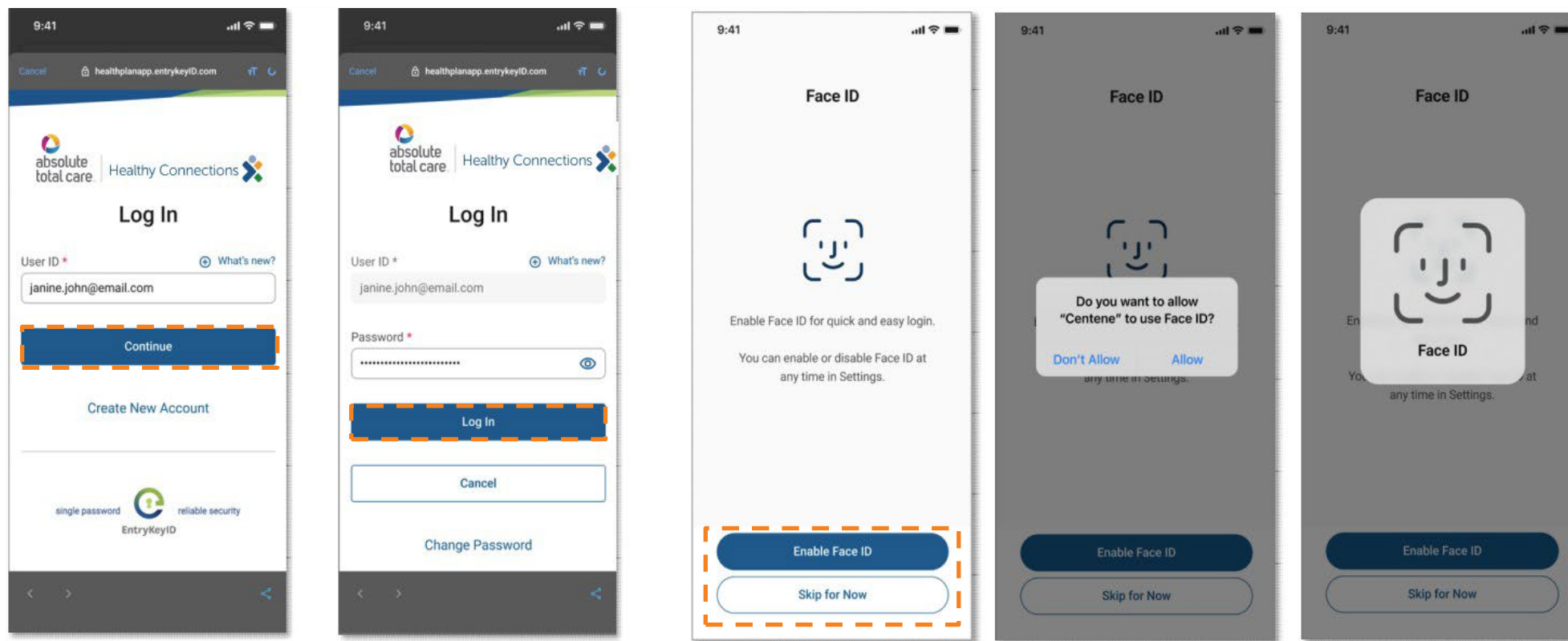




# Member Mobile App User Guide

## 2a LOGIN

Enter your email address in the **“User ID”** box and click **“Continue.”** Enter your **“Password”** and click **“Log In.”** Next, you will have the option to **“as a log in option. Here, you can select “Enable Face ID” or “Skip for Now.”** the app uses **“Biometrics”** for Face ID.



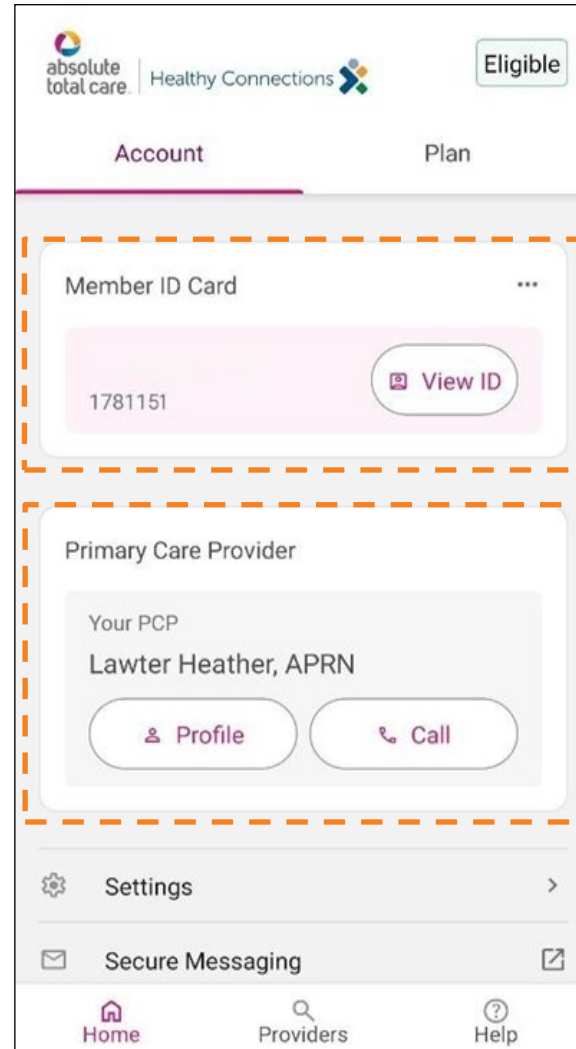


# Member Mobile App User Guide

## 3 HOMEPAGE/ACCOUNT

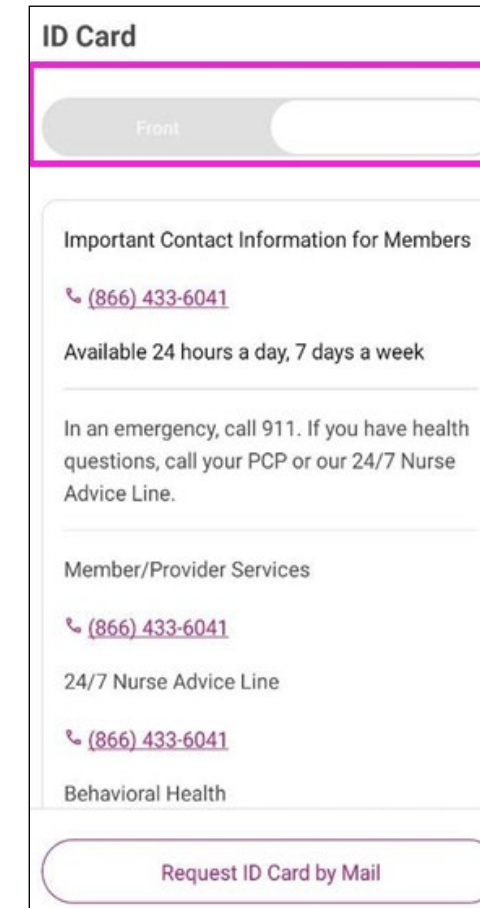
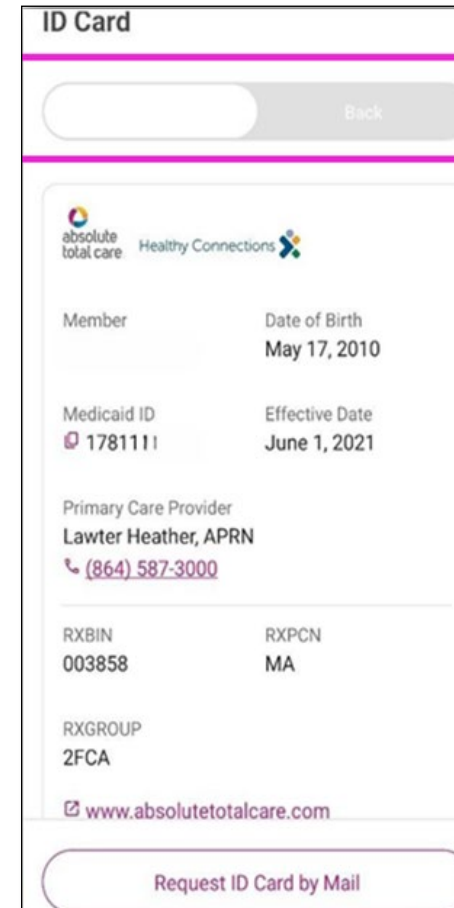
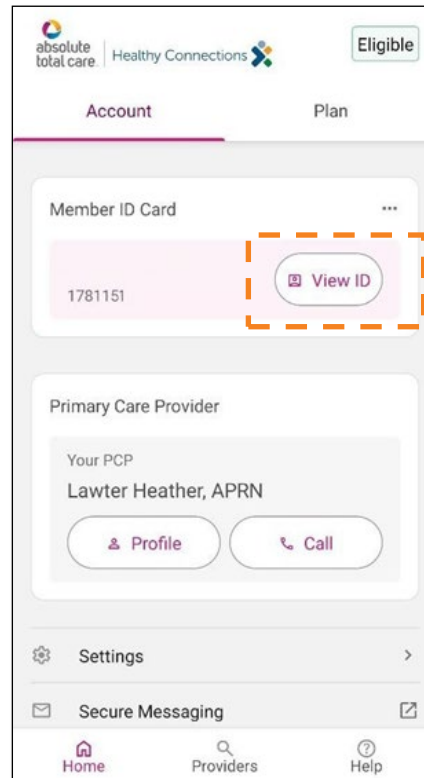
The homepage screen will appear with the following options:

**Member ID Card** and **Primary Care Provider**.



## 4 MEMBER ID CARD

If you click on the **“View ID”** button next to member name, you will be directed to your Absolute Total Care ID card. You will be able to digitally view the **“Front”** and **“Back”** of your ID card.

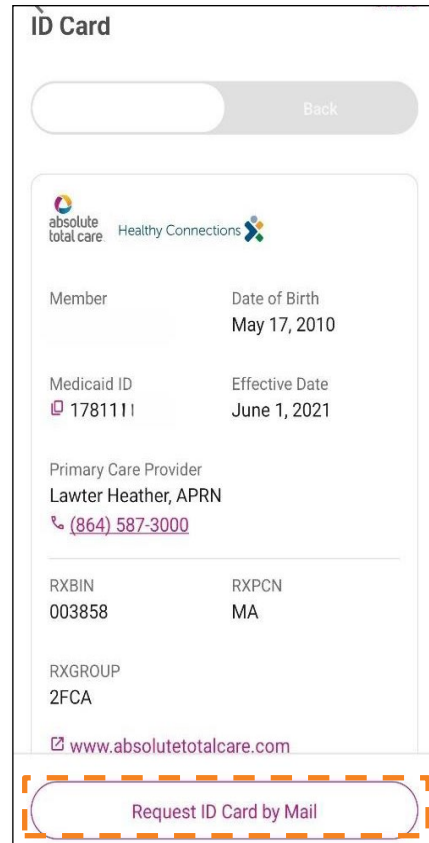




# Member Mobile App User Guide

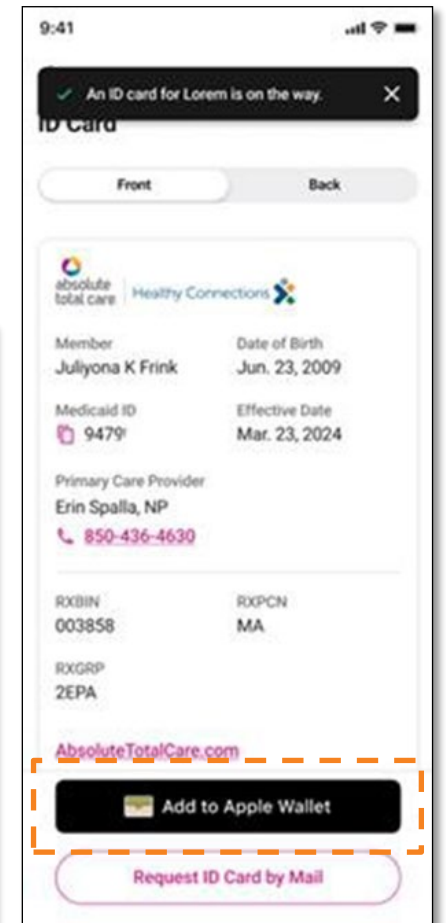
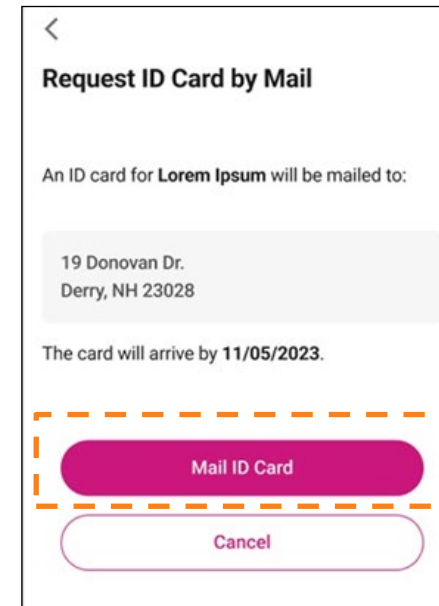
## 5 REQUEST ID CARD

To have your ID card printed and shipped to you, click on **“Request ID Card by Mail.”** After verifying your mailing address, select **“Mail ID Card.”**



## 6 ADD ID CARDS TO MOBILE

To save your ID card to your cellphone device, select **“Add to Apple Wallet,”** select **“Mail ID Card.”**

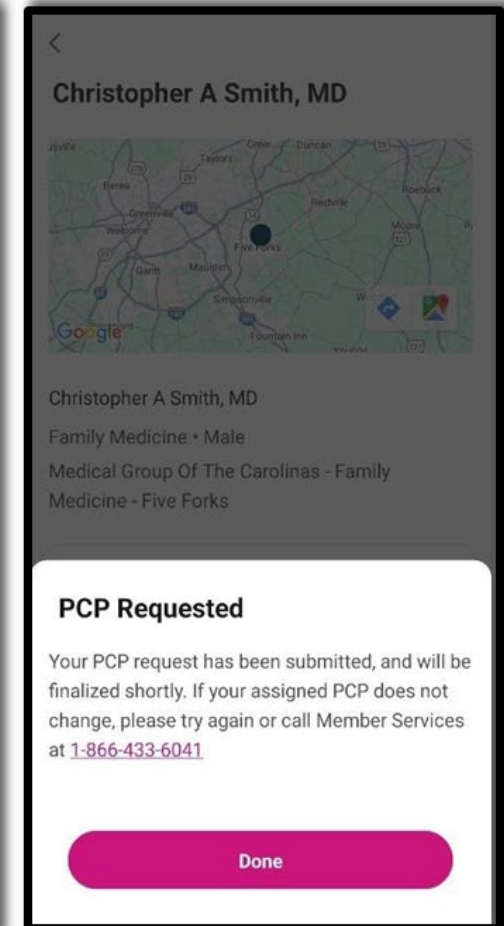
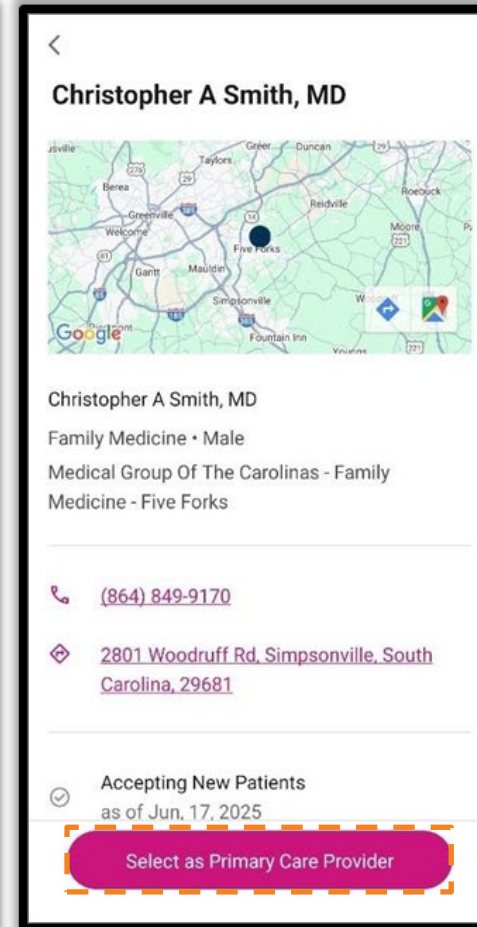
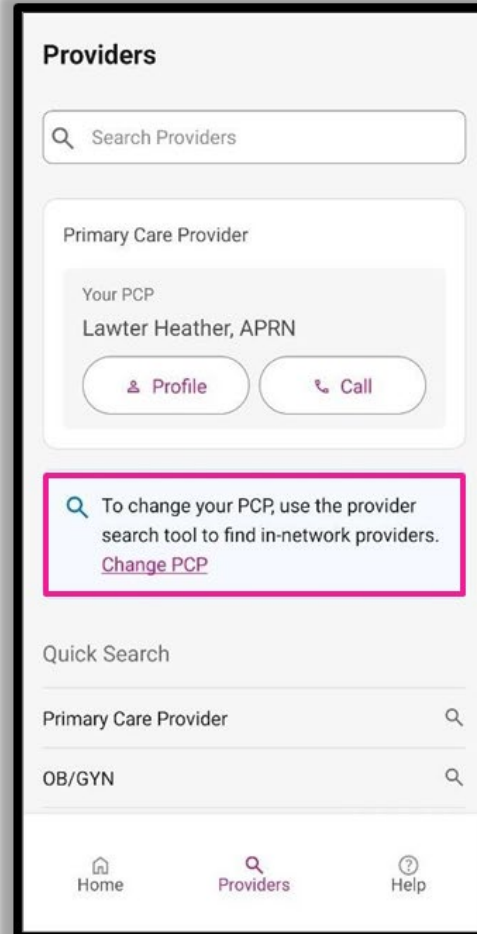


**Note:** The option to save to your cell phone is not available on **Android devices.**



# Member Mobile App User Guide

**7 CHANGE YOUR PCP**  
You can change your Primary Care Provider assigned to you, tap **“Change PCP”**. A search tool, **“Find a Provider”** will pop up. Once you have found a new provider through the search tool, you can tap **“Select as Primary Care Provider”**.



