Arizona provider manual.

oscar

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Introduction

Welcome to Oscar
We think health insurance should be smart, simple, and friendly. That's why we built Oscar, and we're so glad to be working with you. Our goal is to change the way providers and consumers interact with healthcare by using technology, design, and data.

This document outlines our core provider policies and procedures. You can always find the latest copy on hioscar.com/providers. If you ever have questions, please don't hesitate to reach out to us.

We look forward to working together!

Our Philosophy

Great health insurance starts with a great network. We're partnering with forward-thinking providers and world-class health systems to change healthcare for the better. We want to make it simple for you to manage your practice so you can focus on providing care. Best of all, we're here when you need us. Welcome to the Oscar family.

Questions? We're here to help.

Phone
1-855-OSCAR-55

Mail
Oscar Insurance Corporation
P.O. Box 52146
Phoenix, AZ 85072 – 2146

Hours of Operation

- Provider Services: Mon-Fri, 8am-6pm
- Utilization Management: Mon-Fri, 8:30am-5pm

Provider Manual Updates

Provider Manual Updates:

Section: Utilization Management

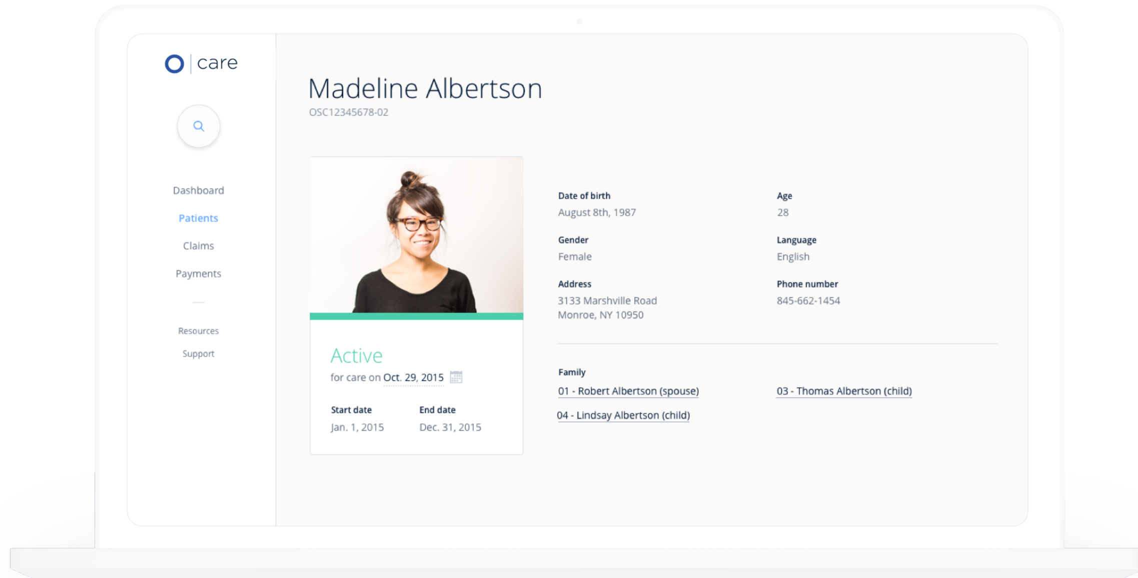
- In the clinical criteria section update the below grid to add the following:

Delegate	Service Categories Delegated for UR

<table>
<tr><td>eviCore</td><td>Medical: specialty outpatient services

Cardiac imaging
Genetic testing
Medical and radiation oncology
Musculoskeletal management
(including chiropractic, and injections for pain management)
Radiology
Sleep therapy and diagnostics (except durable medical equipment and supplies)
Joint and spine surgery
</td></tr>
<tr><td>Optum</td><td>Behavioral health and substance abuse</td></tr>
<tr><td>Liberty</td><td>Pediatric dental</td></tr>
<tr><td>Davis Vision</td><td>Pediatric vision</td></tr>
</table>

Using Oscar for Providers



You can use Oscar's Provider Resources site and Provider Portal to find everything you need to work with Oscar. We built these sites to simplify your team's workflows so that you can focus on delivering great care to members.

Go to hioscar.com/providers to:

- Request to join the network.
- Browse resources such as:
  - Provider Manuals for all markets.
  - Policies (Clinical guidelines, Reimbursement Policies, etc.) and forms.
  - Tutorials and How-To-Guides on using the provider portal.
- Search our provider directory for in-network specialists, lab facilities and more.
- Search our drug formulary to find out what medications Oscar covers.

Create a Provider Portal account to complete the following tasks online:

- Check member eligibility.
- Check status of claims.
- Submit prior Authorizations electronically.
- Sign up for electronic payments.
- Review members' clinical information.
- Connect your staff to your organization (practice) account and grant permission to complete tasks in the Portal.

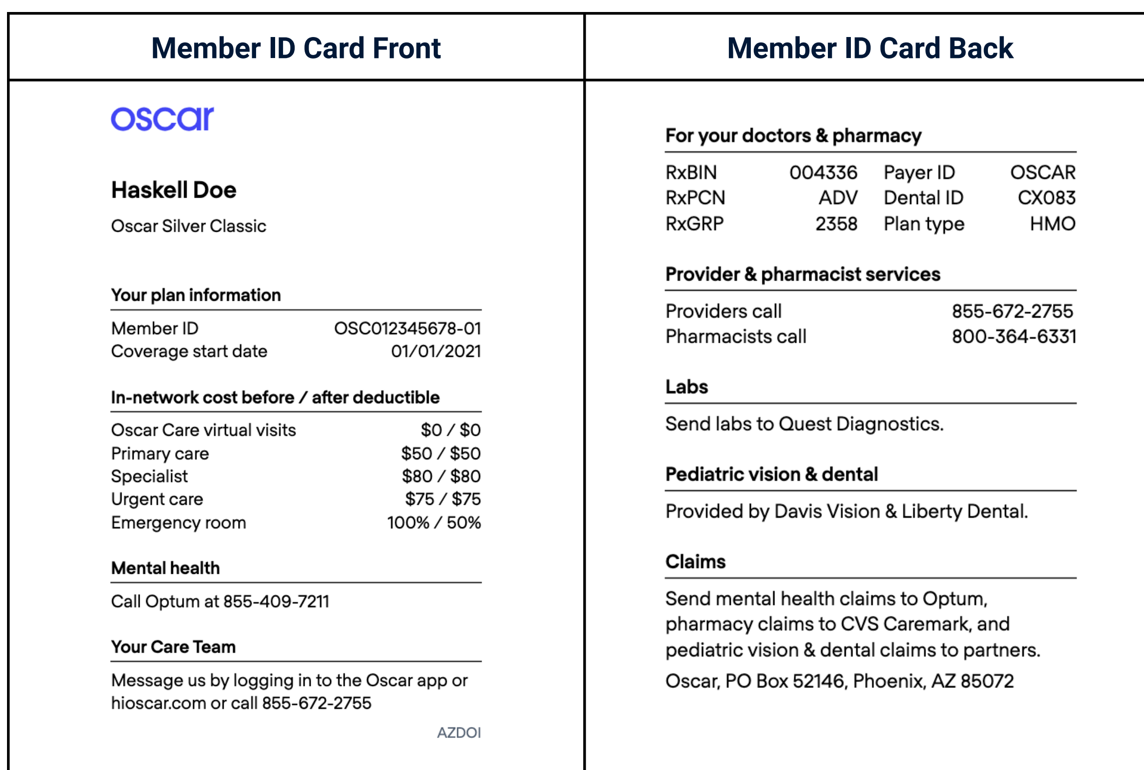
Oscar at a glance:

Check Eligibility and Benefits

Visit hioscar.com/providers or call 1-855-OSCAR-55. Our hours of operation are Mon-Fri 8am-6pm MST.