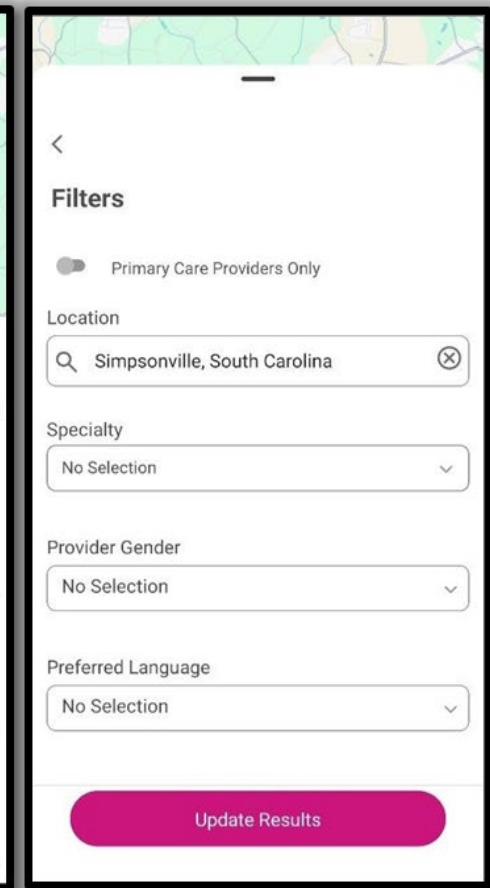
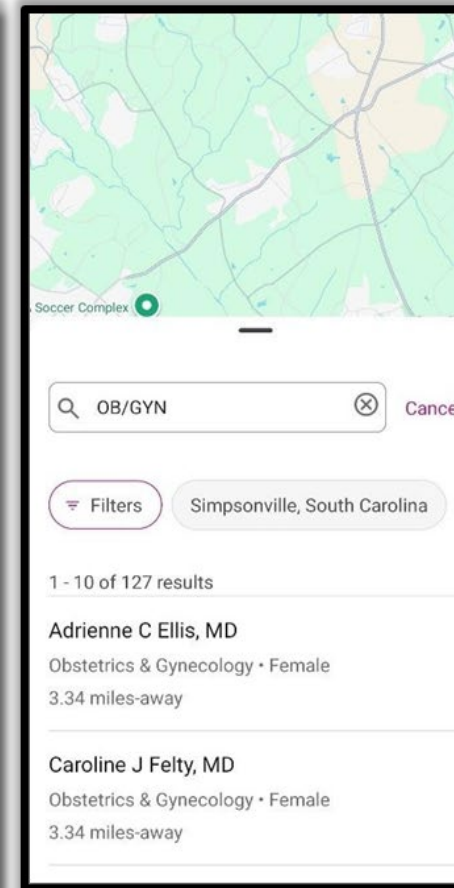
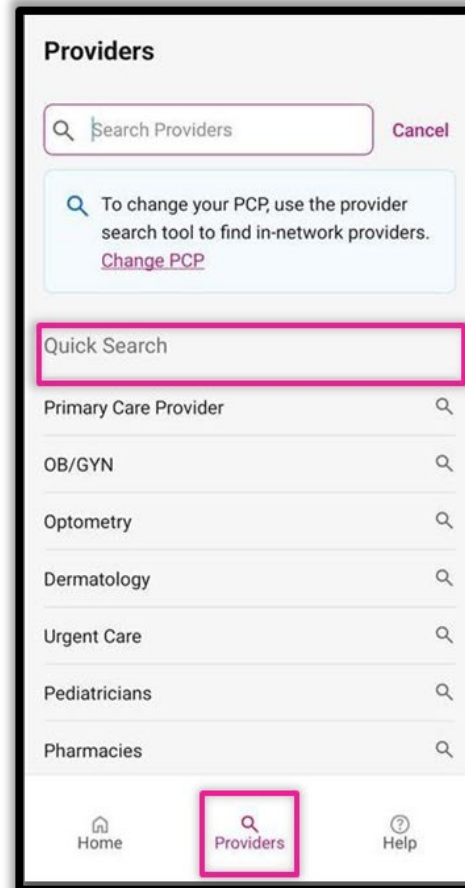
**Note:** When updating your PCP, you will see a dialog message box about your changes.



# Member Mobile App User Guide

## 8 FIND A PROVIDER

Clicking on the “Providers” icon at the bottom will direct you to search for providers. Click on any provider category under “Quick Search” to look for a health-care provider the same way you can on the Absolute Total Care website.

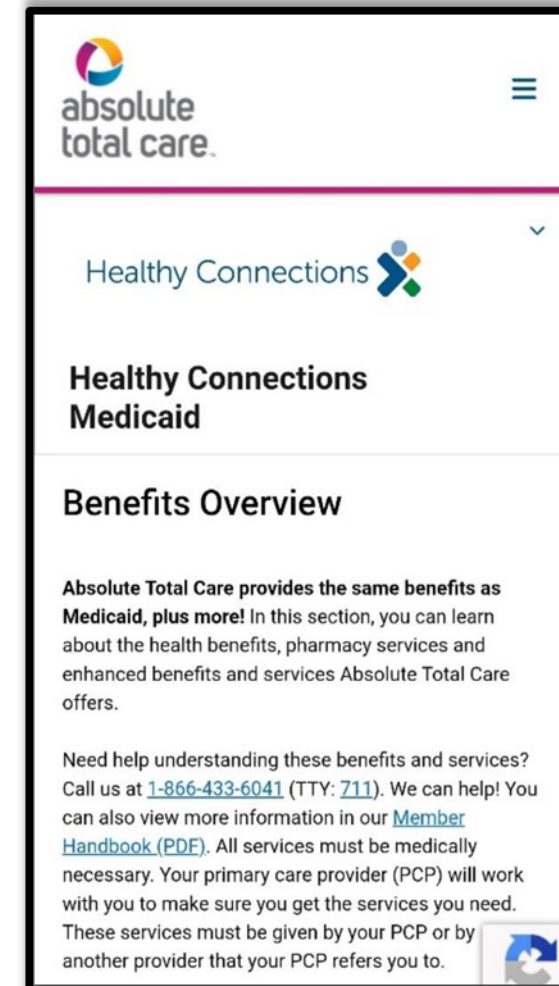
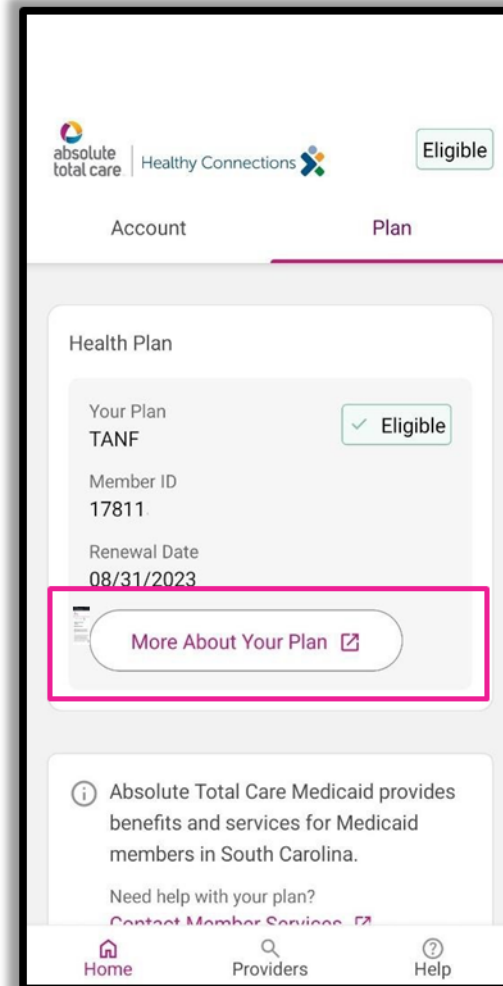




# Member Mobile App User Guide

## 9 MORE ABOUT YOUR PLAN

Tap **“Plan”** from your homepage screen, then select **“More About Your Plan”** where you will be directed to view your benefits on Absolute Total Care’s website.



# Healthy Connections (Medicaid)

## 2026 Member ID Card Overview

### Front of Member ID Card

#### Member Information

- Member Full Name
- Member Date of Birth
- Member ID# (required for claims)
- Effective Date (benefits begin)

#### Primary Care Provider

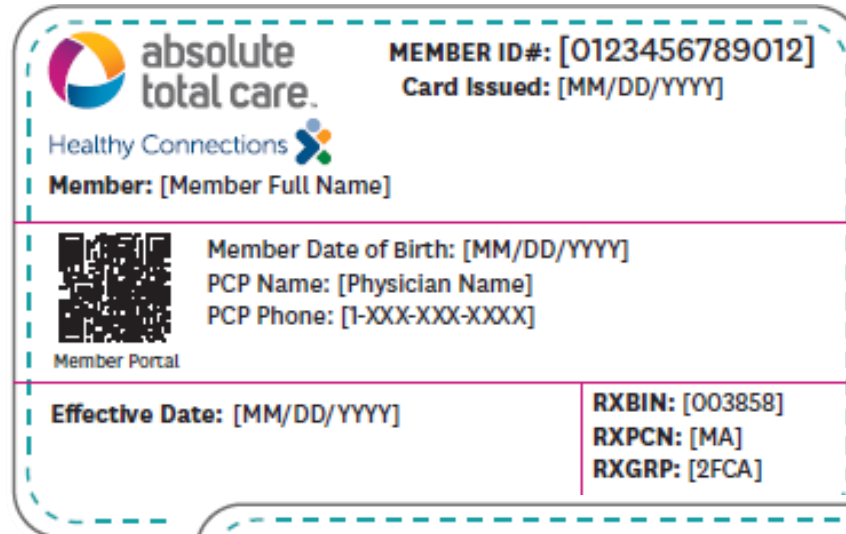
- PCP Name
- PCP Phone Number

#### Digital Access

- Member Portal QR Code

#### Pharmacy Processing

- RXBIN / RXPCN / RXGRP



### Back of Member ID Card

#### Support & Assistance

- Member/Provider Services
- 24/7 Nurse Advice Line
- Behavioral Health

#### Specialty & Home-Based Care

- Imaging, X-rays, Radiology
- DME, Home Health, Infusion

#### Pharmacy Support

- Pharmacy Help Desk (pharmacists only)

#### Administrative Information

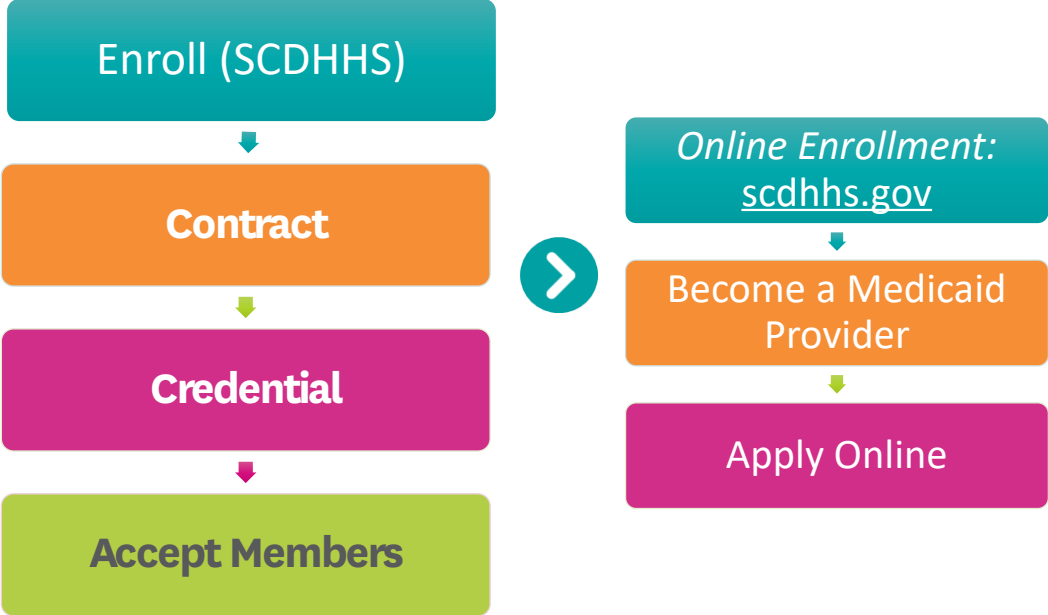
- ATC Billing Address
- ATC Website

# Medicaid Provider Enrollment

## Provider Enrollment & Compliance


- Providers must be enrolled in South Carolina Healthy Connections Medicaid.
- Providers must be contracted and fully credentialed before treating members.
- PCPs may not accept member assignments until credentialing is complete.
- Providers must maintain SC licensure/certification and comply with all federal, state, and local laws, including requirements enforced by SCLLR.

## Enrollment Path



# Provider Enrollment Requirement

 Effective January 22, 2026

 To support program integrity, CMS requires all providers who order, refer, or prescribe services for Medicaid members to be enrolled with the state Medicaid program, even if they do not bill Medicaid directly.

## This requirement applies to:

- Ordering, referring, and prescribing providers
- In-state and out-of-state providers
- Professional, pharmacy, and institutional services

## What this means for South Carolina Providers:

- Providers who order, refer, or prescribe items or services for South Carolina Medicaid members must be enrolled with SCDHHS as a Medicaid provider.
- This applies to providers who:
  - Currently order, refer, or prescribe for Medicaid members
  - Expect to do so in the future
- Enrollment is required regardless of whether claims are submitted.

## Required Action:

- Enroll with South Carolina Medicaid (SCDHHS)

 [www.scdhhs.gov](http://www.scdhhs.gov)

Online Enrollment:  
[scdhhs.gov](http://scdhhs.gov)



Become a Medicaid  
Provider



Apply Online

 This requirement is based on federal regulation 42 CFR § 455.410 under the Affordable Care Act (ACA).

# Medicaid Recordkeeping Requirements

## Recordkeeping Requirements

- Keep complete **original health records** that show **medical necessity** and **services provided**.
- Provide **immediate access** to records when requested, including **audit trails**.
- “Records” include **paper or electronic** information in any format (notes, charts, photos, audio, etc.).
- When submitting claims, follow the **Provider Manual** documentation and **signature** requirements.

## Record Accessibility Policy

- Maintain a health record system that allows **immediate access and retrieval**.
- Allow **authorized agencies** access to records related to **services and payment** for review/copying during normal business hours (e.g., SCDHHS, SAO, SCAG, HHS/GAO, and designees).
- **Electronic records/clinical notes are acceptable** if compliant with the **Uniform Electronic Transactions Act** and **HIPAA**.
- Providers must comply with **HIPAA** requirements.

# Medicaid Record Access and Required Documentation

## Medicaid Record Access (SCDHHS)

- Make records available for review during **normal business hours** (with or without notice), as directed by authorized entities.
- Authorized entities may **copy records** or request **originals**.
- Records are **inaccessible** if not provided within **2 hours** of request.
- Records must be accessible at the provider's **enrolled service address**; providers must **transport/send** records to the documented place of service.

## Required Documentation

- Evidence-based practice documentation
- Consent form(s)
- Authorization (if applicable)
- Medical necessity documentation
- Signed **treatment** plan(s)
- Treatment progress documentation
- Clinical service notes supporting billed claims
- Care coordination documentation
- Discharge/transition plan (if applicable)



*SCDHHS Provider Administrative and Billing Manual pages 24-25*

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# Dual Special Needs Plan (DSNP)

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# MMP to Dual Plan Transition

(Effective January 1, 2026)

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 Like the MMP, the new D-SNP serves individuals eligible for both Medicare and Medicaid, allowing benefits to be coordinated through one health plan.

- South Carolina launched an aligned [Dual Special Needs Plan \(D-SNP\)](#) on January 1, 2026.
- As directed by CMS, the Medicare-Medicaid Plan (MMP), [Wellcare Prime By Absolute Total Care](#), ended December 31, 2025.
- Members were automatically transitioned to [Wellcare Absolute Total Care Dual Align \(HMO D-SNP\)](#).

## Key Information for Providers

Providers can access tools and resources at [go.wellcare.com/ATC](https://go.wellcare.com/ATC) (select For Providers), including:

- Secure Provider Portal registration
- Provider Manual and Quick Reference Guides
- Transition FAQs

For additional support, contact your [Provider Engagement Account Manager](#), or [Provider Services](#) at 1-833-998-5401.