Sample Member ID Card

Please note: actual member cost share will vary based on plan type.



Member ID Card Front	Member ID Card Back
oscar **Haskell Doe** Oscar Silver Classic **Your plan information** Member ID OSC012345678-01 Coverage start date 01/01/2021 **In-network cost before / after deductible** Oscar Care virtual visits $0 / $0 Primary care $50 / $50 Specialist $80 / $80 Urgent care $75 / $75 Emergency room 100% / 50% **Mental health** Call Optum at 855-409-7211 **Your Care Team** Message us by logging in to the Oscar app or hioscar.com or call 855-672-2755 AZDOI	**For your doctors & pharmacy** RxBIN 004336 Payer ID OSCAR RxPCN ADV Dental ID CX083 RxGRP 2358 Plan type HMO **Provider & pharmacist services** Providers call 855-672-2755 Pharmacists call 800-364-6331 **Labs** Send labs to Quest Diagnostics. **Pediatric vision & dental** Provided by Davis Vision & Liberty Dental. **Claims** Send mental health claims to Optum, pharmacy claims to CVS Caremark, and pediatric vision & dental claims to partners. Oscar, PO Box 52146, Phoenix, AZ 85072

Care Management

For diabetes care, cardiac care, or complex care management, refer patients to call 1-855-OSCAR-55. Our Care Managers provide dedicated support to patients who need it.

Find In-Network Partners

Search for in-network providers, lab facilities, pharmacies, and hospitals on hioscar.com/search.

Pharmacy

CVS/Caremark is our Pharmacy Benefits Manager. For drug prior authorizations, call 1-855-OSCAR-55, or initiate one electronically at covermymeds.com/epa/caremark.

Laboratory

Providers must send lab work to an in-network lab facility. Search our online directory for in-network labs and confirm member lab benefits at hioscar.com/providers.

Prior Authorization

To confirm which procedures require prior authorization, request prior authorization, or check the status of an existing authorization, log into hioscar.com/providers or call 1-855-OSCAR-55. A list of services that require prior authorization is also included in the Utilization Management section of this Manual.

Submit Claims

Claim Type	Network	Submit to
Medical Services	Oscar	Electronic payor ID: **OSCAR** Oscar Insurance Company PO Box 52146 Phoenix, AZ 85072-2146
Behavioral Health and Substance Abuse Services	Optum	Electronic Payor ID: **87726** Optum PO Box 30757 Salt Lake City, UT 84130-0757
Pediatric Vision Services	Davis Vision	Vision Care Processing P.O. Box 1525 Latham, NY 12110
Pediatric Dental Services	Argus Dental and Vision	Electronic Payor ID: **ARGUS** Argus Dental & Vision, Inc. Attn: Claims PO Box 211276 Eagan, MN 55121
Prescriptions / Specialty Pharmacy	CVS/Caremark	CVS Caremark Claims Department PO Box 52136 Phoenix, AZ 85072-2136
Transplant Services	Cigna LifeSource	Cigna LifeSource NAC Claims

Please send transplant claims to the contracted vendor for the particular member.	Optum Health	P.O. Box 3539 Scranton, PA 18505 Optum Transplant Claims PO Box 30757 Salt Lake City, UT 84130

Our Providers

Overview

We're so glad to have you in our network!

To help make working with Oscar simple, we have created this Provider Manual to outline our core provider policies and procedures. Please note that provider organizations are responsible for distributing copies of this Provider Manual to their in-network providers.w

Provider Training

All contracted providers and provider organizations are required to provide appropriate training for employees and applicable subcontractors within 90 days of hire and annually. Such training shall cover compliance programs that may include, but are not limited to, Fraud, Waste, and Abuse (FWA), Potential Quality Issues (PQI), and the Health Insurance Portability and Accountability Act (HIPAA).

Provider Review Requirements

Providers must give regulatory and accrediting bodies the right to audit, evaluate, and inspect books, contracts, medical records, patient care documentation, other records of contractors, subcontractors or related entities for services provided on behalf of Oscar for the time period required by applicable law following the termination of the contract or the completion of an audit, whichever is later.

Provider Insurance Requirements

Throughout the term of the contract, providers must maintain a malpractice, general liability and any other insurance and bond in the amounts usual and customary for Covered Services provided with a licensed managed care company admitted to do business in the State and acceptable to Oscar. In the event providers procure a "claims made" policy as distinguished from an occurrence policy, providers must procure and maintain prior to termination of such insurance, continuing "tail" coverage or any other insurance for a period of not less than five (5) years following such termination. Providers must immediately notify Oscar of any material changes in insurance coverage or self-insurance arrangements and must provide a certificate of

insurance coverage to Oscar upon Oscar's request. Copies of insurance policies and/or evidence of self-insurance must be provided to Oscar upon request.

Compliance with the Americans with Disabilities Act (ADA)

Oscar employees, business partners and contracted Provider Organizations must comply with ADA requirements, including compliance with Section 504 of the Rehabilitation Act which requires that electronic and information technology be accessible to people with disabilities and special needs. Web pages, portals and other electronic forms of communication are compliant with these standards. Any documents provided on member-based portals are compliant with the Section 504 standards allowing the use of assistive reading programs.

Please contact Oscar's Member Services department toll free at 1-855-OSCAR-55 with any comments or questions about content and accessibility.

Language Assistance for Persons with Limited English Proficiency

Oscar assesses the linguistic needs of its enrollee population to ensure members have access to translation and interpretation services for medical services, customer service, and health plan administrative documentation, as needed and according to state regulations. Oscar also ensures member access to translated or alternative format documents and communication as necessary, including for the visually and hearing impaired

Delegated providers are required to follow the policies and procedures established by Oscar to ensure those members with limited English proficiency receive appropriate interpretative and translation services.

Confidentiality and Protected Health Information (PHI)

Oscar and its Provider Organizations are considered "Covered Entities" under HIPAA regulation, and must comply with the strictest applicable federal and state standards for the use and disclosure of PHI. Oscar and its providers are required by federal and state laws to protect a member's PHI and are also required to report any breach in confidentiality immediately. Oscar maintains physical, administrative, and technical security measures to safeguard PHI; it is important that any delegated entities maintain these safeguards of PHI as well.

Oscar's Commitment to Cultural Competency

Cultural competency in healthcare is the ability of providers to understand social, ethnic, religious, and linguistic characteristics of a population and use this understanding to improve the quality of care providers deliver. Oscar Health is committed to ensuring that our members are treated with dignity and respect and that their cultural needs are considered when interacting with providers.

What cultural competency means for our members: Socio-cultural differences between members and healthcare professionals influence many aspects of the medical encounter that can impact patient satisfaction, adherence to medical advice, and health outcomes. For

example, members respond better when care instructions are delivered in their own language. Moreover, knowledge of, and sensitivity to, cultural issues can impact the way members communicate their medical needs, and how physicians and nurses can enhance diagnosis and treatment. Cultural education for providers can not only accomplish the goal of culturally sensitive care, but can also help address ethnic disparities in healthcare.