 <https://www.absolutetotalcare.com/providers/provider-news.html>

# Aligned Dual Special Needs Plan (DSNP)



## Member Eligibility and Enrollment

To enroll in Wellcare By Absolute Total Care, individuals must:



- Be entitled to Medicare Part A
- Be enrolled in Medicare Part B
- Have full Medicaid benefits (QMB+, SLMB+, FBDE)
- Be 18 years of age or older
- Permanently reside in the Wellcare By Absolute Total Care service areas
- Not be enrolled in hospice
- Be a U.S. citizen or lawfully present in the United States




 <https://www.absolutetotalcare.com/providers/provider-news.html>

 Provider Services at 1-833-998-5401

## Member Perks

As a Wellcare By Absolute Total Care member, extra benefits are included with member's plan.

 My Wellcare Rewards It pays to make healthy choices <a href="#">Explore Wellcare Rewards</a>	 Over-the-Counter (OTC) Benefits Allowance for Everyday Items <a href="#">Explore OTC Benefits</a>
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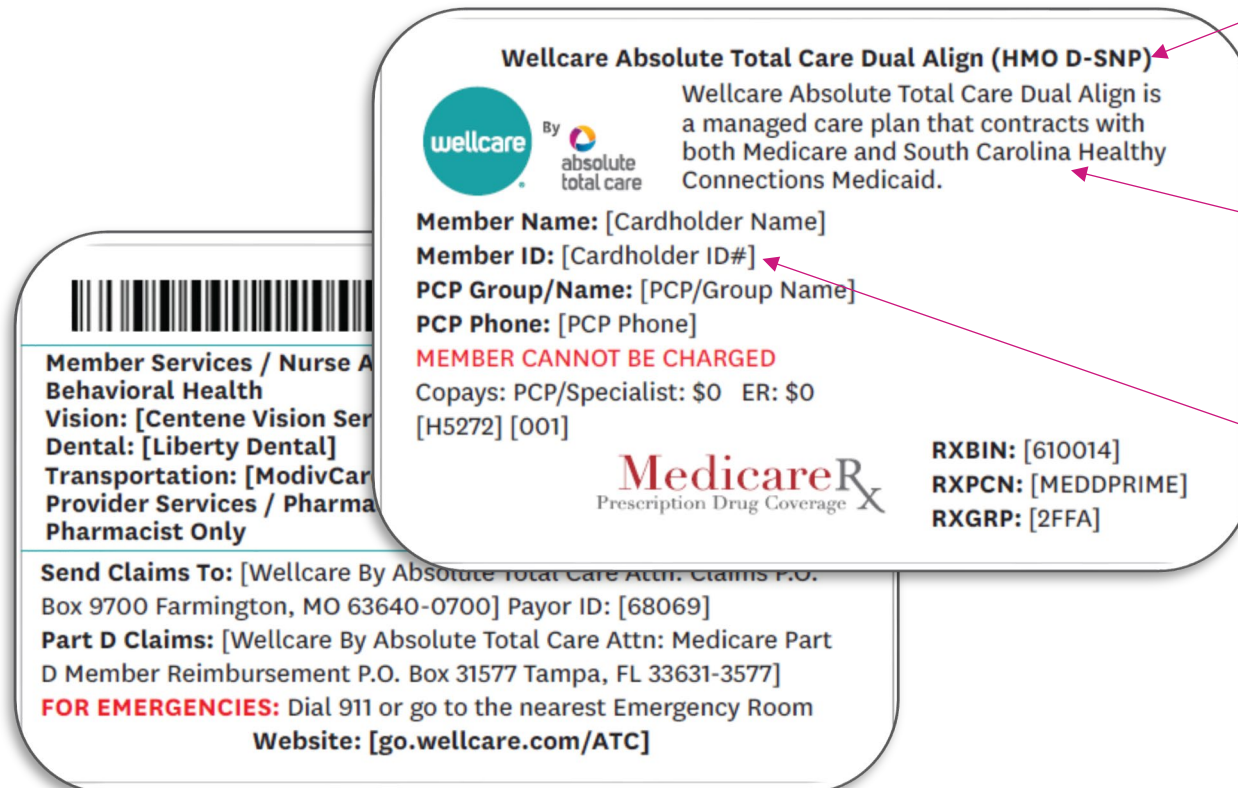
 Telehealth Virtual Visits with a Provider <a href="#">Explore Telehealth Benefits</a>	 Dental Benefits to Make You Smile <a href="#">Explore Dental Benefits</a>	 Wellcare Spendables® Card Added Perks for D-SNP members <a href="#">Explore Wellcare Spendables</a>
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# Medicare Dual Align HMO D-SNP

## 2026 MEMBER ID CARD



- Plan Name: Wellcare Absolute Total Care Dual Align (HMO D-SNP)
- Contract (PBP) Number: H5272-001
- Brand Name: Wellcare By Absolute Total Care



**Plan Name:** Wellcare Absolute Total Care Dual Align (HMO D-  
**Effective Date:** January 1, 2026

**The Label:** Wellcare Absolute Total Care Dual Align is a managed care plan that contracts with both Medicare and Medicaid

**Member ID Number:** A single number used for eligibility verification and claims for all services regardless of whether it's a Medicare or Medicaid covered benefit.



FROM



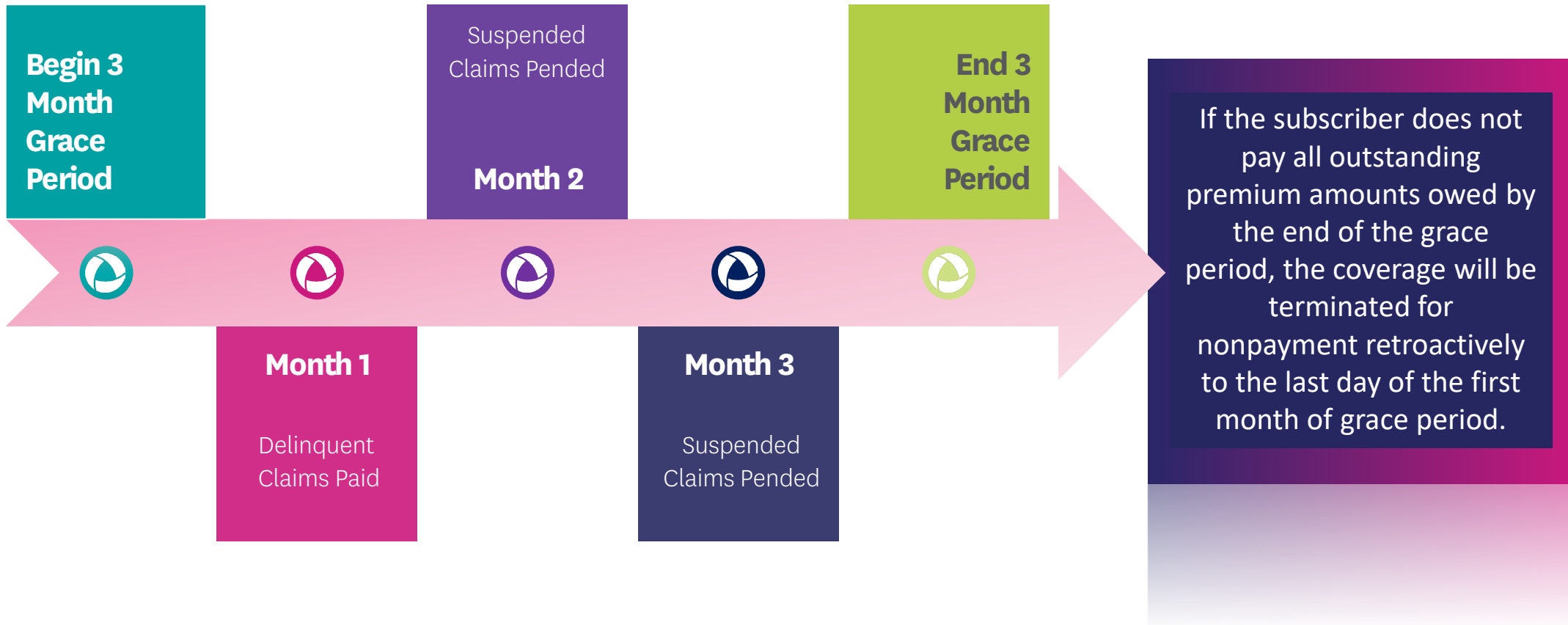
absolute  
total care™

Ambetter from  
Absolute Total Care

[My Health Pays Rewards Program](#)

# Member Eligibility and Grace Period

Marketplace – Ambetter / Ambetter Health




# Marketplace – Ambetter / Ambetter Health

## 2026 MEMBER ID CARD



- Plan Name: **Ambetter from Absolute Total Care**
- Network Name: **PREMIER**
- Brand Name: **Ambetter**

- Plan Name: **Ambetter Health (ICHRA)**
- Network Name: **SOLUTIONS**



REFERRAL NOT REQUIRED

PREMIER

**MEMBER:** [Jane Doe]  
**Subscriber:** [John Doe]  
**Subscriber ID:** [XXXXXXXXXX]    **Member ID:** [XXXXXXXXXXXXXXXXXX]  
**Plan:** [Plan name]  
**[Network Name] Network Coverage Only**  
**RXBIN:** 003858    **RXPCN:** A4    **RXGROUP:** 2DQA    **Effective Date:** [00/00/00]


**COPAYS**

PCP: [\$10 copay after ded.]  
Specialist: [\$25 coin. after ded.]  
Urgent Care: [20% coin. after ded.]  
ER: [\$250 copay after ded.]

**COST SHARES**

INN DED Ind/Fam: [\$7,965/\$18,000]  
OON DED Ind/Fam: [\$22,500/\$45,000]  
INN MOOP Ind/Fam: [\$9,200/\$25,000]  
OON MOOP Ind/Fam: [\$25,000/\$45,000]

For detailed benefit information, please visit [AmbetterHealth.com/copays](http://AmbetterHealth.com/copays)



REFERRAL NOT REQUIRED

SOLUTIONS

**MEMBER:** [Jane Doe]  
**Subscriber:** [John Doe]  
**Subscriber ID:** [XXXXXXXXXX]    **Member ID:** [XXXXXXXXXXXXXXXXXX]  
**Plan:** [Plan name]  
**[Network Name] Network Coverage Only**  
**RXBIN:** 003858    **RXPCN:** A4    **RXGROUP:** 2DQA    **Effective Date:** [00/00/00]

**COPAYS**

PCP: [\$10 copay after ded.]  
Specialist: [\$25 coin. after ded.]  
Urgent Care: [20% coin. after ded.]  
ER: [\$250 copay after ded.]

**COST SHARES**

INN DED Ind/Fam: [\$7,965/\$18,000]  
OON DED Ind/Fam: [\$22,500/\$45,000]  
INN MOOP Ind/Fam: [\$9,200/\$25,000]  
OON MOOP Ind/Fam: [\$25,000/\$45,000]

For detailed benefit information, please visit [AmbetterHealth.com/copays](http://AmbetterHealth.com/copays)

**AmbetterHealth.com/SC**

<p><b>Member/Provider Services:</b> 1-833-270-5443 (Relay 711)  <b>24/7 Nurse Line:</b> 1-833-270-5443</p> <p><b>Numbers below for providers:</b>  <b>Pharmacist Only:</b> 1-833-750-4237  <b>EDI Payor ID:</b> 68069  <b>[Centene Vision Services:</b> 1-833-724-9353]  <b>[Centene Dental Services supported by</b>  <b>United Concordia:</b> 1-833-605-6320]</p>	<p><b>Medical Claims Address:</b>  Ambetter Health  Attn: CLAIMS  PO Box 5010  Farmington, MO  63640-5010</p>
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**AmbetterHealth.com**

<p><b>Member/Provider Services:</b> 1-833-543-3145 (TTY 711)  <b>24/7 Nurse Line:</b> 1-833-543-3145</p> <p><b>Numbers below for providers:</b>  <b>Pharmacist Only:</b> 1-833-750-4237  <b>EDI Payor ID:</b> 68069  <b>[Centene Vision Services:</b> 1-833-724-9353]  <b>[Centene Dental Services supported by</b>  <b>United Concordia:</b> 1-833-605-6320]</p>	<p><b>Medical Claims Address:</b>  Ambetter Health  Attn: CLAIMS  PO Box 5010  Farmington, MO  63640-5010</p>
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AMB25-SC-C-00060

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# Medicare Advantage

Membership, Benefits, and Additional Services

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# Wellcare (Medicare HMO 4847)

## 2026 MEMBER ID CARD OVERVIEW



 Brand Name: Wellcare

Plan Name	Contract (PBP) Number
Wellcare Simple (HMO-POS)	H4847-001
Wellcare Assist (HMO-POS)	H4847-005
Wellcare Giveback (HMO-POS)	H4847-007
Wellcare Patriot Giveback (HMO-POS)	H4847-006



**[Plan Name] [(Plan Type)]**


**MEMBER ID#:** 1234567890123  
**PLAN#:** HXXXX-XXX-000  
**ISSUER #:** (80840) 9151014609

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**Member:** SAMPLE A SAMPLE

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2026



*You can see any PCP in our Network*


**PCP:** [Physician Name]  
**PCP Phone:** 1-XXX-XXX-XXXX  
**PCP Office Visit:** [\$X]


*Member portal*

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**Card Issued:** MM/DD/YYYY

**RXBIN:** 610014  
**RXPCN:** MEDDPRIME  
**RXGRP:** 2FFA





Member Services / Nurse Advice Line	1-XXX-XXX-XXXX (TTY: 711)
Vision: [Provider]	1-XXX-XXX-XXXX (TTY: 711)
Dental: [Provider]	1-XXX-XXX-XXXX (TTY: 711)
Transportation: [Provider]	1-XXX-XXX-XXXX (TTY: 711)
Provider Services / Pharmacy Prior Auth	1-XXX-XXX-XXXX (TTY: 711)
Pharmacist Only	1-XXX-XXX-XXXX (TTY: 711)

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**Medical Claims:** Wellcare Attn: Claims P.O. Box XXXXX Tampa, FL 33631-XXXX Payor ID: 14163

**Part D Claims:** Wellcare Attn: Medicare Part D Member Reimbursement Dept. P.O. Box 31577 Tampa, FL 33631-3577

**FOR EMERGENCIES:** Dial 911 or go to the nearest Emergency Room

[go.wellcare.com/Medicare](http://go.wellcare.com/Medicare)

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# Wellcare (Medicare PPO H7326)

## 2026 MEMBER ID CARD OVERVIEW




 Brand Name: Wellcare

Plan Name	Contract (PBP) Number
Wellcare Simple Open (PPO)	H7326-001
Wellcare Assist Open (PPO)	H7326-007

 [Plan Name] [(Plan Type)]


MEMBER ID#: 1234567890123  
PLAN#: HXXXX-XXX-000  
ISSUER#: (80840) 9151014609

Member: SAMPLE A SAMPLE

2026  Medicare limiting charges apply.  
In Network PCP Office Visit: [\$X]  
Out of Network PCP Office Visit: [\$X]  
Member portal

Card Issued: MM/DD/YYYY

RXBIN: 610014  
RXPCN: MEDDPRIME  
RXGRP: 2FFA





Member Services / Nurse Advice Line 1-XXX-XXX-XXXX (TTY: 711)  
Vision: [Provider] 1-XXX-XXX-XXXX (TTY: 711)  
Dental: [Provider] 1-XXX-XXX-XXXX (TTY: 711)  
Transportation: [Provider] 1-XXX-XXX-XXXX (TTY: 711)  
Provider Services / Pharmacy Prior Auth 1-XXX-XXX-XXXX (TTY: 711)  
Pharmacist Only 1-XXX-XXX-XXXX (TTY: 711)

**Medical Claims:** Wellcare Attn: Claims P.O. Box 31372 Tampa, FL 33631-3372 Payor ID: 14163  
**Part D Claims:** Wellcare Attn: Medicare Part D Member Reimbursement Dept. P.O. Box 31577 Tampa, FL 33631-3577  
**FOR EMERGENCIES:** Dial 911 or go to the nearest Emergency Room

[go.wellcare.com/Medicare](https://go.wellcare.com/Medicare)

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# Model of Care

## Special Needs Plans (SNP)

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# Wellcare Model of Care Overview



wellcare

## What it is?:

Wellcare's Model of Care plan delivers our integrated care management program for members with special needs.

## Who it applies to:

- **D-SNP** (Dual Special Needs Plan) members
- **C-SNP** (Chronic Condition Special Needs Plan) members

## Model of Care Elements:

- ✓ Description of the SNP population (D-SNP and C-SNP)
- ✓ Care coordination, transitions of care, and interdisciplinary care team protocol
- ✓ Provider network
- ✓ Quality measurement

## The goals of our Model of Care are to:

- Improve access to medical, behavioral health, and social services
- Improve coordination of care through an identified point of contact
- Improve transitions of care across healthcare settings and providers
- Improve access to affordable care
- Improve access to preventive health services
- Assure appropriate utilization of services
- Assure cost-effective service delivery
- Improve beneficiary health outcomes



# Model of Care Process

## HRA & Risk Stratification



### Member Outreach & HRA

- ❑ We contact every SNP member to complete a Health Risk Assessment (HRA) within 90 days of enrollment and annually thereafter.
- ❑ The HRA may be completed more frequently if there is a significant change in health status.



### What the HRA Captures

- ❑ Medical, psychosocial, cognitive, and functional needs
- ❑ Social determinants of health needs
- ❑ Medical and behavioral health history



### Risk Scoring & Triage

- ❑ The HRA is scored for risk to assist with triage.
- ❑ HRA risk level helps determine the appropriate level of care management and ICT composition.

# Model of Care Process



## Care Coordination & Ongoing Support

### **Comprehensive Care Coordination & Communication**

Improved information sharing among members, providers, and Wellcare care management

### **Individualized Care Planning (ICP)**

Care reflects member-identified preferences and goals documented in the ICP

### **Interdisciplinary Care Team (ICT) Model**

Integrated support across medical, behavioral health, and social determinants of health

### **Primary Care Engagement**

Reinforces the member's relationship with their PCP and medical home



Each member receives an annual **Individualized Care Plan (ICP)**

- The ICP outlines the member's health goals and planned interventions.

Each member receives an annual **face-to-face encounter**

- Conducted in person or virtually with a provider or Wellcare care coordination staff.



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# Case Management

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# Case Management Services



**Case Management** is a **FREE** service provided by **Absolute Total Care** to help our members get the care and services they need. Our goal is to support our members in managing their health and improving their quality of life.



## How do you use case management program services?

Our **Case Management** services include:

- Referrals to specialists and other services
- **Coordinating Care** between doctors and other providers
- **Developing Care Plans** and setting health goals
- **Learning About Other Services** that can make our member's lives easier



## How do you become eligible for case management?

**Members** may become **eligible** through:

- Referrals or medical claims
- A review of medical information by a **Care Manager**
- After being hospitalized
- A **Care Manager** may reach out to members to discuss your healthcare needs
- Provider referral

# Case Management Referrals



Medicaid  
(Healthy Connections)  
1-866-433-6041



Wellcare By Absolute Total  
Care Dual Aligned  
1-833-998-5401



Medicare  
(Medicare Advantage)  
1-866-635-7045



Ambetter from Absolute  
Total Care  
1-833-270-5443

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# Patient Eligibility Verification Overview

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# Eligibility



- Member eligibility should be checked each month and each time prior to rendering services for all lines of business.
- IVR is available 24 hours a day, seven days a week.



Absolute Total Care  
(Medicaid)  
1-866-433-6041



Wellcare Medicare  
Advantage  
1-866-270-5223



Wellcare By Absolute Total Care  
Dual Align (HMO D-SNP)  
1-833-998-5401  
(Effective 1/1/2026)



Ambetter from  
Absolute Total Care  
(Marketplace)  
1-833-270-5443

Eligibility can be verified through [Absolute Total Care Provider Portal](#), [Wellcare Provider Portal](#), [Avality Essentials](#) or the Interactive Voice Response (IVR)


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# Provider Secure Web Portal

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# Absolute Total Care Provider Portal



absolute total care | Healthy Connections  [Manage Practice](#) [Eligibility](#) [Patients](#) [Authorizations](#) [Claims](#) [Messaging](#)



Viewing Eligibility For : TIN

**Eligibility Check**

Plan Type: Absolute Total Care

SC - Medicare / MMP

Behavioral Health from Absolute Total Care

Wellcare Absolute Total Care (Dual Align)

Ambetter

Absolute Total Care

Date of Service:  (mm/dd/yyyy)

Member ID:  (mm/dd/yyyy)

ELIGIBLE	DATE OF SERVICE	PATIENT NAME	DATE CHECKED	CARE GAPS	LOG ER VISIT
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# Wellcare Provider Portal

wellcare

- ✓ Designed for participating Wellcare providers
- ✓ Verify eligibility and benefits
- ✓ Submit and track claims and authorizations
- ✓ Access patient details, care gaps, and support tools

The screenshot displays the 'My Patients' section of the Wellcare Provider Portal. At the top, there is a navigation bar with 'Home', 'My Patients', 'Care Management', 'Claims', 'My Practice', and 'Resources'. Below this is a blue header for 'My Patients' with a 'Back To Home' link and font size controls. The main heading is 'Check Member Eligibility', followed by a brief description: 'This section allows you to search for members and check eligibility. If you need additional assistance, please select the Help button. There, you can access FAQs or select your state and plan to chat with a Customer Service agent.'

The search form includes a dropdown for 'Select search criteria to find a member' (set to 'Member ID'), a 'Member ID' input field, a 'Medicaid ID' input field, a 'Medicare ID' input field, and a date picker for 'Check patient eligibility on this date' (set to 11/24/2025). A green 'Search' button is located at the bottom right of the form. A link '+ Enter multiple member IDs to display' is also present.

Below the form, there are links for 'Filter Results' and 'Download Report'. At the bottom, a table header is visible with columns: Member Name, Member ID, Eligible, Effective Date, Term Date, Plan Name, Care Gaps, Important Info, and PCP. The table currently shows 'No items to display'.

Log in to the [Wellcare Provider Portal](#) to begin using these tools.

# Availity Essentials: New Multi-Payer Portal



## Multi-Payer Portal

### Comprehensive Administrative Tools

Availity Essentials offers tools to validate eligibility, submit claims and check claim status efficiently.

### Integration with Health Plans

The platform supports multiple health plans like **Absolute Total Care** and **Wellcare** for streamlined processes

### Reduced Administrative Burden

Centralized functionalities minimize errors and improve workflow, enhancing provider satisfaction.

### Enhanced Patient Care

Accurate and efficient administrative processes contribute to better patient care outcomes.



### New Accounts:

The Availity Administrator registers and manages user accounts and must have the legal authority to sign agreements. Visit [Register and Get Started with Availity Essentials](#) for training.



### Existing Accounts:

Log in to enjoy full functionality. Add apps to My Favorites and save provider information for faster transactions.



### Contact Info:

Availity Client Services:  
**1-800-AVAILITY (282-4548)**,  
Mon–Fri, 8 AM–8 PM EST.  
For general questions:  
Contact Provider Services or  
your Provider Engagement  
Account Manager

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# Prior Authorization Requirements

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# Services Requiring Prior Authorization

## Prior Authorization (PA)

- Use the [Pre-Auth Check Tool](#) to determine whether a service code requires prior authorization.
- [Inpatient and Outpatient Authorization Forms](#), service requirements, and [medical necessity criteria](#) are available under [Provider Resources](#) on our website.
- Criteria used in utilization management decisions are available upon request to the provider, member, or authorized representative by contacting the [Utilization Management Department](#).

## Medical Necessity (Medicaid)

- “Medical necessity” or “medically necessary” services are those covered under the [state Medicaid program](#), including applicable quantitative and non-quantitative treatment limits, as defined in state statutes, regulations, the state plan, and other state policies.

## Medical necessary services must:

- Be [essential](#) to prevent, diagnose, treat, or prevent the worsening of a condition that endangers life, causes pain or suffering, results in illness, or causes physical impairment.
- Be provided at the [appropriate setting and level of care](#) for the member’s condition.
- Be consistent with [objective, evidence-based clinical criteria and standards of medical practice](#).

Check Code

Submit PA

Review

Decision

# Pre-Auth Check Tool



Use our tool to see if a pre-authorization is needed. It's quick and easy. If an authorization is needed, you can login to your provider portal account to submit one online or fill out the appropriate fax form on the Provider Manuals and Forms page.



[Absolute Total Care Provider Manuals and Forms](#)

[Wellcare Provider Manuals and Forms](#)

Check Code

Submit PA

Review

Decision

[Wellcare by Absolute Total Care \(AIP\) Pre-Auth check](#)

[Healthy Connections Medicaid Pre-Auth Check](#)

[Ambetter Pre-Auth Check](#)

[Wellcare Medicare Advantage Pre-Auth Check](#)

# Provider Documentation Responsibilities

## Medicaid Documentation Requirements

As a condition of Medicaid participation, providers must maintain complete and accurate health records that clearly support medical necessity and services provided.

- Records must be available for **immediate access**, including for audits
- Documentation must fully disclose treatment provided and medical necessity
- Providers must follow documentation and signature requirements outlined in the applicable **Provider Manual**



Records include:

Clinical notes, charts, electronic records, images, reports, and other supporting documentation.

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# Network Development and Participation

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# Network Development and Participation




## Network Participation




The enrollment, credentialing and recredentialing processes exist to ensure that participating providers **meet and remain compliant** to the criteria established by Absolute Total Care.




These processes also ensure that providers **remain compliant with government regulations and standards** of accrediting bodies



## Network Development



To request a **new** agreement, send an email to [ATC\\_Contracting@centene.com](mailto:ATC_Contracting@centene.com)



For contract updates and questions (i.e., change of ownership, TIN changes, amendments, etc.), send an email to [ATC\\_Contracting@centene.com](mailto:ATC_Contracting@centene.com)

# Network Development and Participation



To initiate the credentialing process for a new practitioner at Absolute Total Care, providers are required to submit a Provider Profile Sheet along with a Current W-9 to [SouthCarolinaPDM@centene.com](mailto:SouthCarolinaPDM@centene.com).

- The process takes about 60 days to complete. For follow-ups before receiving the Welcome Letter, email [SouthCarolinaPDM@centene.com](mailto:SouthCarolinaPDM@centene.com).
- Recredentialing occurs every 36 months.
- To update existing participating providers and locations, email the Provider Profile Sheet to [SouthCarolinaPDM@centene.com](mailto:SouthCarolinaPDM@centene.com).



To enroll a new practitioner with Wellcare, providers need to submit a completed Provider Profile Sheet along with a Current W-9 to [atcnetworkrelations@centene.com](mailto:atcnetworkrelations@centene.com).

- The process takes roughly 60 days to complete.
- Recredentialing occurs every 36 months.
- Providers can update existing participating providers and locations by emailing their assigned representatives or at [atcnetworkrelations@centene.com](mailto:atcnetworkrelations@centene.com).

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# Credentialing Rights

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## Review of Credentialing Information

Practitioners may review the information Absolute Total Care uses for credentialing and recredentialing, including data from external primary sources. Access does **not** include references, personal recommendations, or peer-review protected information.



## Right to Correct Information

If any credentialing or recredentialing information is inaccurate—or if primary source verification differs from what was submitted—practitioners may request correction of errors provided by another party.



## How to Request a Review

Submit a written request to the Absolute Total Care Credentialing Department. After receiving the information, practitioners have **14 days** to submit a written explanation of any errors or discrepancies. Absolute Total Care's Credentialing Committee will review and incorporate updates as appropriate.

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# Cultural Competency

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# Cultural Competency Overview






## What Cultural Competency Means

-  A set of interpersonal skills that support understanding, appreciation, acceptance, and respect for cultural differences and similarities
-  Includes awareness of how cultural factors influence relationships with members
-  Supports effective, respectful communication across diverse populations




## Our Commitment to Our Members

-  Absolute Total Care is committed to building and sustaining healthy PCP–member relationships
-  Members are entitled to dignified, appropriate, and quality care
-  Culturally responsive care supports better communication and improved health outcomes

# Cultural Competency Expectations

## Network providers must ensure that:


- ✓ Members are informed of [free access](#) to medical interpreters, signers, and TTY services to support effective communication.
  - ✓ Care is delivered with consideration of members' [race/ethnicity and language](#), and how these factors may influence health or illness.
  - ✓ Office staff who routinely interact with members [receive and participate in cultural competency training](#).
  - ✓ Staff responsible for data collection make [reasonable efforts](#) to collect race and language information and clearly explain race/ethnicity categories so members can accurately self-identify.
  - ✓ Treatment plans and clinical guidelines reflect consideration of factors that may influence care decisions, including:
    - Race, country of origin, native language
    - Social class, religion, age, gender
    - Mental or physical abilities, heritage, acculturation, sexual orientation, and related characteristics
  - ✓ Office locations display [printed materials](#) in English, Spanish, and other prevalent non-English languages as required by SCDHHS.
-  Visit [absolutetotalcare.com](https://absolutetotalcare.com) to learn about our Cultural Competency Plan or call [1-866-433-6041](tel:1-866-433-6041) for a hard copy.

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# Interpreter / Translation Services

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# ASL Interpretation Services

www.lsaweb.com

### Client Policy Guide: ASL Face-to-Face Interpreting Requests

Thank you for choosing LSA as your language services provider! We are committed to providing you with exceptional service from the minute you submit a request to the conclusion of any assignment.

In order to guarantee that all requests are received and responded to in a timely fashion, we are providing you with our policies for requesting American Sign Language (ASL) interpreting services, including ASL interpretation, English transliteration (signed and oral) and Deaf interpretation. LSA is proud to offer RID nationally certified interpreters and qualified pre-certified interpreters.

#### Types of Interpreting Situations

##### Legal

Applies to court trials, hearings, depositions or any legal matter that becomes part of a legal record. LSA uses a team of two interpreters for all legal assignments.

##### Mental Health

The need for completely accurate and effective communication is critical in the mental health setting. For this reason, LSA uses a Deaf / hearing team (which consist of one Deaf interpreter and one hearing interpreter) for most mental health assignments. Deaf interpreters have the highest level of linguistic skill in ASL and the best cultural connection to the Deaf consumer. There are times when a Deaf consumer will require a Deaf / hearing team for non mental health assignments due to limited language skills.

##### Conference / Platform Interpreting

Applies to any type of conference, seminar, town hall meeting or religious service. LSA requires a minimum of four weeks' notice for conference interpreting services lasting more than one day.

So that we can determine interpreter and CART needs for your conference, please be sure to include a checkbox on your registration form indicating the need for services, as well as a clearly defined response deadline four weeks before the conference start date.

Conference interpreting always requires a team of interpreters. For larger conferences with several breakout sessions, several teams may be necessary.

##### Team Interpreting

For occupational safety, requests for 1.5 hours or more of interpreting services may require a team of two interpreters, depending upon the complexity of the assignment.

#### Submitting Requests

Please try to submit your community / routine interpreting requests at least two business days in advance. Emergency / rush situations may be requested on demand but they will incur additional surcharges.

It is the institution's responsibility (not the Deaf consumer's) to request interpreting services. We recommend you do this when the appointment is booked with the Deaf consumer, or immediately after.


We kindly ask that you submit your ASL interpretation requests to LSA in one of the following two ways:

**Online:** Once your account is set up to submit online requests, you can enter requests via the LSA website any time of the day, any day of the week. Please note that requests received after 6:30 p.m. Monday through Friday will be processed the next business day. Please contact LSA's Client Services department at 800.305.9763 (option #7) or via e-mail at [clientservices@lsaweb.com](mailto:clientservices@lsaweb.com) to enable your account for online requests.

**Telephone:** You may call 866.827.7028 at any time to make a face-to-face interpreting request. If calling outside of our standard business hours (before 8:00 a.m. EST and after 6:30 p.m. EST Monday through Friday, and on the weekends), LSA's call center staff will be able to assist you.

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Language Services Associates • 455 Business Center Drive • Suite 100 • Horsham, PA 19044 • 800.305.9673

www.lsaweb.com

### Extra Time

Please try to provide us with a realistic estimate for the total length of time for the assignment, including any extra time that should be taken into consideration. For example, if there are security check-in procedures, or paperwork that needs to be filled out prior to the appointment, that information should be included in your request. In these instances, if the appointment is scheduled for 8:30 a.m., you should place your request for 8:15 a.m.

Sometimes assignments will go over the contracted time period. If the interpreter is available to stay after the projected end of an assignment, extra time will be charged to you in half-hour increments. Please understand that interpreters book their own schedules and may not be able to stay longer due to other commitments. If your meetings frequently run over the scheduled time, please expand the time of your request.

### Cancellation / No Show Policy

In the event a request for interpreting services is cancelled with more than two business days notice, there will be no charge to the requesting organization. Please note that if a holiday falls within the notice time period, an additional day notice is required.

Requests cancelled with less than two business days notice will be billed for the interpreter time reserved. If more than two hours were reserved, the payable fee will be for the time reserved per interpreter. If there was travel time involved, and the interpreter actually traveled to the assignment location, travel fees will also be charged.

### Deaf Consumer No-Show

In the event a Deaf consumer does not arrive as scheduled for an assignment, it is customary for the interpreter to wait approximately 30 minutes before leaving the assignment location. The requesting organization will be billed for the time reserved per interpreter.

### Interpreter No-Show

If the interpreter does not arrive for the scheduled assignment, please call LSA's Face-to-Face Interpreting division immediately. We will make every attempt to provide a substitute interpreter. If a substitute interpreter is not available, the assignment will be canceled and there will be no charge to the requesting organization.


### Travel Policy

Depending on your specific agreement with LSA, travel compensation may be charged for:

**Portal to Portal** – Travel compensation is charged at half the hourly interpreting rate for interpreters who travel to the site of an assignment.

**Mileage / Tolls / Parking** – These are all charged to the client as applicable. The current mileage rate is charged as set by the Internal Revenue Service.

Please feel free to contact a member of LSA's Face-to-Face Interpreting division at 866.827.7028 with any questions or concerns regarding our policies for placing ASL face-to-face interpreting requests.



Please request a copy of this policy from your **Provider Engagement Administrator** if needed.