Cultural competency resources: Oscar strives to offer providers the resources they need to deliver high-quality, culturally sensitive services. This E-learning is offered by the U.S. Department of Health and Human Services free of charge and equips providers with the necessary competencies to improve the quality of treatment for our diverse member population. We encourage our providers to utilize this training to learn more about how to improve their interaction with members who have specific language or ethnic preferences.

Language Assistance Program: Oscar operates a Language Assistance Program that recognizes the cultural diversity of our member population and addresses cultural differences. This language service is provided through Certified Languages International (CLI). If you have questions about how to use the language service or general questions about Oscar's approach to cultural competency, please call 1-855-OSCAR-55.

Our Network Partners

Overview

For behavioral health and substance abuse, pediatric dental, pediatric vision, and prescription/specialty pharmacy services, Oscar engages with the network partners listed below. Providers of these services must be in the respective partner's networks, and claims must be submitted to the address listed. The network partners below also handle contracting, credentialing, and, in some instances, utilization management and review for these services. For more information on the vendors Oscar uses for utilization management and reviews, please see the Utilization Management section of this Manual.

Service	Network Partner	Submit to:
Behavioral Health and Substance Abuse Services	Optum	Electronic Payor ID: 87726 Optum PO Box 30757 Salt Lake City, UT 84130-0757

Pediatric Vision Services	Davis Vision	Vision Care Processing P.O. Box 1525 Latham, NY 12110
Pediatric Dental Services	Argus Dental and Vision	Electronic Payor ID: ARGUS Argus Dental & Vision, Inc. Attn: Claims PO Box 211276 Eagan, MN 55121
Prescriptions / Specialty Pharmacy	CVS/Caremark	CVS Caremark Claims Department PO Box 52136 Phoenix, AZ 85072-2136

Our Members

We treat our members the way we want to be treated. This document describes all the rights you have as an Oscar member.

Statement of Member Rights and Responsibilities

Oscar is committed to treating you in a manner that respects your rights.

We want you to be able to actively participate in your care and to be able communicate with your practitioners and providers about your healthcare needs. This will allow you to have a role in your care and ask questions about care plans and instructions in order for you to better understand and follow them.

As an Oscar member, you have a right to:

- Receive information about the member rights and responsibilities.
- Receive information about Oscar, our services, our practitioners and providers. For more information, please see our website at www.hioscar.com or call member services at 1-855-OSCAR-55 (1-855-672-2755).
- Be treated with respect and recognition of your dignity and your right to privacy by all of Oscar's providers, practitioners, vendors and staff.
- Participate with practitioners and providers in making decisions about your healthcare.
- A candid discussion with your practitioners and providers about appropriate or medically necessary treatment options for your condition(s), regardless of cost or benefit coverage.

- To voice grievances or appeals about Oscar and our contracted providers and practitioners regarding the care or services they provide. Grievances may be communicated by calling member services at 1-844-567-2272.
- Make recommendations regarding Oscar's member rights and responsibilities policy.

As an Oscar member, you have a responsibility to:

- Supply information (to the extent that you can) that Oscar, its practitioners and its providers need in order to provide and coordinate care.
- Follow plans and instructions for care that you have agreed to with your practitioners.
- Understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

Enrollment and Eligibility

Overview

An individual who resides in the Plan Service Area, and is not entitled to or enrolled in Medicare, is eligible for Oscar coverage. The Subscriber's Spouse or Domestic Partner and all Dependent children (including those who qualify under a "Qualified Medical Child Support Order") may also be eligible to enroll with Oscar at the same time. Qualified individuals are only permitted to enroll in a Qualified Health Plan (QHP), or as an enrollee to change QHPs, during the annual open enrollment period or a special enrollment period for which the Qualified individual has experienced a qualifying event.

Open Enrollment Period

The annual open enrollment period for individual health insurance plans is designated by the Department of Health and Human Services. Individuals may enroll in a plan, switch from another plan to Oscar or from Oscar to another plan, and apply for subsidies within this period. This is the only time period during which individuals may obtain an Oscar individual plan, both off and on the health insurance marketplace, unless the individual has a qualifying life event and qualifies for a special enrollment period.

Special Enrollment Period

A special enrollment period is a period during which a qualified individual (together with his or her Spouse and Dependents, if applicable), experiences a qualifying life event or changes in eligibility, outside of the open enrollment period. Individuals may enroll in a plan, switch from another plan to Oscar, or switch from Oscar to another plan.

Grace Periods

Oscar's grace period policy is as follows, unless otherwise specified by applicable state or federal law.

For members not receiving subsidies (advance premium tax credit or APTC): Oscar provides a grace period of 31 days to members who are not receiving APTC and who have previously paid at least one full month's premium during the benefit year. During the grace period, the policy will remain active. If any premium is not paid by the end of the grace period, coverage will be terminated as of the end of the period for which premium has been paid. Any payments made to a provider on behalf of a member who ultimately loses coverage due to non-payment of premiums will be refunded to Oscar by the provider within forty-five (45) days of receipt of written request by Oscar. Any amounts not paid within forty-five (45) days of receipt of notice from Oscar may be offset by Oscar from amounts otherwise owed to the provider without any further action required. Oscar will deny claims that are received and not processed with dates of service beginning on the day following the last day the premium was paid after Oscar has confirmed that the grace period expired without premiums being paid in full.

For members receiving APTC: Oscar provides a grace period of three consecutive months to members receiving APTC who have previously paid at least one full month's premium during the benefit year. During the grace period, the Oscar will:

1. Pay all appropriate claims for services rendered to the member during the first month of the grace period and pend and/or deny claims for services rendered to the enrollee in the second and third months of the grace period; and,
2. Notify providers at the time the provider confirms the member's eligibility of the possibility for denied claims when a member is in the second and third months of the grace period; and,
3. Request a refund of any payments made in the second or third months of the grace period if the member is ultimately terminated.

If a member receiving APTC exhausts the 3-month grace period without paying all outstanding premiums, Oscar will terminate the member's coverage as of the last day of the first month of the 3-month grace period and deny claims incurred during months two and three of the 3-month grace period. Any payments made to providers on behalf of members who ultimately lose coverage due to non-payment of premium with dates of service beginning after the last day of the first month of the 3-month grace period will be refunded to Oscar by the provider within forty-five (45) days of receipt of written request by Oscar. Any amounts not paid within forty-five (45) days of receipt of notice from Oscar may be offset by Oscar from amounts otherwise owed to the provider without any further action required. Oscar will deny claims that are received and not processed with dates of service beginning after the last day of the first month of the 3-month grace period after Oscar has confirmed that the grace period has expired without premiums being paid in full.

If the member pays in full during the 3-month grace period, claims will be processed as usual.

Claims and Payment

Overview

Providers may submit claims for Oscar members electronically or via mail. In-network providers will be reimbursed according to the rates established in their provider agreements. This section outlines Oscar's claims processes and policies.

In the event that multiple contracted rates apply to a claim (including scenarios in which a provider is both directly contracted with Oscar and part of a leased network or contracted provider organization), or that contracted rates exceed billed charges, Oscar, in its sole discretion, may pay the claim at billed charges or in accordance with the agreement with the lesser reimbursement rate.