# Requesting Interpreter Services

At Wellcare Health Plans, Inc., we value everything you do to deliver quality care to our members – your patients – and to ensure they have a positive health care experience. That’s why we strive to see that members who need language services have adequate communication support. We have resources available to provide assistance when you identify members who have potential cultural or language barriers. These include:

- Interpreter services for languages other than English or members who have limited English proficiency
- Sign language interpreter services for the hearing impaired
- Telephone system technology (TTY line) for the hearing impaired

Providers can access communication support for medical encounters as follows:

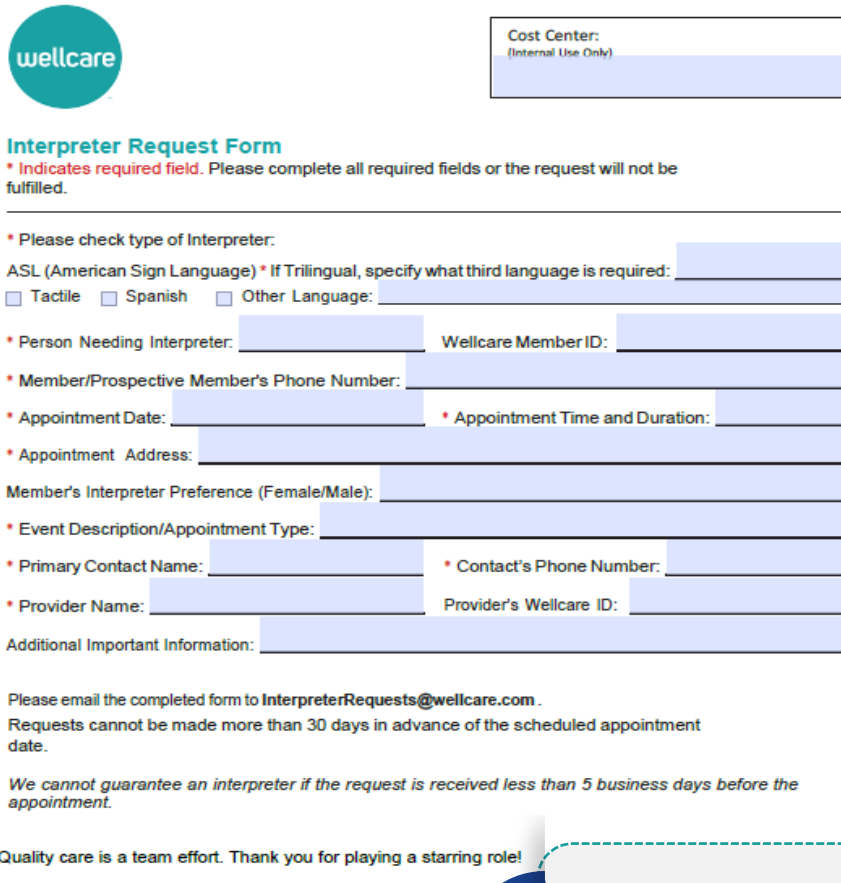
- **Non-urgent** – If a member needs a sign language or foreign language interpreter for a medical appointment, the Customer Service Department arranges for this service through a locally contracted vendor. **Live, in-person translation is preferred to telephonic translation in non-urgent cases; the telephonic service will only be used when an interpreter for the required language cannot be found in or near the particular area.** Please request interpreter services at least 5 business days in advance by completing the Interpreter Request Form and emailing it to [InterpreterRequests@wellcare.com](mailto:InterpreterRequests@wellcare.com).
- **Urgent/Emergent** – If a member needs language translation at the time of an urgent or emergent encounter and the provider does not have bilingual staff, the provider should call Customer Service. The Customer Service agent will work to patch in a translator for telephonic translation.

As a general rule, Wellcare discourages the use of patients’ family members, particularly minor children, as translators. Family members may not be capable of translating medical terminology. In addition, patients may hesitate to speak candidly about their health problems in the presence of young family members.

Wellcare pays all costs of commercial language services required by its members, including services rendered in a provider’s office or facility, as long as the translator is not on the staff of the facility.

## Electronic Media for the Hearing Impaired

Members have access to the TTY line for hearing impaired services. Wellcare’s Customer Service Department is responsible for any necessary follow-up calls to the member. The toll-free TTY number can be found on the member’s identification card.



The screenshot shows the 'Interpreter Request Form' with a Wellcare logo in the top left. A 'Cost Center' field is at the top right. The form includes a title 'Interpreter Request Form' and a note: '\* Indicates required field. Please complete all required fields or the request will not be fulfilled.' Below this are several fields: 'Please check type of Interpreter:' with a sub-field for 'ASL (American Sign Language) \* If Trilingual, specify what third language is required:' and checkboxes for 'Tactile', 'Spanish', and 'Other Language:'. Other fields include 'Person Needing Interpreter:' and 'Wellcare Member ID:', 'Member/Prospective Member’s Phone Number:', 'Appointment Date:' and '\* Appointment Time and Duration:', 'Appointment Address:', 'Member’s Interpreter Preference (Female/Male):', 'Event Description/Appointment Type:', 'Primary Contact Name:' and '\* Contact’s Phone Number:', 'Provider Name:' and 'Provider’s Wellcare ID:'. An 'Additional Important Information:' field is at the bottom. A note at the bottom of the form reads: 'Please email the completed form to [InterpreterRequests@wellcare.com](mailto:InterpreterRequests@wellcare.com). Requests cannot be made more than 30 days in advance of the scheduled appointment date. We cannot guarantee an interpreter if the request is received less than 5 business days before the appointment.'

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



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# Annual Provider Training Requirements

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# Annual Provider Training Requirements



## Fraud, Waste & Abuse

Intentional deception or misrepresentation (fraud), careless or inefficient use of resources (waste), and practices that are inconsistent with sound fiscal or medical practices (abuse), all of which lead to unnecessary costs to the healthcare system.



## General Compliance

Ensures compliance with industry regulations. This reduces the risk of violations that could lead to legal consequences.



## Model of Care (MOC)

A structured approach to delivering healthcare services that outlines how, when, and by whom care is provided to meet patients' needs effectively and efficiently.



## Cultural Competency

The ability of healthcare providers and organizations to understand, respect, and effectively respond to the cultural and linguistic needs of diverse patient populations.



## Person-Centered Planning

A collaborative approach to care that focuses on an individual's unique goals, preferences, and strengths to guide decision-making and support.

**We partner with each of our contracted providers to ensure that you have received the necessary training to deliver quality care to our members and your patients and to be compliant with Centers for Medicare & Medicaid Services (CMS) and state requirements. All Medicare Advantage Organization (MAO) contracted providers are required to complete the following trainings within 90 days of contracting and annually thereafter.**

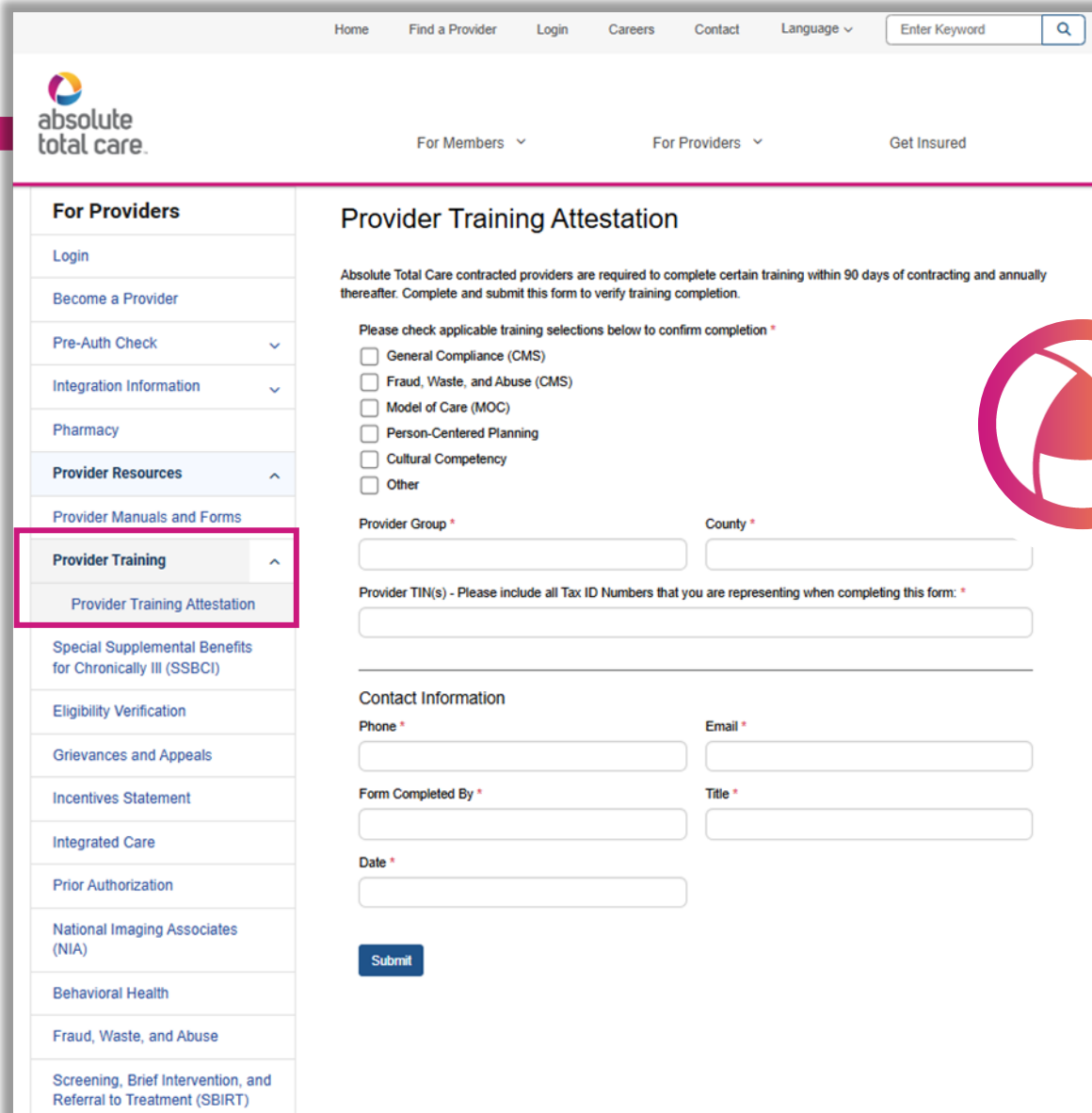
# Annual Provider Training Requirements



Required Training	Training Location
General Compliance	<a href="https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/medicare-provider-compliance-tips/medicare-provider-compliance-tips.html">https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/medicare-provider-compliance-tips/medicare-provider-compliance-tips.html</a>
Fraud, Waste and Abuse	<a href="https://cmsnationaltrainingprogram.cms.gov/resources">https://cmsnationaltrainingprogram.cms.gov/resources</a>
Model of Care (MOC)	<a href="https://www.wellcare.com/south-carolina/providers/medicare/training">https://www.wellcare.com/south-carolina/providers/medicare/training</a>
Person-Centered Planning	<a href="https://www.absolutetotalcare.com/providers/resources/provider-training.html">https://www.absolutetotalcare.com/providers/resources/provider-training.html</a>
Cultural Competency	<a href="https://www.absolutetotalcare.com/providers/resources/provider-training.html">https://www.absolutetotalcare.com/providers/resources/provider-training.html</a> <a href="https://www.ahrq.gov/sdoh/clas/index.html">https://www.ahrq.gov/sdoh/clas/index.html</a>



# Provider Training Attestation



The screenshot shows the Absolute Total Care website interface. At the top, there is a navigation bar with links for Home, Find a Provider, Login, Careers, Contact, and Language. A search bar is also present. Below the navigation bar, there are dropdown menus for 'For Members', 'For Providers', and 'Get Insured'. The main content area is titled 'Provider Training Attestation'. It includes a sidebar on the left with a menu where 'Provider Training' is highlighted, and 'Provider Training Attestation' is selected. The main form area contains the following sections:

- Provider Training Attestation**
  - Absolute Total Care contracted providers are required to complete certain training within 90 days of contracting and annually thereafter. Complete and submit this form to verify training completion.
  - Please check applicable training selections below to confirm completion \*
    - General Compliance (CMS)
    - Fraud, Waste, and Abuse (CMS)
    - Model of Care (MOC)
    - Person-Centered Planning
    - Cultural Competency
    - Other
  - Provider Group \*  County \*
  - Provider TIN(s) - Please include all Tax ID Numbers that you are representing when completing this form: \*
  - Contact Information
    - Phone \*  Email \*
    - Form Completed By \*  Title \*
    - Date \*
  -

Network providers are required to complete assigned training and attest to completion as part of network participation. Attestation confirms provider has reviewed and understands applicable requirements and agrees to comply with Absolute Total Care policies and standards.



## Provider Training

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# Authorized Vendors

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# Authorized Vendors



- Vision Services need to be verified by [Envolve Vision](#).
- Musculoskeletal Services need to be verified by [National Imaging Associates \(NIA\)\\*](#)
- Hospice requests should be submitted to SCDHHS Medicaid Fee for Service program.
- Oncology/supportive drugs for members aged 18 and older need to be verified by [New Century Health](#).
- Dental Services for members under 21 need to be verified by [SCDHHS](#) through the EPSDT program.
- Complex imaging, MRA, MRI, PET, CT scans need to be verified by [National Imaging Associates \(NIA\)](#).
- Outpatient rehabilitative and habilitative physical medicine services PT, OT, and Speech need to be verified by [National Imaging Associates \(NIA\)](#).



# Authorized Vendors and Partners



## **eviCore**

Our in-network vendor for Lab Management and Sleep Diagnostics programs; clinical criteria are accessible through the program links.

## **New Century Health**

Our in-network vendor for Oncology Pathways Solutions: Medical and Radiation Oncology, as well as Cardiology Management Program.

## **CareCentrix**

Provides in-network access to Skilled Nursing Facilities, Long Term Acute Care and Inpatient Rehab.

## **National Imaging Associates**

Provides in-network access to Skilled Nursing Facilities, Long Term Acute Care and Inpatient Rehab.



## HEALTH PLAN PARTNERS Contracted Networks

### HEARING

[TruHearing](#)

Phone: 1-800-334-1807

### VISION

[Centene Vision](#)

### DENTAL

[Liberty](#)

Phone: 1-866-544-4362

### TRANSPORTATION

[Modivcare](#)

Phone: 1-877-718-4201



## [SC Care Provider QRG](#)

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# Payment and Clinical Policies

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# Clinical Policies & Medical Necessity

Clinical policies help determine whether services are **medically necessary** using:

- Generally accepted standards of medical practice
- Peer-reviewed medical literature
- Government agency and program approval status
- Evidence-based guidelines and positions from leading national health professional organizations
- Clinical input from physicians practicing in relevant specialty areas
- Other available clinical information

## Clinical Policy Resources

 [Behavioral Health Clinical Policies](#)

 [Medical Clinical Policies](#)



## What These Policies Do

- Support accurate claims payment using **generally accepted principles of correct coding**
- Help determine whether services are appropriately coded for reimbursement

View Medicaid payment policies here:

 [Payment Clinical Policies](#)

## Key Sources of Payment Rules

### Centers for Medicare & Medicaid Services (CMS)

- *Claims Processing Manual (Pub. 100-04)*
- *National Correct Coding Initiative (NCCI)*
  - Procedure-to-procedure (PTP) edits
  - Medically Unlikely Edits (MUEs)

### American Medical Association (AMA)

- Current Procedural Terminology (CPT®) guidance for reporting procedures and services

### Health Plan Clinical Policies

- Based on medical necessity and appropriateness of care

### State-Specific Reimbursement Guidance

- Additional rules and edits based on local regulations

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# Claims 411

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# Claims Adjustments, Reconsiderations, and Disputes



## Claims Adjustments

Requests to change initial claim



## Reconsideration

Submitted when a provider disagrees with how a clean or adjusted claim was processed.



## Disputes

Submitted when a provider has received an unsatisfactory response to a previous reconsideration request.