Claims Submission

Electronic Submission

Oscar highly recommends that providers submit claims electronically via Availity, Eligible or Change Healthcare using Oscar's Payor ID: OSCAR. .

For any issues setting up the ability to submit claims electronically, please contact the billing vendor to ensure that they have Oscar's payor ID in their system.

Paper Claim Submission

If a claim cannot be submitted electronically, a paper UB-04 or CMS-1500 should be submitted to:

Oscar Health Plan, Inc.
PO Box 52146
Phoenix AZ, 85072–2146

Timely Filing of Claims

Providers must claim benefits by sending Oscar properly completed claim forms itemizing the services rendered or supplies provided and the accompanying charges within the timely filing deadline. Oscar will not be liable for benefits if Oscar does not receive completed claim forms within this time period. Claim forms must be used; canceled checks or receipts are not acceptable.

In-Network Providers

Providers should refer to their respective contracts for timely filing deadlines when submitting claims. Unless a different timely filing deadline is specified in the contract, the timely filing deadline for a provider to submit claims will be **180 calendar days** from the last date of service.

Out-of-Network Providers
Out-of-network providers in Arizona shall submit all claims within 180 days from the last date of service, unless the state where such services were provided mandates a different timely filing deadline, which shall control.

Claim Forms

For all claims submitted via mail, Oscar requires the CMS 1500 Form for professional services and the UB-04 form for facility services.

CMS 1500 Form: Required for all physician services claims, including internal medicine, gynecology, and psychiatry. The International Classification of Diseases (ICD-10) diagnosis codes and HCPCS/CPT procedure codes must be used. All field information is required unless otherwise noted.

UB-04 Form: Required for all institutional services claims. All field information is required unless otherwise noted.

Copies of both claim forms are available in the Forms section of this manual. If unlisted or miscellaneous codes are used, notes and/or a description of the services rendered must accompany the claim. Using unlisted or miscellaneous codes will delay claims payment and should be avoided to the extent possible. Claims received with unlisted or miscellaneous codes that have no supporting documentation may be denied, and the member may not be held liable for payment.

Requests for Additional Information

During the claims adjudication process, Oscar may request additional information—such as medical records, acquisition invoices, or itemized bills— from the provider in order to better ascertain financial liability and whether or not the services on the claim should be reimbursed. Oscar will make any requests for more information within timelines set by state regulation or the provider's contract with Oscar.

Guidelines for Additional Information

The following content guidelines for medical records and itemized bills will ensure timely processing of claims requiring additional information. All requested documents must be legible and must present the information in a way that can be reasonably interpreted.

Medical Record Content
Complete medical records requested for the purpose of claim payment must include the content outlined below only for the requested dates of service. The content is as follows, but is not limited to:

- Member demographics

- Biographical Information
- Consultation reports including specialist consultations
- History & physical examination
- Daily clinician notes
- Laboratory reports
- Vitals
- Medication list
- Imaging results, if applicable
- Diagnostic tests
- Preventative health records including immunizations
- Operative notes, if applicable
- Inpatient/ER discharge summary reports, if applicable
- Progress or office visit notes, if applicable

Itemized Bill Content
An itemized bill will appropriately reflect line items, supplies, and services billed under the applicable revenue codes. A complete itemized bill must contain the following information:

- Member demographics
- Admit date / discharge date
- Revenue codes
- CPT and HCPCS codes, if applicable
- Date of service per item
- Description of service per tem
- Quantities per item
- Amount billed per item
- Total billed charges

Providers should refer to their respective contracts for timelines when submitting requested additional information for claims. Unless a different timeline is specified in the contract, providers must submit the requested information to Oscar, along with the associated Explanation of Payment (EOP) and/or a copy of the information request letter, within **90 calendar days** of the initial request. If all requested documentation is not received within this timeframe, Oscar will deny the claim. The member cannot be held financially responsible for claims denied due to the provider's failure to submit requested documentation. All requested documentation must be sent to:

Via Mail
Oscar Health Plan, Inc.
PO Box 52146
Phoenix AZ, 85072–2146

Via Fax
(888) 977-2062

Via Electronic Portal

In-network providers can access their online account through [https://provider.hioscar.com/search.](https://provider.hioscar.com/search)

Oscar will not be liable for interest or penalties when payment is denied or recouped as a result of failure to submit required or requested documentation for claims.

If the requested documentation received from the provider is insufficient or incomplete, Oscar will send additional requests to the provider detailing what information is still outstanding. All requests (including subsequent requests made per incomplete documentation) must be fulfilled within 90 calendar days from the initial request. Oscar will not be liable for claim payment or interest unless and until the documentation request has been properly satisfied, at which time the applicable timeframe for processing the claim will commence.

Timely Processing of Claims

Oscar and its delegated provider organizations and hospitals are required to meet the claims timeliness standards established by state law. Oscar will abide by the guidelines of the Arizona Department of Insurance (ADOI), which stipulate that all undisputed claims requiring no additional information must be processed and paid or denied within **30 calendar days**, unless otherwise set forth in the provider contract.

Interest Payments

Interest on Late Payments: Oscar and its delegated provider organizations will pay interest at a rate of **ten percent (10%) per annum**, unless otherwise specified in the provider contract, of the payment issued to the provider (excluding copayments, coinsurance amounts, and deductibles) on claims for which the original payment is not mailed before Oscar's state-mandated timely payment deadline.

If a claim is pended with a request for additional information, the timely payment deadline will be calculated from the date all requested additional information is received.

Interest on Underpayments: If Oscar processes a claim incorrectly and adjusts the clean claim, interest on the adjusted payment amount (excluding copayments, coinsurance amounts, and deductibles) is due from the original date the claim payment was due.

Good Faith Payments

If Oscar determines that it has denied or reimbursed a claim correctly but agrees to overturn the denial or issue additional payment in the interest of the member, these "Good Faith Payments" will not be eligible for any interest or penalties related to late payment.

Incomplete Claims

Unless otherwise required by law or regulation, a complete claim include all of the following:

- Detailed and descriptive medical and patient data

- All the data elements of the UB-04 or CMS-1500 (or successor standard) forms (including but not limited to member identification number, National Provider Identifier (NPI), date(s) of service, and a complete and accurate breakdown of services)

In addition, a complete claim:
- Does not involve coordination of benefits
- Has no defect or error (including any new procedures with no CPT codes, experimental procedures or other circumstances not contemplated at the time of execution of your agreement) that prevents timely adjudication

Claims that are determined to be incomplete due to incorrect or missing required information (e.g. invalid CPT codes) will be denied. Providers will need to re-submit these claims with the appropriate information for the claims to be adjudicated.

Claim Denials

Oscar will send an Explanation of Benefits to members in situations where a denied claim could lead to member financial responsibility. The Explanation of Benefits will include the reason for denial as well as an explanation of appeal rights.

Claim Corrections and Late Charges

Providers who believe they have submitted an incorrect or incomplete may submit an updated claim within 180 calendar days of the last date of service (the same timely filing limit established in the "Timely Filing of Claims" section above). Providers must submit a corrected claim when previously submitted claim information has changed (e.g. procedure codes, diagnosis codes, dates of service, etc.). When a claim is submitted as a correction or replacement, the entire claim must be submitted. Paper CMS 1500 corrected claim submissions must use frequency code 7 under Item 22 (Resubmission Code) and the corresponding original reference code field must list the original payor claim ID. Paper UB-04 corrected claims must be submitted with Claim Frequency Type 7 as the third digit under Type of Bill (Form Locator 04). Electronic corrected claims must be submitted with frequency code 7 in Element CLM05-3 (Claim Frequency Type Code). Updated claim submissions that do not have these codes may be denied as duplicate submissions.

Interim Billing

Oscar does not accept interim claims for inpatient services. Claims may only be billed upon patient discharge.

Claims for Emergency Services

Emergency services do not require prior authorization. However, post-stabilization services require notification and may be subject to concurrent or retrospective review and medical necessity determination.

Claims Payment Audits

Oscar has the right to access confidential medical and billing records for the purpose of claims payment, assessing quality of care (including medical evaluations and audits), and performing utilization management functions.

Oscar conducts claims audits to ensure that billing is in accordance with Current Procedural Terminology (CPT) guidelines, Oscar's Reimbursement Policies, benefit policies, medical policies (including authorization requirements), and provider contract terms.

At any time Oscar or its contracted reviewers may request on-site, electronic or hard copy medical records, utilization review sheets and/or itemized bills related to Claims for the purposes of conducting audits and reviews to determine Medical Necessity, diagnosis and other coding and documentation of services rendered.

Claim audits may be performed on a pre-payment or post-payment basis, subject to the terms of the provider contract. Claim audits involving review of claims data, claims payments, and medical records, and are performed on areas including, but not limited to:

- Billing with incorrect coding — CPT, ICD-10, modifiers, bundling/unbundling services
- DRG validation
- Duplicate billing/services
- Prior authorizations not received/denied
- Historical claims review
- Coordination of benefits
- Insurance liability and recovery
- Potential fraud, waste or abuse

Post-payment reviews may involve a sampling and extrapolation methodology, where applicable, and may involve any amount of claims with no specified minimum amount involved or potential recovery probability. The estimated error rate may be projected across all claims to determine overpayment. Providers must supply all requested medical records. Failure to do so may result in denial of the entire sample and apply to all claims within the review.

If an internal or contracted reviewer identifies an overpayment for any reviewed claims, Oscar will make appropriate adjustments to the payments. If the reviewer is unable to review the records, Oscar will make adjustments to payments based upon the information available to us at that time. Any adverse determination will be subject to the appeal rights specified herein and in the terms of the provider's contract with Oscar.

Claims Overpayment

Should Oscar determine that it has overpaid a claim, Oscar will submit a written refund request to the provider. This request will include the patient's name, date(s) of service, amount of overpayment, all interest and/or penalties associated with the overpayment, and an explanation

of how Oscar determined that an overpayment had been made. Oscar must make any refund requests within **one year (365 calendar days)** of the date of payment of the affected claim.

However, such time limit shall not apply where state law explicitly permits, including but not limited to, certain instances relating to suspected or actual fraud, waste, or abuse.

Upon receiving this request, the provider must issue the refund or submit a clear, written explanation of why the refund request is being contested within **45 calendar days** of the date the notice of overpayment was received. If the provider contests the refund request, the provider must identify the portion of the overpayment that is contested and the specific reasons for contesting the overpayment.

Providers should send refund checks or written notices contesting refund requests to:

Oscar Health Plan, Inc.
ATTN: Provider Refunds
615 S. River Drive
Tempe, AZ 85281

Should the provider fail to issue the refund or notify Oscar of a contested overpayment within 45 calendar days, the amount of the overpayment may be deducted from future claims payments until Oscar has been fully reimbursed. A written explanation will accompany all deductions made from future claims payments.

Collection of Cost Share

Covered services provided to Oscar members may be subject to a deductible, a coinsurance amount, and/or a copayment amount. In these cases, the member will be liable for reimbursing the provider the relevant amount.

Oscar encourages providers to collect copayments upfront but to defer the collection of coinsurance and deductible amounts until Oscar has adjudicated the claim and an Explanation of Payment (EOP) or 835 electronic remittance notice has been received. If a provider prefers to collect member cost share upfront, the provider is expected to collect the cost share type as outlined in the member's Schedule of Benefits (found at hioscar.com/forms), never exceeding the full negotiated rate for the services rendered. Oscar encourages providers to check with the member whether the member expects other medical or prescription spending to occur on that day. If the member anticipates further spending, Oscar encourages the provider to account for those amounts in the upfront collection.

If a provider collects an upfront amount that exceeds the member's cost share indicated in the EOP, Oscar requires the provider to issue a refund to the member within **10 working days** of receipt of the EOP.

Copayment and coinsurance amounts for the most common services are indicated on a member's ID card. Providers can also check a member's outstanding copayment amount, coinsurance amount, or deductible by calling Oscar Member Services at 1-855-OSCAR-55 or logging onto hioscar.com/providers.

Balance Billing

Except for cost sharing (copayments, coinsurance, deductibles, etc.), providers shall not invoice or balance bill Oscar members for the difference between the provider's billed charges and the reimbursement paid by Oscar. Additionally, if providers do not comply with rules laid out in their contracts, in this manual, or by state regulators (e.g. timely filing, pre-authorization checks, etc.), providers cannot hold members liable for payment.

Verifying Eligibility

While providers are responsible for verifying member coverage and benefits prior to rendering any non-emergency services or treatments, we've made it easy for you to identify our members.

Since we offer different plans and you may not participate in every plan, it is important that you verify the member is eligible for the specific plan(s) in which you participate. If a member is eligible for an Oscar plan in which you do not participate, you should refer them to a provider that participates in that plan or tell the member to call Oscar Member Services so that we can arrange for the member to see a provider who participates in their plan.

Providers can confirm member eligibility by:

- Checking online at provider.hioscar.com
- Calling Member Services at 1-855-OSCAR-55

All Oscar members receive and should present to you a Member Identification Card (ID) with the following information:

- Name of the Member's plan
- Member ID #
- Member first and last name
- Contact information for Member Services

Oscar will not pay claims for members not eligible on the date of service, or for individuals not covered by Oscar.

Out-of-Network Providers

Oscar will reimburse out-of-network providers for services covered as network exceptions, where no in-network provider is accessible or available that can provide the member timely covered services. Services that do not constitute a network exception under Arizona law will not be covered or reimbursed. In the event any member receives a balance bill from an

out-of-network provider for services covered as a network exception, the member should immediately notify Oscar.

Reimbursement Policies

Oscar reimburses in-network providers according to the policies attached in the Appendix. Oscar may modify reimbursement policies at any time by publishing new versions in this manual. Refer to the Appendix for Oscar's reimbursement policies.

Related forms and policies

- CMS 1500 Form
- UB-04 Form
- Reimbursement Policies

Enrolling in ACH & ERA

Oscar offers ACH/EFT and ERA to both in network and out of network providers. Please follow the instructions below based on your network status.

In Network Providers

Please enroll via the Manage Payments section of the Oscar Provider portal. In network providers must enroll in ACH before enrolling in ERA.

If you do not have an account with the Oscar Provider portal, you can create one here.

Out of Network Providers

Out of Network Providers are required to enroll in ACH and ERA at the same time.