MEDICAID <i>Submission Timeframes (from date of service)</i>		
Submission Timeframes	Par	Non-Par
Claim Initial/Resubmission	365 days	365 days
Claim Adjustment	365	365
Claim Dispute	60	60
Decision Timeframes	Par	Non-Par
Dispute Decision	30	30
Mailing Address		
P.O. Box 3050 Farmington, MO 63640-3821		
MARKETPLACE <i>Submission Timeframes (from date of service)</i>		
Submission Timeframes	Par	Non-Par
Claim Initial/Resubmission	180 days	180 days
Claim Adjustment	60	60
Claim Reconsideration	60	60
Claim Dispute	60	60
Decision Timeframes	Par	Non-Par
Appeal Decision	30	30
Dispute Decision	30	30
Mailing Address		
P.O. Box 5010 Farmington, MO 63640-5010		

# Claims Submission



## Secure Provider Portal

[www.AbsoluteTotalCare.com/login](http://www.AbsoluteTotalCare.com/login)

## EDI Payer Numbers – Medical

68069 – Emdeon/WebMD/Envoy/PayerPath  
42772 – RelayHealth/McKesson  
68055 – Allscripts/Payerpath/Practice Insights

## EDI Payer Numbers – Behavioral Health

68068 – Emdeon/WebMD/Envoy/Availity  
68068 – RelayHealth/McKesson  
68059 – Allscripts/Payerpath/Practice Insights

• *Claims submitted at the local office will not be accepted.*



## Absolute Total Care

(Medical & Behavioral Health)  
P.O. Box 3050  
Farmington, MO  
63640-3821

## Behavioral Health

P.O. Box 7001  
Farmington, MO  
63640-3811



Follow the applicable procedure based on your line of business



## Secure Provider Portal

<http://www.absolutetotalcare.com/login>

## EDI Payer Number – Medical

68069 – Emdeon/WebMD/Envoy/PayerPath

• *Claims submitted at the local office will not be accepted.*



## Ambetter from Absolute Total Care

P.O. Box 5010  
Farmington, MO 63640-5010



## Secure Provider Portal

[www.AbsoluteTotalCare.com/login](http://www.AbsoluteTotalCare.com/login)

## EDI Payer Number – Medical

68069 – Emdeon/WebMD/Envoy/PayerPath

• *Claims submitted at the local office will not be accepted.*



## Wellcare By Absolute Total Care

Attn: Claims  
P.O. Box 9700  
Farmington, MO 63640-0700

# Claims Submission Guidelines



**!** Complete all required fields based on claim type (CMS-1500 or UB-04) to avoid processing delays.

Form Field	What to Enter	CMS-1500	UB-04
<b>Billing Provider</b> (name, address, NPI)	Name, address, <b>10-digit NPI</b> , and taxonomy of the billing entity	Box 33	Box 1
<b>Subscriber</b> (required)	Subscriber name, address, DOB, sex, and <b>Health Plan ID exactly as shown on the member ID card</b>	Boxes 1a, 4, 7, 11	Boxes 58, 60
<b>Patient</b>	Patient name, address, DOB, sex, relationship to subscriber, status, and <b>Health Plan ID exactly as shown on the member ID card</b>	Boxes 2, 3, 5, 6, 8	Boxes 8, 9, 10, 11
<b>Attending Provider (NPI)</b>	<b>10-digit NPI and taxonomy</b> for the attending practitioner	N/A	Box 76
<b>Rendering Provider</b>	<b>10-digit NPI and taxonomy</b> for the practitioner who rendered the service (may be blank if sole proprietor and billing provider NPI is used)	Box 24J	Box 56
<b>Service Facility</b>	Name, address, <b>10-digit NPI</b> , and taxonomy where services were rendered (may be blank if sole proprietor)	Box 32	Box 1

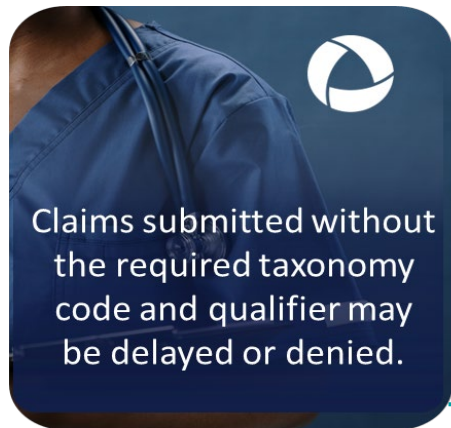
# Taxonomy Requirements

## Paper Submissions

### Paper Submission UB-04

**Billing** – Box 81CCa should contain the qualifier of “B3” in the left column and the taxonomy code in the middle column.

80 REMARKS	81CC a	B3	282N00000X
	b		
	c		
	d		



Claims submitted without the required taxonomy code and qualifier may be delayed or denied.

Taxonomy codes are 10-digit federally established numbers which health care providers use to identify their unique specialty areas.



### Paper Submission CMS 1500

**Rendering** – Box 24i should contain the qualifier “ZZ.” Box 24j (shaded area) should contain the taxonomy code.

24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES		E. DIAGNOSIS	F. \$ CHARGES	G. DAYS	H. EPST/	I. ID.	J. RENDERING	
From	To		SERVICE		(Explain Unusual Circumstances)	MODIFIER	POINTER		OR	Family	QUAL.	PROVIDER ID. #	
MM	DD	YY	MM	DD	YY				UNITS	Plan			
												ZZ	208U00000X
												NPI	REQUIRED

**Billing** – Box 33b should contain the qualifier “ZZ” along with the taxonomy code.

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # ( )
SIGNED _____ DATE _____	a. NPI _____ b. _____	a. REQUIRED _____ b. ZZ208U00000X

**Referring** – If a referring provider is indicated in Box 17 on the claim, Box 17a should contain the qualifier of “ZZ” along with the taxonomy code in the next column.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. ZZ	208U00000X
	17b. NPI	REQUIRED

# Taxonomy Requirements

## Electronic Submissions

### Electronic Submission UB-04

Taxonomy Code Example: 282N00000X

#### **ELECTRONIC SUBMISSION:**

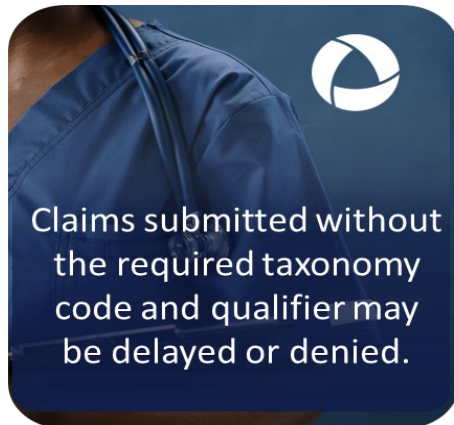
**Billing** - Loop 2000A - PRV01 "BI" = "Billing"; PRV02 – "PXC" qualifier; PRV03 = 10 character taxonomy code

### Electronic Submission CMS 1500

**Rendering** – Loop 2310B PRV01 "PE" = Referring PRV02 = "ZZ" qualifier PRV03 = 10 character taxonomy code

**Billing** – Loop 2000A-PRV01 "BI" PRV02 = "ZZ" qualifier PRV03 = 10 character taxonomy

**Referring** –If a referring provider is indicated in Box 17 on the claim, Box 17a should contain the qualifier of "ZZ" along with the taxonomy code.



Claims submitted without the required taxonomy code and qualifier may be delayed or denied.



Taxonomy codes are 10-digit federally established numbers which health care providers use to identify their unique specialty areas.





# Wellcare Medicare Advantage

Provider Timeframes, Claim Adjustments and Disputes



Type	Par	Non-Par
Initial Claim/Resubmission	180*	180*
Claim Payment Dispute	90*	90*
Claim Payment Policy Dispute	30***	30***
Appeal (Medical)	90	60**

\*From date of service

\*\*Waiver of Liability required

\*\*\*From date of last processed claim

Mailing Address



ATTN: Claims Department  
P.O. Box 31372  
Tampa, FL 33631-3372

# Wellcare Medicare Advantage

## Claims Submission

wellcare

### CLAIM SUBMISSION INFORMATION

#### SUBMISSION INQUIRIES

EDI team [EDIBA@centene.com](mailto:EDIBA@centene.com) or call Provider Services.

#### PREFERRED EDI CLEARINGHOUSE

Availity: **1-800-282-4548**

Web portal for direct data entry (DDE) claims:  
[availity.com/Essentials-Portal-Registration](http://availity.com/Essentials-Portal-Registration)

**PAYER IDS:** 14736 (CH-Chargeable)  
59354 (RF- Reporting only)

**Timely Filing guidelines:** 180 days from date of service.

#### EFT

Register: [payspanhealth.com](http://payspanhealth.com) or call **1-877-331-7154**

Email: [providersupport@payspanhealth.com](mailto:providersupport@payspanhealth.com)

#### MAIL PAPER CLAIMS TO:

**Wellcare**

Attn: Claims Department

P.O. Box 31372

Tampa, FL 33631-3372

wellcare™

Visit our **claims** page to locate detailed claims information, addresses, claim forms, and guidelines.



Claims submitted at the local office will not be accepted.

Follow the appropriate procedure for your line of business to submit your claim.

# Wellcare By Absolute Total Care Dual Align (HMO D-SNP)



Provider Timeframes, Claim Adjustments and Disputes

Effective 1/1/2026

- Claims submitted at the local office will not be accepted.
- Follow the appropriate procedure for your line of business to submit your claim.

## Wellcare Absolute Total Care Dual Align (HMO D-SNP)

Submission Timeframes	Par	Non-Par
Claim Initial/Resubmission	365 days	365 days
Claim Reconsideration	180 days	365 days
Claim Appeal	120 days	60 days
Claim Dispute	60 days	60 days
Decision Timeframes	Par	Non-Par
Appeal Decision	60 days	60 days
Dispute Decision	30 days	30 days

# Wellcare By Absolute Total Care Dual Align (HMO D-SNP)



Claim Submissions

Effective 1/1/2026

## CLAIM SUBMISSION INFORMATION

### SUBMISSION INQUIRIES

EDI team: [EDIBA@centene.com](mailto:EDIBA@centene.com) or call Provider Services

### PREFERRED EDI CLEARINGHOUSE

Availity:  
Web portal for direct data entry (DDE) claims:  
[Avility.com/Essentials-Portal-Registration](https://www.avility.com/Essentials-Portal-Registration)

### Secure Provider Portal:

[www.AbsoluteTotalCare.com/login](https://www.AbsoluteTotalCare.com/login)

### PAYER ID

68069-Emdeon/WebMD/Envoy/PayerPath

**Timely Filing guidelines:** 365 days from date of service

### EFT

Register: [payspanhealth.com](https://payspanhealth.com)  
or call 1-877-331-7154

Email:

[providersupport@payspanhealth.com](mailto:providersupport@payspanhealth.com)

### MAIL PAPER CLAIMS TO:

**Wellcare by Absolute Total Care**

Attn: Claims Department

P.O. Box 9700

Farmington, MO 63640-0700



Claims submitted at the local office will not be accepted.

Follow the appropriate procedure for your line of business to submit your claim.

# Common Claim Rejections and Denials



## Common Claim Rejections

- Incorrect Member details
- Member Inactive
- Incorrect Claim Form
- Taxonomy Missing



Rejection occurs  
BEFORE the claim  
enters processing



## Common Claim Denials

- Timely Filing
- Duplicate Claim
- Coordination of Benefits (COB)
- No Authorization on File that  
Matches Service(s) Billed



Claim denials occur  
AFTER the claim has  
been processed

# Top Claim Rejections and Causes



## Incorrect Member Details

- Misspelled names
- Inaccurate DOB
- Incorrect Member ID
- Incorrect line of business



## Incorrect Claim Form

- Eligibility should be verified often and prior to rendering services.



## Member Inactive at Time of Service

- File claims based on CMS guidelines or Contractual agreement



## Missing Taxonomy

- Providers are required to submit claims with the correct Taxonomy code and qualifier consistent with provider's specialty



Claim **REJECTIONS** occur **BEFORE** claims are entered into the system and processed. This is usually due to a technical issue or inaccurate formatting.

# Top Denials Rejections and Explanations



## Duplicate Claim Service

- A duplicate claim is a claim submitted more than once for the same service, DOS, Provider and member – without any changes or corrections



## Timely Filing

- Timely Filing is the maximum amount of time allowed between the DOS and the date a claim was submitted



## Coordination of Benefits (COB)

- **COB is the process used to determine the order in which multiple insurance plans pay for the services**



## No Authorization on file that Matches Service(s) Billed

- Due to either the prior authorization was not obtained or approved authorization does not match the billed services to include CPT/HCPCS, Provider, location or date



Claim DENIAL happens AFTER the claim has been processed and is denied due to but not limited to issues such as lack of medical necessity, coverage limitations, incorrect billing codes or timeliness of filing.

# Preventing “Duplicate Claim” Denials

## How it Happens

- System Errors
- Miscommunication
- Resubmitted before initial claim is processed



A Claim DENIAL happens AFTER the claim has been processed and is denied due to but not limited to issues such as lack of medical necessity, coverage limitations, incorrect billing codes or timeliness of filing.

## Why it Matters

- Unnecessary denials
- Reimbursement delays
- Increased administrative work
- Audit trigger / Compliance risk
- Less time on duplicates means more time for patient care and operations

## Best Practices

- Verify claim status before resubmitting
- Modify/correct claim as needed
- Refer to the reconsideration and dispute process
- Keep staff trained and up to date on procedures and guidelines

# Preventing “Timely Filing” Denials



## How it happens

- Filing claim past the Timely Filing guidelines outlined per the line of business or individual provider agreement



## Why it matters

- Faster claim processing
- Reduces lost revenue
- Increased administrative work
- Billing efficiency



A Claim **DENIAL** happens **AFTER** the claim has been processed and is denied due to but not limited to issues such as lack of medical necessity, coverage limitations, incorrect billing codes or timeliness of filing.



## Best Practices

- Submit claims immediately after rendering services
- Implement software alerts and tracking to monitor deadlines
- Keep detailed records of submission attempts and confirmations
- Conduct regular billing audits and train staff on guidelines

# Preventing “Coordination of Benefits” (COB) Denials



## How it happens

- Missing COB information or updates
- Incorrect Primary/Secondary insurance designation
- Claim submitted to secondary payer without primary EOB
- Member did not notify payer of coverage changes
- Duplicate or overlapping coverage records



## Why it matters

- Faster claim processing
- Reduces lost revenue
- Increased administrative work



## Best Practices

- Verify eligibility and coverage each visit
- Ask member about other insurance
- Update COB details with payers regularly
- Submit claims in correct order: Primary first, then secondary
- Include primary EOB when billing secondary payer
- Train staff on COB workflows and guidelines



A Claim **DENIAL** happens **AFTER** the claim has been processed and is denied due to but not limited to issues such as lack of medical necessity, coverage limitations, incorrect billing codes or timeliness of filing.

# Preventing “No Authorization on File” Denials



## How it happens

- Approved Prior Authorization does not match the billed service to include CPT/HCPC Codes, Provider, location or requested date(s)
- Provider failed to obtain Prior Authorization



## Why it matters

- Faster claim processing
- Reduces lost revenue
- Increased administrative work



## Best Practices

- Regularly review Prior Auth requirements
- Verify Authorization details prior to rendering services
- Confirm approved authorization details prior to submitting claim
- Update authorization request immediately, if needed, prior to filing claim
- Authorization number must be included on the submitted claim:  
CMS 1500 BOX 23, UB-04 BOX 63



A Claim **DENIAL** happens **AFTER** the claim has been processed and is denied due to but not limited to issues such as lack of medical necessity, coverage limitations, incorrect billing codes or timeliness of filing.

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# Electronic Funds Transfer

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PaySpan<sup>®</sup> provides an innovative web-based solution for Electronic Funds Transfers (EFTs) and Electronic Remittance Advices (ERAs). This service is provided at no cost to providers and allows online enrollment.

## PAYSPAN<sup>®</sup>

- Elimination of paper checks/virtual credit card payment.
- Convenient payments and retrieval of remittance information.
- Electronic Remittance Advice (ERAs) presented online.
- HIPAA 835 electronic remittance files for download directly to a HIPAA-Compliant Practice Management for Patient Accounting System.
- Reduce accounting expenses: Electronic remittance advices can be imported directly into practice management or patient accounting systems.
- Improve cash flow: Electronic payments can mean faster payments, leading to improvements in cash flow.
- Maintain control over bank accounts: You keep total control over the destination of claim payment funds. Multiple practices and accounts are supported.
- Match payments to advices quickly: You can associate electronic payments with ERAs quickly and easily.
- Manage multiple payers: Reuse enrollment information to connect with multiple payers. Assign different payers to different bank accounts, as desired.

## PAPER CHECKS WITH PAYSPAN®

- Payments previously issued by check are now processed through the Zelis Payments Network.
- Providers receive payments electronically via ACH, based on their enrollment preference.
- ACH+ offers faster electronic payments—without check delays or credit card fees.



*Questions about a payment or access to funds?*

Contact Zelis Provider Services at 1-877-828-8770 or [ClientService@zelispayments.com](mailto:ClientService@zelispayments.com)

## PAYSPAN® RESOURCES

- Providers can register using PaySpan's enhanced provider registration process at <http://www.payspanhealth.com/>.
- Providers can access additional resources by clicking **Need More Help** on the PaySpan® homepage or link directly to <https://www.payspanhealth.com/nps/Support/Index>
- PaySpan® Health Support can be reached via email at [providersupport@payspanhealth.com](mailto:providersupport@payspanhealth.com), by phone at 1-877-331-7154 or on the web at <https://www.payspanhealth.com/>.

# Quality Improvement

# Partnership for Quality (P4Q) Bonus Program

The **2026 Partnership for Quality Program** has been extended to all South Carolina Product lines:



**Absolute Total Care** understands that the provider-member relationship is a key component in ensuring superior healthcare and the satisfaction of our members. Because **Absolute Total Care** recognizes these important partnerships, we are pleased to offer the 2026 **Partnership for Quality (P4Q) Bonus Program**, which rewards PCPs for improving quality and closing gaps in care.

The measurement period is Jan. 1 to Dec. 31, 2026.

**Absolute Total Care** must receive all claims/encounters by **January 31, 2027.**

# Partnership for Quality (P4Q)




**2026 Partnership for Quality**

Absolute Total Care is pleased to announce the launch of the 2026 Partnership for Quality (P4Q) Program. Primary care providers can earn additional compensation by addressing preventive care activities and closing care gaps for our members.


Program Measures	Amount Per
ADD - ADHD Maintenance Phase Visit	\$50
BCS - Breast Cancer Screening	\$50
CBP - Controlling High Blood Pressure	\$50
EED - Diabetes - Dilated Eye Exam	\$50
GSD - Diabetes HbA1c < 8	\$50
BPD - Diabetes BP < 140/90	\$50
CHL - Chlamydia Screening In Women	\$50
CIS - Childhood Immunization Status Combo 10	\$50
COL - Colorectal Cancer Screening	\$50
IMA - Immunizations for Adolescents Combo 2	\$50
KED - Kidney Health for Patients With Diabetes	\$50
PPC - Postpartum Visit	\$50
PPC - Prenatal Visit (Timeliness)	\$50
PRS-E - Prenatal Immunizations	\$50
SPC - Statin Therapy for Patients with CVD	\$50
SPC - Statin Adherence for Patients with CVD	\$50
SPD - Statin Therapy for Patients With Diabetes	\$50
SPD - Statin Adherence for Patients with Diabetes	\$50

## P4Q Program Instructions

- 1 Schedule visits & close care gaps**
  - Contact patients to schedule appointments
  - Order required tests and preventive screenings
  - Complete all preventive care by December 31, 2026
- 2 Document & submit required data**
  - Document care, treatment, and diagnoses in the medical record
  - Submit all applicable diagnosis codes via claims, encounters, or approved NCQA supplemental files (ICD-10, CPT, CPT II) by January 31, 2027
- 3 Review results with patients**
  - Review and discuss test and screening results
  - Provide counseling as appropriate



The 2026 Partnership for Quality (P4Q) Program offers additional compensation for providers who address preventive care and close care gaps

- 
- Providers may earn additional compensation through the Continuity of Care Plus (CoC+) program
  - Use the Appointment Agenda during patient visits to guide care and validate insights
  - Earn up to \$450 per patient by meeting program requirements

# Partnership for Quality (P4Q)



**2026 Partnership for Quality Program**

Wellcare is pleased to announce the launch of the 2026 Partnership for Quality (P4Q) Program. Primary care providers can earn additional compensation by addressing preventive care activities and closing care gaps for our members. In addition, providers can earn even more by caring for our Clinical Priority Members.