Out of Network Provider Enrollment Steps:

1. Complete the Oscar ACH & ERA enrollment form here
2. Complete the Change Healthcare ERA Enrollment form
3. Contact Oscar once you have received two small deposits into your bank account

For questions, please contact 1-855-OSCAR-55 or email us at providerrelations @hioscar.com.

Utilization Management

Overview

Oscar's Utilization Management (UM) Program promotes the delivery of high quality, medically necessary, cost-efficient care for members. The UM Plan outlines policies and procedures by

which Oscar determines medical necessity, access, availability, appropriateness, and efficiency for clinical services and procedures based on a member's health benefits.

Oscar's Utilization Review (UR) activities include pre-service (precertification or prior authorization), concurrent, and post-service (retrospective) reviews.

It is important to note that neither prior authorization nor notification is required for Emergent or Urgent Care; however, post-emergent inpatient admissions do require authorization. Oscar does not require its members to select primary care physicians (PCPs) for their plans, and thus does not require review for referral to specialists or to any other provider in the Oscar network.

Oscar maintains a UR process to:

- Gather pertinent clinical information for each case
- Apply case-specific criteria based on an individual's characteristics (e.g., age, comorbidities, family health history, and other factors)
- Notify providers and members of the utilization decision according to the timeframes outlined below for approvals and denials

Authorization is provided when a requested service is a covered benefit, deemed medically necessary, and provided in the most efficient and cost-effective manner without compromising quality of care. Benefits are provided only for services that are medically necessary. When setting or place of service is part of a review, services that can be safely provided in a lower-cost setting will not be deemed medically necessary if they are performed in a higher- cost setting. For example, Oscar will not approve an inpatient admission for surgery if the surgery could have been performed on an outpatient basis or an infusion or injection of a specialty drug provided in the outpatient department of a hospital if the drug can be provided in a physician's office or the home setting.

In some cases, Oscar uses vendors with expertise in particular clinical functions to oversee utilization and coverage determinations. For these cases, the UM Program includes the management and oversight of these vendors as detailed in the Delegation and Oversight section of this Manual.

In order to minimize the potential for care delays, Oscar Arizona recommends that Precertification requests be received by phone, fax, or through a secure online portal within the following timeframes when feasible:

- At least five (5) days prior to an elective admission as an inpatient in a hospital, extended care or rehabilitation facility, or hospice facility
- At least thirty (30) days prior to the initial evaluation for organ transplant services
- At least thirty (30) days prior to receiving clinical trial services
- At least five (5) days prior to a scheduled inpatient behavioral health or substance abuse treatment admission
- At least five (5) days prior to the start of home healthcare services

Oscar requires the requesting provider to submit the following information when requesting an authorization:

- Member information including first and last name, Oscar ID, and date of birth
- Treating/Billing provider name information (NPI, TIN, and contact information)
- Facility, if applicable, (NPI, TIN, and contact information)
- Requestor's contact information (phone and fax number)
- For pharmacy reviews, drug name, strength, dosing, and the member's diagnosis
- The healthcare service being requested including procedure codes, requested number of units or visits, and length of treatment(s).

If we do not receive the information necessary to intake your authorization, you will be notified of the missing elements and asked to resubmit your request.

For faster processing Oscar requests authorization requests include:

- Complete and signed Clinical information relevant to the authorization request which may include clinical notes including consultation notes, labs, radiology, and other health pertinent information. Please note these should not be draft versions or contain incomplete sections.
- Diagnostic codes (required for pharmacy)
- Referring Provider

Clinical Criteria

The UM Program, under the direction of the Chief Clinical Officer (CCO) and an Arizona-licensed Medical Director and with input and review by a quality subcommittee, develops and approves written Clinical Criteria and protocols for the determination of Medical Necessity and appropriateness of healthcare procedures and services. Clinical Criteria are:

- Based on nationally-recognized standards;
- Developed in accordance with the current standards of national accreditation entities;
- Developed to ensure quality of care and access to needed healthcare services;
- Evidence-based; and
- Evaluated and updated at least annually.

Current criteria used by Oscar Arizona include:

- Oscar's Clinical Guidelines
- MCG
- CVS Criteria
- Hayes, Inc.
- Up-to-Date
- Authoritative peer-reviewed textbooks and journals
- National society guidelines
- Agency for Healthcare Research and Quality
- NIH Consensus Statements

MCG criteria are national, standardized benchmark criteria developed with input and involvement from physicians and other licensed healthcare providers, and based upon generally accepted medical standards. Oscar uses the most recently released version of MCG criteria. MCG criteria are reviewed and updated annually.

As listed above, Oscar may cite current clinical evidence from established and reliable sources. Oscar also evaluates the adoption of new medical technologies for medical/surgical procedures, behavioral health, pharmaceuticals, and medical devices to be used in the utilization decision process. For the services listed below, Oscar has partnered with the outside vendor listed. These vendors have adopted their own specialty criteria, which are reviewed and approved annually. These vendors are subject to oversight by Oscar's UM staff as explained in the Delegation and Oversight section.

Delegate	Service Categories Delegated for UR
eviCore	Medical: specialty outpatient services ● Cardiac imaging ● Genetic testing ● Medical and radiation oncology ● Musculoskeletal management ○ (including chiropractic, and injections for pain management) ● Radiology ● Sleep therapy and diagnostics (except durable medical equipment and supplies) ● Joint and spine surgery
Optum	Behavioral health and substance abuse
Liberty	Pediatric dental
Davis Vision	Pediatric vision

Oscar also considers the local network and delivery system available to members with specific needs, e.g. for services rendered by skilled nursing facilities, subacute facilities, and home health agencies. Oscar reviews an individual member's unique situation and provides specific guidance tailored to the member and any special circumstance.

The UM Program maintains a list of medical procedures and services that require utilization review, which is shared on the Oscar website. This list is reviewed annually by the Chief Clinical Officer and an Arizona-licensed Medical Director as well as by the Utilization Management Subcommittee. The following factors are considered when building this list:

- Risk of fraud, waste, and abuse (including overuse and misuse)
- Availability of alternatives that may be a more appropriate first course of treatment
- Whether coverage of a given benefit is contingent on medical necessity

Clinical criteria are made available to enrollees and providers at https://www.hioscar.com/clinical-guidelines. A hard copy of Oscar's Clinical Criteria is also available upon request by calling 1-855-OSCAR-55. Additional clinical criteria (e.g., MCG) are made available to members and providers upon request. In the case of an adverse determination, the clinical criteria relevant to the review are summarized in a letter to the provider and member.

Authorization Requests and Communication

To confirm authorization requirements for a specific code or service or to submit an authorization request, use Oscar's Provider Portal at https://provider.hioscar.com or call 1-855-OSCAR-55. Providers can use this same phone number to request authorization and check the status of an existing authorization. For services where Oscar delegates utilization review, you will be transferred to or instructed to contact the appropriate vendor. For authorization requests handled by Oscar, providers may also request authorization by faxing the Authorization Request Form included in the Forms section of this Manual to 1-844-965-9053.

All determinations or requests for more information in order to make an initial UR determination are made in a timely fashion appropriate for the member's specific condition, not to exceed the time frames required by NCQA or Arizona state and/or federal regulations. Decisions are communicated verbally and/or in writing to members and providers as required by regulations.

Oscar will not reverse a UM approval where the provider reasonably relied upon written or oral authorization of Oscar (or its agents) prior to providing the service to the covered person, except in cases where there is material misrepresentation or fraud.

Program Staff

Oscar's Arizona-licensed Medical Director is ultimately responsible for the Arizona UM Program. With a full, unrestricted license to practice medicine issued by the state of Arizona, the Arizona-licensed Medical Director maintains authority over all Arizona UM activities, including implementation, supervision, oversight, and evaluation of the Program. This includes ultimate oversight and accountability for all adverse determinations relating to members in an Arizona Oscar plan, whether made by an Oscar employee or delegated utilization review agent.

Table 1. Oscar UR staff

	Participation in UM program	Authority to issue Adverse Determination?
Licensed Physicians	Review, approve, and/or deny UM requests based on Oscar documents, policies, procedures, and established Clinical Criteria; communicate with providers and members.	Yes
Licensed Pharmacists	Review and approve UM pharmaceutical requests based on Oscar documents, policies, procedures, and established Clinical Criteria; deny initial requests and escalate non-approval appeals for physician review; communicate with providers and members.	Initial Requests (excluding NF requests) - No Appeals - No
Licensed Nurses	Review and approve UM requests based on Oscar documents, policies, procedures, and established Clinical Criteria; escalate non-approvals for physician review; communicate with providers and members.	No
Clinical Operations Staff	Oversee UM operations to ensure compliance and that all necessary resources are available to clinical staff; contribute to quality oversight and reporting.	No
Board-Certified Physician Consultants	Apply domain expertise where a specialty review is required; provide determination recommendation to Oscar licensed physician.	No
Non-licensed Staff - Processors	Provide clerical support for Inpatient Services, Outpatient Services, and case management areas including: data entry, creation of letters, reports and files, verification of member eligibility and benefits, and serving as the initial point of contact for members and Providers regarding UM activities. Review and approve certain UM requests when no clinical judgment is required using explicit UM criteria. Escalate non-approvals for review by a clinician.	No

Any adverse determinations (medical necessity denials) are reviewed and ultimately made by a physician or psychologist with an active license by a state licensing agency in the United States.

Oscar promotes consistent application of review criteria across its UM staff by conducting regular internal audits of determinations made by all clinical UM staff as well as annual inter-rater reliability testing (IRR). In IRR testing, clinicians are given the same clinical scenario

and asked to demonstrate their decision-making so that differences in determinations can be used as the basis for remediation and training.

Oscar staff are available at least 8 hours per day during normal business hours, and outside normal business hours for urgent requests. Staff are identified by name, title, and organization name when initiating or returning calls regarding UM issues. TDD/TTY services and language assistance are available (via the main Oscar phone number, 1-855-OSCAR-55) for callers as well.

Oscar's Utilization Management (UM) Program affirms the following:

- UM decision making is based only on appropriateness of care and service and existence of coverage
- Oscar does not reward practitioners or other individuals for issuing denials of coverage
- Oscar does not reward practitioners, providers, or employees who perform utilization reviews for issuing denial of coverage or for encouraging underutilization

Services Requiring Authorization

Oscar requires authorization for the services listed below. It is important to submit any elective or pre-service requests in advance to ensure everything is in place for your patients to get the right care. Please note that the list of services within each category might not be exhaustive. To confirm requirements for a specific code or service, request authorization, or to check the status of an existing authorization, reference the New Authorization tool at https://provider.hioscar.com or call 1-855-OSCAR-55. Authorization requests may also be submitted by faxing the attached Authorization Request Form to 1-844-965-9053.

Review for certain services is delegated to eviCore healthcare. To access eviCore's clinical criteria and authorization request forms, please visit evicore.com/healthplan/Oscar. For any other services not indicated in these resources, you can call 1-855-OSCAR-55 or follow the instructions on the Oscar Authorization Request Form included in the Forms section of this manual.

For instructions on confirming authorization requirements for a specific code or service, please see the above "Authorization Requests and Communication" section. For services where Oscar delegates utilization review, you will be transferred to or instructed to contact the appropriate vendor.

The services outlined in the table below are subject to authorization. If prior authorization is not obtained, they are subject to post-service (retrospective) review. Some services that may be a part of an ongoing course of treatment may also be subject to concurrent review. Review requirements (prior authorization, concurrent, and/or retrospective review) for Behavioral Health & Substance Abuse and Pharmacy are subject to the policies and procedures of Optum and CVS/Caremark, respectively.

Inclusion of a benefit in the Oscar Authorization List is not a guarantee of coverage. Coverage of these benefits may vary by plan, and the Authorization list is subject to change. To verify coverage or authorization requirements, please call 1-855-OSCAR-55.

Oscar Authorization List	
Category	**Subcategories**
Inpatient Admissions	● Acute/Elective Hospital ● Hospice ● Long-term Acute Care ● Rehabilitation, Acute/Subacute ● Skilled Nursing Facility
Behavioral Health & Substance Use Disorder	● All Inpatient Admissions (Non-Emergent) ○ Acute hospital ○ Acute / Subacute Rehabilitation ○ Residential treatment ○ Skilled nursing facility ● Adaptive behavior assessment & therapy ● Applied behavioral analysis (ABA) ● Detoxification programs ● Electroconvulsive treatment (ECT) ● Extended office visits ● Intensive outpatient treatment ● Outpatient psychiatric testing ● Partial hospitalization treatmentTranscranial magnetic stimulation (TMS)
Pharmaceuticals	Physician-Administered Drugs (e.g., Botulinum toxin, intravenous Immunoglobulin, amifostine, leucovorin calcium, peginesatide) Physician-Administered Drug authorization requests under the Medical benefit are reviewed by Oscar. To learn whether a Physician-Administered Drug class is subject to review for preferred drug brands, check Oscar's Clinical Guideline: Preferred Physician-Administered Specialty Drugs (CG052) or call 1-855-OSCAR-55. To learn whether a Prescription medication on the Pharmacy benefit requires auth or step therapy, check Oscar's formulary or call 1-855-OSCAR-55.
Site of Care	● Imaging ● Outpatient procedures ● Physician-Administered Drugs

Durable Medical Equipment (DME), Prosthetics, Orthotics, and Supplies	High cost DME >$1000 (Please call 1-855-OSCAR-55 to determine if a particular item requires PA) • Bone growth stimulators • Braces and Orthoses • Continuous glucose monitors / insulin pumps • Hearing aids • Hearing implants (cochlear, BAHA) • Hospital beds, including mattresses and overlays • Hospital grade breast pumps • Negative pressure wound therapy pumps • Noninvasive positive pressure ventilation (CPAP, BiPAP) • Powered wheelchairs and ambulatory devices • Ocular and corneal Implants • Oxygen therapy • Parenteral and enteral pumps and supplies • Prostheses • Speech devices • Wearable defibrillators
Rehabilitative & Habilitative Services	Home Health Services • Home health aide • Occupational therapy • Physical therapy • Private duty nursing • Skilled nursing • Social work • Speech therapy Outpatient • Occupational therapy • Physical therapy

Treatments & Procedures	• Apheresis
	• Cardiovascular
	  ○ Ablation for arrhythmia
	  ○ Angioplasty & stenting
	  ○ Cardiac catheterization
	  ○ Electrophysiology studies
	  ○ Implantable cardiac devices
	  ○ Varicose vein treatment
	• Chiropractic Services
	• Digestive
	  ○ Bariatric surgery
	  ○ Gastric neurostimulators
	• Eye
	  ○ Blepharoplasty