**P4Q Program Measures**

Measure	P4Q Amount per Member	P4Q Amount per Clinical Priority Member	Combined P4Q and Clinical Priority Member Earning Potential	Common Ways to Close the Gap
Annual Preventive Visit (APV)	\$25	\$25	\$50	Annual Wellness Visit and/or Routine Physical Exam
Breast Cancer Screening (BCS)	\$50	\$10	\$60	Mammogram
Controlling High Blood Pressure (CBP)	\$100	\$25	\$125	Documented blood pressure reading
Colorectal Cancer Screen (COL)	\$50	\$10	\$60	Fit kit, colonoscopy, CT colonography
Diabetes - Dilated Eye Exam (EED)	\$25	\$10	\$35	Comprehensive eye exam or retinal screening with proper diagnosis codes
Diabetes HbA1C ≤ 9 (GSD)	\$100	\$25	\$125	Blood test
Kidney Health Evaluation for Patients with Diabetes (KED)	\$50	\$10	\$60	Urine screening and blood test

(continued)

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The 2026 Partnership for Quality (P4Q) Program offers additional compensation for providers who address preventive care and close care gaps

## P4Q Program Instructions

- Schedule visits & close care gaps**
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- Review results with patients**
  - Review and discuss test and screening results
  - Provide counseling as appropriate



## Earn more with Continuity of Care Plus (CoC+)

You may be eligible for additional compensation through the Continuity of Care Plus (CoC+) program. During your patient visits, use the Appointment Agenda as a guide, and assess the validity of each insight listed. Providers may earn additional compensation of up to \$450 per patient based on meeting program requirements.

For more information on participating in additional compensation programs, please contact your Provider Representative.

# Partnership for Quality (P4Q)

## 2026 Partnership for Quality

Ambetter from Absolute Total Care is pleased to announce the launch of the 2026 Partnership for Quality (P4Q) Program. Primary care providers can earn additional compensation by addressing preventive care activities and closing care gaps for our members.

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BPD - Diabetes BP < 140/90	\$50
CHL - Chlamydia Screening In Women	\$50
CIS - Childhood Immunization Status Combo 10	\$50
COL - Colorectal Cancer Screening	\$50
IMA - Immunizations for Adolescents Combo 2	\$50
KED - Kidney Health for Patients With Diabetes	\$50
PPC - Postpartum Visit	\$50
PPC - Prenatal Visit (Timeliness)	\$50
PRS-E - Prenatal Immunizations	\$50
SPC - Statin Therapy for Patients with CVD	\$50
SPC - Statin Adherence for Patients with CVD	\$50
SPD - Statin Therapy for Patients With	\$50
SPD - Statin Adherence for Patients With	\$50



The 2026 Partnership for Quality (P4Q) Program offers additional compensation for providers who address preventive care and close care gaps

## P4Q Program Instructions

- 1 **Schedule visits & close care gaps**
  - Contact patients to schedule appointments
  - Order required tests and preventive screenings
  - Complete all preventive care by December 31, 2026
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  - Document care, treatment, and diagnoses in the medical record
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  - Review and discuss test and screening results
  - Provide counseling as appropriate



- Providers may earn additional compensation through the Continuity of Care Plus (CoC+) program
- Use the Appointment Agenda during patient visits to guide care and validate insights
- Earn up to \$450 per patient by meeting program requirements

# Partnership for Quality (P4Q)

## 2026 Partnership for Quality Program



Wellcare By Absolute Total Care is pleased to announce the launch of the 2026 Partnership for Quality (P4Q) Program.

Primary care providers can earn additional compensation by addressing preventive care activities and closing care gaps for our members. In addition, providers can earn even more by caring for our Clinical Priority Members.

### P4Q Program Measures

Measure	P4Q Amount per Member	P4Q Amount per Clinical Priority Member	Combined P4Q and Clinical Priority Member Earning Potential	Common Ways to Close the Gap
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Breast Cancer Screening (BCS)	\$50	\$10	\$60	Mammogram
Controlling High Blood Pressure (CBP)	\$100	\$25	\$125	Documented blood pressure reading
Colorectal Cancer Screen (COL)	\$50	\$10	\$60	Fit kit, colonoscopy, CT colonography
Diabetes - Dilated Eye Exam (EED)	\$25	\$10	\$35	Comprehensive eye exam or retinal screening with proper diagnosis codes
Diabetes HbA1C > 9 (GSD)	\$100	\$25	\$125	Blood test
Kidney Health Evaluation for Patients with Diabetes (KED)	\$50	\$10	\$60	Urine screening and blood test

(continued)

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The 2026 Partnership for Quality (P4Q) Program offers additional compensation for providers who address preventive care and close care gaps

## P4Q Program Instructions



1

### Schedule visits & close care gaps

- Contact patients to schedule appointments
- Order required tests and preventive screenings
- Complete all preventive care by December 31, 2026

2

### Document & submit required data

- Document care, treatment, and diagnoses in the medical record
- Submit all applicable diagnosis codes via claims, encounters, or approved NCQA supplemental files (ICD-10, CPT, CPT II) by January 31, 2027

3

### Review results with patients

- Review and discuss test and screening results
- Provide counseling as appropriate

## Earn More with Continuity of Care Plus (CoC+)

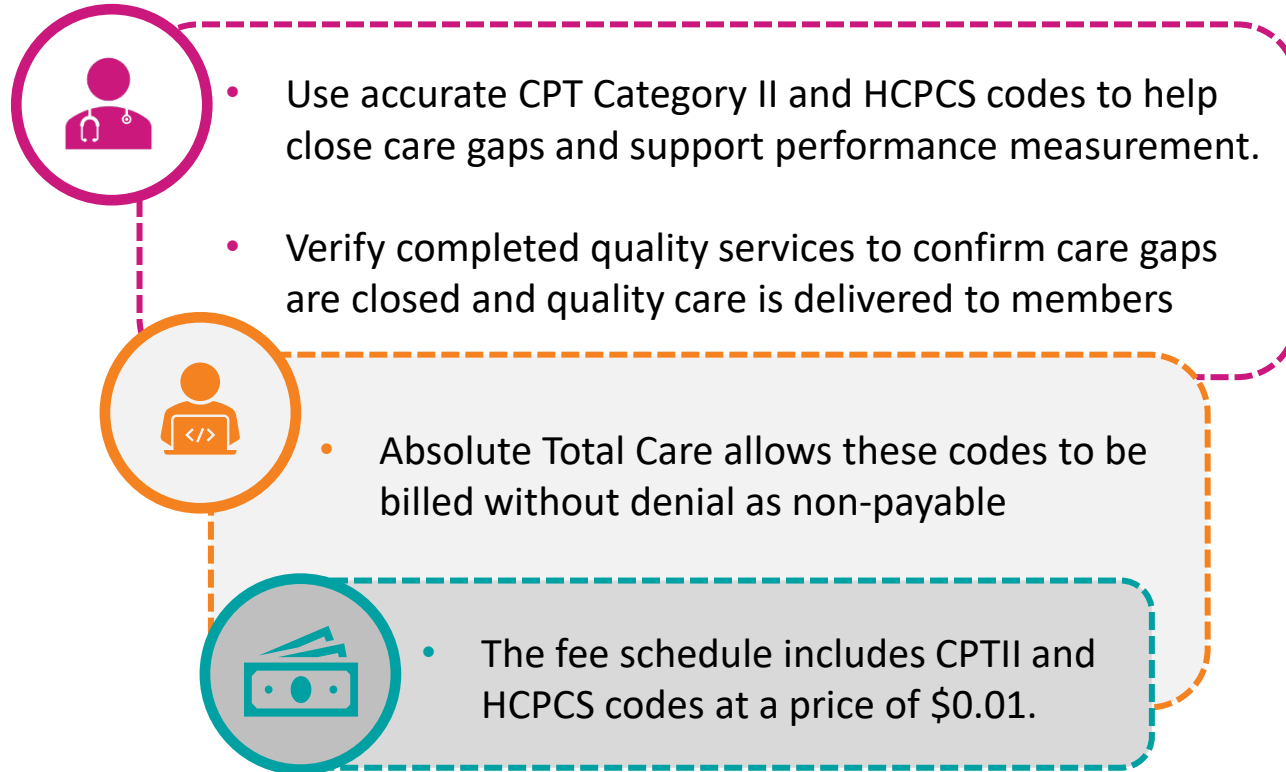
You may be eligible for additional compensation through the Continuity of Care Plus (CoC+) program. During your patient visits, use the Appointment Agenda as a guide, and assess the validity of each insight listed. Providers may earn additional compensation of up to \$450 per patient based on meeting program requirements.



For more information on participating in additional compensation programs, please contact your Provider Representative.

# Billing CPT II and HCPCS Quality Codes

## Important Information on CPT II & HCPCS Codes



CPTII Codes and HCPCS Billing PRO\_91371E\_Approved\_01112022.pdf

## What measures do these codes apply to?

### Controlling Blood Pressure

- Blood pressure results

### A1C levels

### Diabetic Retinal Eye Exams

### Care of Older Adults

- Pain Assessment
- Medication List and Review
- Functional Status Assessment

### Medication Reconciliation Post Discharge

- Medication List and Review after hospital discharge

# Electronic Medical Records (EMR) System



Streamline provider office staff activities regarding HEDIS Hybrid chart chase requests



Decrease and avoid duplication of over utilization or retrieval efforts



Contribute to enhanced HEDIS performance metrics



Remote access to EMR allows designated health plan representatives access to your medical records directly through remote access.



Contact Jane Brown via email at [jane.f.brown@centene.com](mailto:jane.f.brown@centene.com)

# Supplemental Data Feeds



**Monthly Supplemental Data Feed:** This type of file transfer utilizes specific data extracts from the Electronic Medical Record (EMR). Data is transmitted securely via Secure file transfer protocol (SFTP).

Close care gaps

Potential  
incentives

Improve HEDIS  
scores

Reduces  
medical record  
requests

Contact Jane Brown via email at [jane.f.brown@centene.com](mailto:jane.f.brown@centene.com)

# CAHPS<sup>®</sup>

## Consumer Assessment of Healthcare Providers and Systems

# CAHPS® Provider Resource Guide



## CAHPS (Consumer Assessment of Healthcare Providers and Systems)



CAHPS/HOS Provider Resource Guide

PROVIDER ENGAGEMENT COLLATERAL

[CAHPS Core Method](#)  
[Provider Quick Tips Guide](#)

### CAHPS (Consumer Assessment of Healthcare Providers and Systems)

Every year, a random sample of HEALTH PLAN members are surveyed about their experience with their doctors, services, and health plan. It is an important component of ensuring that patients are satisfied, not only with the health outcomes but also with their health care experience.

CAHPS surveys allow patients to evaluate the aspects of delivery that matter the most to them. At HEALTH PLAN, we are committed to partnering with our providers to deliver an outstanding patient experience.

As a provider, you are the most critical component of that experience. We want to ensure that you know exactly how your patients are evaluating your care. Please take a moment to review and to familiarize yourself with some of the key topics included in the survey.

#### CAHPS MEASURE: GETTING NEEDED CARE

The Getting Needed Care measure assesses the ease with which patients received the care, tests, or treatment they needed. It also assesses how often they were able to go to a specialist appointment scheduled when needed.

##### Incorporate the following into your daily practice:

- Use staff to help **coordinate specialty appointments** for urgent cases
- Encourage patients and caregivers to view results on the **patient portal** when available
- Inform patients of when and where care is needed **after hours**
- Offer appointments or refills via **text and/or email**

#### CAHPS MEASURE: GETTING CARE QUICKLY

The Getting Care Quickly measure assesses how often patients get the care they need as soon as they request it and how often appointment wait times exceed 15 minutes.

##### Incorporate the following into your daily practice:

- Ensure a **few appointments each day** are available to accommodate urgent visits
- Offer appointments with a **nurse practitioner or physician assistant** for short notice appointments
- Maintain an **effective triage system** to ensure the triage and/or very sick patients are seen right away or provided alternate care via phone and urgent care
- Keep patients informed if there is a longer wait time than expected and give them an **option to reschedule**

CAHPS/HOS Provider Resource Guide

CAHPS/HOS Provider Resource Guide

PROVIDER ENGAGEMENT COLLATERAL

[Core Concepts](#)  
[Key Elements of Using Teach-back](#)

#### CAHPS MEASURE: CARE COORDINATION

The Care Coordination measure assesses providers' assistance with managing the disparate and confusing health care system, including access to medical records, timely follow-up on test results, and education on prescription medications.

##### Incorporate the following into your daily practice:

- Ensure there are open appointment slots for **patients recently discharged** from a facility
- Migrate PO and specialty practices through **EMR or fax** to get reports promptly
- Ask patients if they have seen any other providers; **discuss visits to specialty care** as needed
- Encourage patients to **bring in their medications** to each visit

#### CAHPS MEASURE: HOW WELL DOCTORS COMMUNICATE

The How Well Doctors Communicate measure assesses patients' perception of the quality of communication with their doctor. Consider using the Teach-Back Method to ensure patients understand their health information.

##### What is Teach-back?

- A way to ensure you – the healthcare provider – have explained information clearly. It is not a test or quiz of patients
- Asking a patient (or family member) to explain in their own words what they need to know or do, in a caring way
- A way to check for understanding and, if needed, to explain and check again
- A research-based health literacy intervention that improves patient-provider communication and patient health outcomes

#### CAHPS MEASURE: RATING OF HEALTH CARE QUALITY

The CAHPS survey asks patients to rate the overall quality of their health care on a 0-10 scale.

##### Incorporate the following into your daily practice:

- Encourage patients to make their **routine appointments** for checkups or follow up visits as soon as they can – weeks or even months in advance
- Ensure that **open care gaps** are addressed during each patient visit
- Make use of the **provider portal** when requesting prior authorization

CAHPS/HOS Provider Resource Guide



## Consumer Assessment of Healthcare Providers and Systems (CAHPS) | Absolute Total Care

# Provider Focus Quick Tips



## Getting Care Quickly

- Use triage to ensure frail or very sick patients are seen promptly or directed to urgent care.
- Offer NP or PA visits when the primary provider is unavailable.
- Reserve daily slots for urgent visits.
- Meet the 15-minute wait-time standard with timely staff attention.
- Notify patients of delays and offer rescheduling



## Getting Needed Care

- Coordinate urgent specialty appointments with the appropriate specialty office.
- Encourage patients and caregivers to review results in the patient portal, if available.



## Care Coordination

- Keep appointments available for recently discharged patients.
- Coordinate PCP and specialty care via EMR or fax to ensure timely reports.
- Ask about visits with other providers and document as needed.
- Encourage patients to bring medications to each visit



## Routine Care Planning

- Encourage patients to schedule routine and follow-up visits in advance.

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# Accessibility and Availability Standards

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# Accessibility and Availability



**Accessibility** is defined as the extent to which a member can obtain needed services in a timely and convenient manner. This includes both telephone access and the ease of scheduling appointments, when applicable.



**Availability** is defined as the extent to which Absolute Total Care contracts with the appropriate type and number of practitioners and providers necessary to meet the needs of its members within defined geographical areas.



- All Providers must adhere to standards of timeliness for appointments and in-office waiting times.
- These standards take into consideration the immediacy of the Member's needs.
- **Absolute Total Care** and **Wellcare** will monitor Providers against the standards for each line of business to help Members obtain needed health services within acceptable appointment times, in-office waiting times and after-hours standards.
- Providers not in compliance with these standards will be required to implement corrective actions.

# Access Standards Medicaid

## Behavioral Provider Appointment Access Standards

Initial visit for routine care	Within 10 business days
Follow-Up routine care for established patients	Within 15 business days
Care for a non-life-threatening emergency	Within 6 hours or referred to the emergency room or behavioral health crisis unit
Emergent or emergency visits	Immediately upon presentation at a service delivery site
24 Hour coverage	24 hours a day, 7 days a week or triage system approved by Absolute Total Care
Office wait time for scheduled routine appointments	Not to exceed 45 minutes
Walk-in Appointments/non-urgent	Should be seen if possible or schedules for an appointment

## Other Required Specialty Care Provider Appointment Access Standards

Routine Visits for non-symptomatic care	Within 4-12 weeks
Urgent medical condition visits	Within 48 hours
Emergent or emergency visits	Immediately upon referral
Indian Medical Referrals	Allow for Indian Health Care provider referrals of an Indian member

# Access Standards Medicaid

## Primary Care Provider (PCP) Appointment Access Standards

Routine Visits for established patients	Within 15 business days <b>*NEW*</b>
Urgent or non-emergency visits	Within 48 hours
Emergent or emergency visits	Immediately upon presentation at a service delivery site
24-hour coverage	24 hours a day, 7 days a week or triage system approved by Absolute Total Care
Office wait time for scheduled routine appointments	Not to exceed 45 minutes
Walk-in appointments/non-urgent	Should be seen if possible or scheduled for an appointment

## Specialty Care Provider Appointment Access Standards

### Obstetrics & Gynecology (OB/GYNs), Oncologists, Retail Pharmacy and Autism Services

Routine Visits for established patients	Within 15 business days
Urgent or non-emergency visits	Within 48 hours
Emergent or emergency visits	Immediately upon presentation at a service delivery site
24-hour coverage	24 hours a day, 7 days a week or triage system approved by ATC
Office wait time for scheduled routine appointments	Not to exceed 45 minutes
Walk-in appointments/non-urgent	Should be seen if possible or scheduled for an appointment

# Access Standards

## Wellcare By Absolute Total Care



Primary Care and Specialist Appointment Type	Access Standard
PCP-Urgent	Within 24 hours
PCP-Non-urgent	Within 7 business days
PCP-Regular and routine	Within 30 business days
All specialists (including high volume and high impact) - Urgent	Within 24 hours
All specialists (including high volume and high impact) - Non-Urgent	Within 30 business days
Behavioral health provider - Urgent care	48 hours
Behavioral health provider – Initial routine care	Within 10 business days
Behavioral health provider – Non-life-threatening emergency	Within 6 hours
Behavioral health provider – Initial routine care follow-up	Within 10 business days
In-office wait times for all standards	Not to exceed 15 minutes

# Access Standards Wellcare Advantage



Primary Care and Specialist Appointment Type	Access Standard
<b>PCP-Urgent</b>	<b>Within 24 hours</b>
<b>PCP-Non-urgent</b>	<b>Within 1 week of the request</b>
<b>PCP-Regular and routine</b>	<b>Within 30 calendar days</b>
<b>All specialists (including high volume and high impact) - Urgent</b>	<b>Within 24 hours</b>
<b>All specialists (including high volume and high impact) - Non-Urgent</b>	<b>Within 30 calendar days</b>
<b>Behavioral health provider - Urgent care</b>	<b>48 hours</b>
<b>Behavioral health provider – Initial routine care</b>	<b>Within 10 business days</b>
<b>Behavioral health provider – Non-life-threatening emergency</b>	<b>6 hours</b>
<b>Behavioral health provider – Initial routine care follow-up</b>	<b>Within 10 business days</b>

# Access Standards Ambetter



Appointment Type	Access Standard
PCP's - Routine visit	30 calendar days
PCP's – Adult sick visit	48 hours
PCP's – Pediatric sick visit	24 hours
Behavioral health non-life-threatening emergency	6 hours or direct member to crisis center or emergency room (ER)
Specialist	Within 30 calendar days
Urgent care providers	24 hours
Behavioral health urgent care	48 hours
After hours care	Answering service 24 hours a day, 7 days a week or instructions on how to reach a physician
Emergency	24 hours a day, 7 days a week



*Absolute Total Care  
is committed to  
giving our providers  
tools and support  
you need.*



Scan the QR Code to learn more about our Provider Resources, such as manuals, forms, and quick reference guides

[absolutetotalcare.com](http://absolutetotalcare.com)

# wellcare™



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you need.*



Scan the QR Code to learn more about our Provider Resources, such as manuals, forms, and quick reference guides

[wellcare.com/medicare](https://wellcare.com/medicare)



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# Appendix

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# Healthy Connections (Medicaid)

## 2026 Member ID Card Overview

### Front of Member ID Card

#### Member Information

- Member Full Name
- Member Date of Birth
- Member ID# (required for claims)
- Effective Date (benefits begin)

#### Primary Care Provider

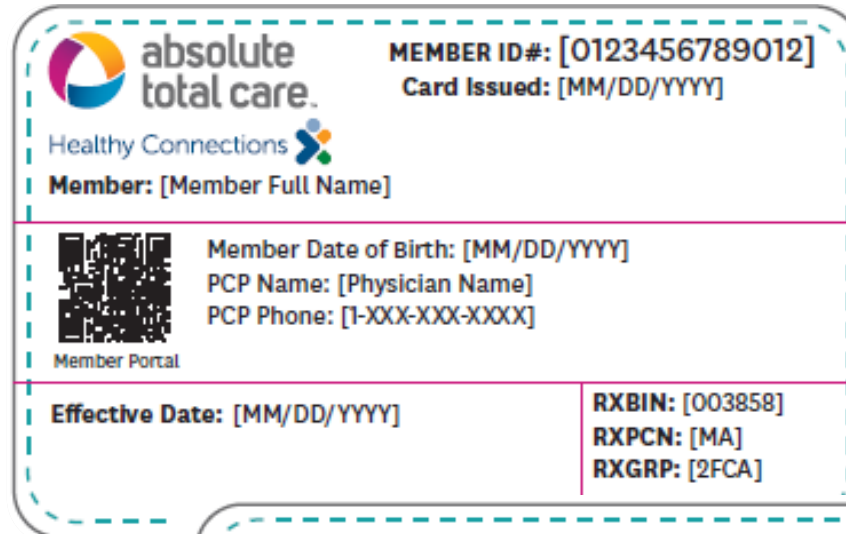
- PCP Name
- PCP Phone Number

#### Digital Access

- Member Portal QR Code

#### Pharmacy Processing

- RXBIN / RXPCN / RXGRP



### Back of Member ID Card

#### Support & Assistance

- Member/Provider Services
- 24/7 Nurse Advice Line
- Behavioral Health

#### Specialty & Home-Based Care

- Imaging, X-rays, Radiology
- DME, Home Health, Infusion

#### Pharmacy Support

- Pharmacy Help Desk (pharmacists only)

#### Administrative Information

- ATC Billing Address
- ATC Website

# Medicare Dual Align HMO D-SNP

## 2026 MEMBER ID CARD



- Plan Name: Wellcare Absolute Total Care Dual Align (HMO D-SNP)
- Contract (PBP) Number: H5272-001
- Brand Name: Wellcare By Absolute Total Care

**Plan Name:** Wellcare Absolute Total Care Dual Align (HMO D-SNP)  
**Effective Date:** January 1, 2026

**The Label:** Wellcare Absolute Total Care Dual Align is a managed care plan that contracts with both Medicare and Medicaid

**Member ID Number:** A single number used for eligibility verification and claims for all services regardless of whether it's a Medicare or Medicaid covered benefit.

**Wellcare Absolute Total Care Dual Align (HMO D-SNP)**

Wellcare Absolute Total Care Dual Align is a managed care plan that contracts with both Medicare and South Carolina Healthy Connections Medicaid.

**Member Name:** [Cardholder Name]  
**Member ID:** [Cardholder ID#]  
**PCP Group/Name:** [PCP/Group Name]  
**PCP Phone:** [PCP Phone]

**MEMBER CANNOT BE CHARGED**  
Copays: PCP/Specialist: \$0 ER: \$0  
[H5272] [001]

**MedicareRx**  
Prescription Drug Coverage

**RXBIN:** [610014]  
**RXPCN:** [MEDDPRIME]  
**RXGRP:** [2FFA]

**Member Services / Nurse A Behavioral Health**  
Vision: [Centene Vision Ser  
Dental: [Liberty Dental]  
Transportation: [ModivCar  
Provider Services / Pharma  
Pharmacist Only

**Send Claims To:** [Wellcare By Absolute Total Care Attn: Claims P.O.  
Box 9700 Farmington, MO 63640-0700] Payor ID: [68069]  
**Part D Claims:** [Wellcare By Absolute Total Care Attn: Medicare Part  
D Member Reimbursement P.O. Box 31577 Tampa, FL 33631-3577]  
**FOR EMERGENCIES:** Dial 911 or go to the nearest Emergency Room  
**Website:** [go.wellcare.com/ATC]


# Wellcare (Medicare HMO 4847)

## 2026 MEMBER ID CARD OVERVIEW



 Brand Name: Wellcare

Plan Name	Contract (PBP) Number
Wellcare Simple (HMO-POS)	H4847-001
Wellcare Assist (HMO-POS)	H4847-005
Wellcare Giveback (HMO-POS)	H4847-007
Wellcare Patriot Giveback (HMO-POS)	H4847-006




**[Plan Name] [(Plan Type)]**

**MEMBER ID#:** 1234567890123  
**PLAN#:** HXXXX-XXX-000  
**ISSUER #:** (80840) 9151014609

---

**Member:** SAMPLE A SAMPLE

2026



*You can see any PCP in our Network*


**PCP:** [Physician Name]  
**PCP Phone:** 1-XXX-XXX-XXXX  
**PCP Office Visit:** [\$X]

Member portal

---

**Card Issued:** MM/DD/YYYY

**RXBIN:** 610014  
**RXPCN:** MEDDPRIME  
**RXGRP:** 2FFA





Member Services / Nurse Advice Line	1-XXX-XXX-XXXX (TTY: 711)
Vision: [Provider]	1-XXX-XXX-XXXX (TTY: 711)
Dental: [Provider]	1-XXX-XXX-XXXX (TTY: 711)
Transportation: [Provider]	1-XXX-XXX-XXXX (TTY: 711)
Provider Services / Pharmacy Prior Auth	1-XXX-XXX-XXXX (TTY: 711)
Pharmacist Only	1-XXX-XXX-XXXX (TTY: 711)

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**Medical Claims:** Wellcare Attn: Claims P.O. Box XXXXX Tampa, FL 33631-XXXX Payor ID: 14163

**Part D Claims:** Wellcare Attn: Medicare Part D Member Reimbursement Dept. P.O. Box 31577 Tampa, FL 33631-3577

**FOR EMERGENCIES:** Dial 911 or go to the nearest Emergency Room

[go.wellcare.com/Medicare](http://go.wellcare.com/Medicare)

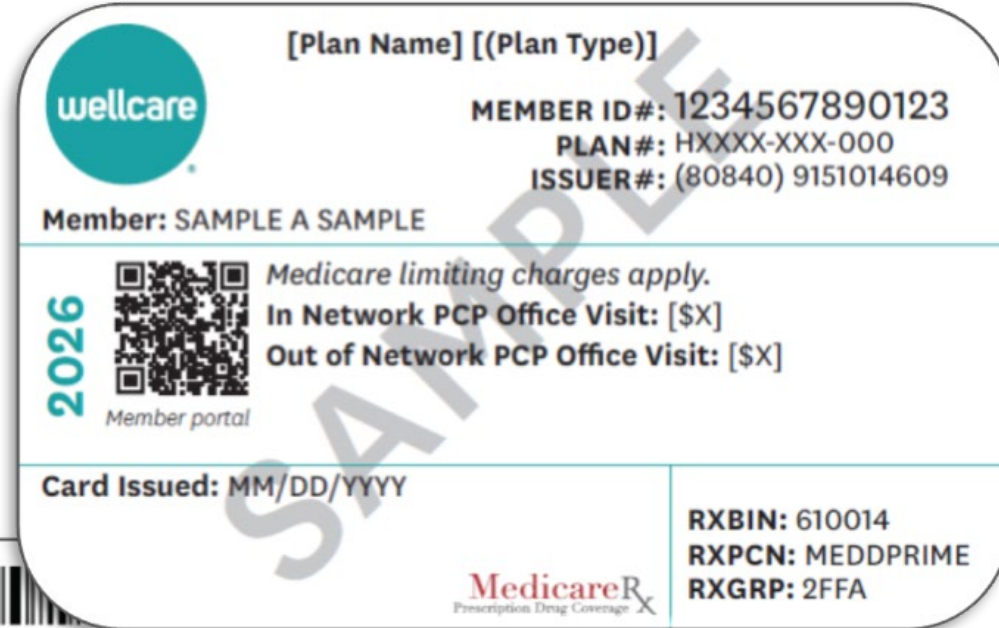
# Wellcare (Medicare PPO H7326)

## 2026 MEMBER ID CARD OVERVIEW




 Brand Name: Wellcare


Plan Name	Contract (PBP) Number
Wellcare Simple Open (PPO)	H7326-001
Wellcare Assist Open (PPO)	H7326-007



[Plan Name] [(Plan Type)]

 **MEMBER ID#:** 1234567890123  
**PLAN#:** HXXXX-XXX-000  
**ISSUER#:** (80840) 9151014609

**Member:** SAMPLE A SAMPLE

**2026**  *Member portal*

*Medicare limiting charges apply.*  
**In Network PCP Office Visit:** [\$X]  
**Out of Network PCP Office Visit:** [\$X]

**Card Issued:** MM/DD/YYYY

**RXBIN:** 610014  
**RXPCN:** MEDDPRIME  
**RXGRP:** 2FFA

**MedicareRx**  
Prescription Drug Coverage





Member Services / Nurse Advice Line	1-XXX-XXX-XXXX (TTY: 711)
Vision: [Provider]	1-XXX-XXX-XXXX (TTY: 711)
Dental: [Provider]	1-XXX-XXX-XXXX (TTY: 711)
Transportation: [Provider]	1-XXX-XXX-XXXX (TTY: 711)
Provider Services / Pharmacy Prior Auth	1-XXX-XXX-XXXX (TTY: 711)
Pharmacist Only	1-XXX-XXX-XXXX (TTY: 711)

**Medical Claims:** Wellcare Attn: Claims P.O. Box 31372 Tampa, FL 33631-3372 Payor ID: 14163  
**Part D Claims:** Wellcare Attn: Medicare Part D Member Reimbursement Dept. P.O. Box 31577 Tampa, FL 33631-3577  
**FOR EMERGENCIES:** Dial 911 or go to the nearest Emergency Room


[go.wellcare.com/Medicare](https://go.wellcare.com/Medicare)

# Marketplace – Ambetter / Ambetter Health



Plan Name: **Ambetter from Absolute Total Care**  
 Network Name: **PREMIERE**  
 Brand Name: **Ambetter**

Plan Name: **Ambetter Health (ICHRA)**  
 Network Name: **SOLUTIONS**



**REFERRAL NOT REQUIRED**

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PREMIER

**MEMBER:** [Jane Doe]  
**Subscriber:** [John Doe]  
**Subscriber ID:** [XXXXXXXXXX]    **Member ID:** [XXXXXXXXXXXXXXXXXX]  
**Plan:** [Plan name]  
**[Network Name] Network Coverage Only**  
**RXBIN:** 003858    **RXPCN:** A4    **RXGROUP:** 2DQA    **Effective Date:** [00/00/00]

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**COPAYS**  
 PCP: [\$10 copay after ded.]  
 Specialist: [\$25 coin. after ded.]  
 Urgent Care: [20% coin. after ded.]  
 ER: [\$250 copay after ded.]

**COST SHARES**  
 INN DED Ind/Fam: [\$7,965/\$18,000]  
 OON DED Ind/Fam: [\$22,500/\$45,000]  
 INN MOOP Ind/Fam: [\$9,200/\$25,000]  
 OON MOOP Ind/Fam: [\$25,000/\$45,000]

For detailed benefit information, please visit [AmbetterHealth.com/copays](http://AmbetterHealth.com/copays)


**AmbetterHealth.com/SC**

<p><b>Member/Provider Services:</b> 1-833-270-5443 (Relay 711)</p> <p><b>24/7 Nurse Line:</b> 1-833-270-5443</p> <p><b>Numbers below for providers:</b>  <b>Pharmacist Only:</b> 1-833-750-4237                      EDI Payor ID: 68069                      [Centene Vision Services: 1-833-724-9353]                      [Centene Dental Services supported by                      United Concordia: 1-833-605-6320]</p>	<p><b>Medical Claims Address:</b>                      Ambetter from                      Absolute Total Care                      Attn: CLAIMS                      PO Box 5010                      Farmington, MO                      63640-5010</p>
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AMB25-SC-C-00060



**REFERRAL NOT REQUIRED**

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SOLUTIONS

**MEMBER:** [Jane Doe]  
**Subscriber:** [John Doe]  
**Subscriber ID:** [XXXXXXXXXX]    **Member ID:** [XXXXXXXXXXXXXXXXXX]  
**Plan:** [Plan name]  
**[Network Name] Network Coverage Only**  
**RXBIN:** 003858    **RXPCN:** A4    **RXGROUP:** 2DQA    **Effective Date:** [00/00/00]

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 Urgent Care: [20% coin. after ded.]  
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**COST SHARES**  
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 OON DED Ind/Fam: [\$22,500/\$45,000]  
 INN MOOP Ind/Fam: [\$9,200/\$25,000]  
 OON MOOP Ind/Fam: [\$25,000/\$45,000]

For detailed benefit information, please visit [AmbetterHealth.com/copays](http://AmbetterHealth.com/copays)

**AmbetterHealth.com**

<p><b>Member/Provider Services:</b> 1-833-543-3145 (TTY 711)</p> <p><b>24/7 Nurse Line:</b> 1-833-543-3145</p> <p><b>Numbers below for providers:</b>  <b>Pharmacist Only:</b> 1-833-750-4237                      EDI Payor ID: 68069                      [Centene Vision Services: 1-833-724-9353]                      [Centene Dental Services supported by                      United Concordia: 1-833-605-6320]</p>	<p><b>Medical Claims Address:</b>                      Ambetter Health                      Attn: CLAIMS                      PO Box 5010                      Farmington, MO                      63640-5010</p>
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absolute  
total care™

Thank You.