	○ Brow ptosis repair ○ Refractive surgery ● Gene Therapy ● Gender Affirmation / Sex Reassignment Surgery ● Gynecologic ○ Transabdominal Cerclage ○ Vulvectomy ● Head & Neck ○ Nasal/Sinus endoscopic procedures ○ Otoplasty ○ Orthognathic jaw surgery ○ Rhinoplasty ○ Temporomandibular joint (TMJ) surgery ○ Uvuloplasty ● Home Births ● Hyperbaric Oxygen Therapy ● Interventional Pain Procedures ○ Epidurals ○ Facet joint injections ○ Implantable drug delivery ○ Regional blocks ○ Spinal cord / Neuromuscular stimulators ○ Trigger point injections ● Medical Oncology ○ CAR T-Cell Therapy ○ Chemotherapy ○ Supportive oncology drugs ● Musculoskeletal Surgery ○ Bunionectomy ○ Hammertoe ○ Joint arthroscopy / arthroplasty / arthrodesis ○ Spinal surgery ● Neurostimulation ● Organ & Tissue Transplants ○ Bone marrow ○ Heart ○ Islet cell ○ Kidney ○ Lung ● Penile implants ● Prostate ○ Benign prostatic hyperplasia (BPH) treatment ● Radiation Therapy ○ Brachytherapy ○ Intensity modulated radiation therapy ○ Hyperthermia treatment

	○ Intraoperative therapy ○ Neutron Beam therapy ○ Proton Beam therapy ○ Radiologic guidance ○ Stereotactic radiation therapy ● Skin ○ Injectable dermal implant ○ Panniculectomy ○ Skin / Tissue grafts & substitutes ○ UV / Laser therapy ●
Tests & Evaluations	● Advanced Imaging ○ Angiography ○ Cardiac imaging (e.g., echo) ○ CT scans ○ MRI ○ PET scans ○ Stress tests ○ Vascular ultrasounds (duplex study) ● Attended Sleep Studies ○ Polysomnography ○ Split night studies ● Genetic Testing ○ Cancer diagnosis ○ Carrier status ○ Disease prediction ○ Non-cancer diagnosis ○ Non-medical genetic testing ○ Pharmacogenomic testing ○ Preimplantation genetic screening ○ Prenatal genetic screening
Transportation	● Non-Emergency Transportation ○ Ambulettes ○ Air ambulances ○ Ground ambulances ○ Water ambulances
Unlisted Services	Inclusive of behavioral, medical, and pharmaceutical services

Emergency, Urgent, and Ambulance Services

No prior authorization is required for emergent or urgent services, including emergency ambulance. Members who reasonably believe they have an emergent medical condition that requires an emergency response are encouraged to appropriately use the 911 emergency response system where available. Emergency ambulance services are covered from the site of

the medical emergency to the nearest appropriate facility or between facilities when a higher level of care is required to stabilize and treat an emergency medical condition.

Oscar participating hospitals are responsible for notifying Oscar of an emergent/urgent inpatient admission within 24 hours or by the end of the first business day following admission, unless otherwise specified in your contract. Non-participating hospitals are required to notify Oscar prior to any emergent/urgent inpatient admission, when further care or treatment is needed following stabilization of an emergent/urgent condition. Failure to comply with Oscar's notification requirements will result in an administrative denial of the claim. Members cannot be held financially responsible for claims denied due to failure to notify. Notification may be communicated by fax (1-844-965-9053) or phone (1-855-OSCAR-55) to Oscar's Clinical Review Team.

Experimental and Investigational Treatments

Oscar reserves the right to deny benefits as experimental, investigational, or unproven for any service, treatment, therapy, procedure, device or drug that is utilized in a manner contrary to standard medical practice or that has not been demonstrated through medical research to have a beneficial impact on health outcomes. If coverage is denied, an appeal may be submitted, including any pertinent medical records and/or supporting medical evidence. Oscar is responsible for all decision-making related to experimental, investigational, and unproven services, and such requests will be reviewed in accordance with Oscar's clinical criteria.

Delegation and Oversight

Oscar contracts with vendors to conduct UR for certain service categories, as detailed in the Clinical Criteria section above. In these cases, Oscar UM staff is responsible for oversight of the delegated vendor for both clinical and operational purposes. The Arizona-licensed Medical Director has final oversight and authority over any UR determinations and may reverse any adverse determination made by a delegate.

Monitoring and Reporting of UM

Oscar retains documented UM policies and procedures as specified within the UM Plan and as required by federal and state regulation. You may contact Oscar Provider Relations with any questions about the UM plan and related documentation, including but not limited to:

- UM Plan, policies, and procedures, including clinical criteria and guidelines
- Utilization records including prior authorization approvals and denial letters
- Case management records
- Evidence of appropriate licensure, including of physician and other clinical reviewers responsible for conducting utilization reviews

Oscar has utilization and claims management systems to identify, track, and monitor care provided to members and to ensure its appropriateness. Oscar does not reward practitioners, providers, or employees who perform utilization reviews for issuing denial of coverage or for

encouraging underutilization. Utilization review decisions are based on medical necessity and benefit eligibility.

Peer to Peer Process

In the case of an Initial Adverse Determination, the provider of record is notified in the denial notification of the opportunity to discuss a medical necessity denial with an Oscar UM physician. If a request to schedule a peer-to-peer is received, scheduling and decisions will occur in a timely fashion appropriate for the member's specific condition, not to exceed timeframes required by applicable state regulations. The Oscar physician will make two attempts to contact the provider of record during the scheduled time. If the provider is unreachable, the Oscar physician will supply his or her name, position, and contact information for Oscar Clinical Review to reschedule the peer to peer.

Appeals Process

In cases where an authorization request is denied, the enrollee or the enrollee's authorized representative will have an opportunity to appeal the decision. The appeal will be handled through a structured appeals process and a licensed physician not involved in the initial coverage decision will review the appeal. Upon resolution of every internal appeal, a resolution letter is sent to the member, which, in the case of an adverse determination, will include information regarding any additional appeal rights the member might have and instructions on how to dispute the determination. A copy of this letter will also be faxed to the provider and the member's authorized representative, if applicable.

Any appeal of a denied utilization review (UR) decision in which the services were determined not to be medically necessary, should be filed within 180 days of the provider's receipt of the denial (adverse determination). In order to file an appeal, the provider should specify they are seeking to file an appeal of a denied UR decision with the Clinical Review team, whether the appeal is submitted via telephone or in writing. Attached to this Manual is a one page Oscar Appeal Form, which the provider may submit along with additional clinical information in order to file an appeal.

In Arizona, members or their authorized representatives may request an Independent Medical Review of disputed healthcare services if they believe that healthcare services have been improperly denied, modified, or delayed by Oscar Arizona or one of its contracting practitioners.

Related forms:

Authorization Request Form
One Page Oscar Appeal Form (optional)

Quality Management

Overview

Oscar is dedicated to providing best-in-class experience and quality of healthcare for our members. Oscar's vision is to reinvent how a health plan functions and its role in the lives of its members, and our quality strategy and structure provides the foundation to achieve that vision. We are focused on improving outcomes with innovative quality reporting, case management, care coordination, disease management, compliance activities, and programs to reduce hospital admissions, improve patient safety, reduce medical errors, and minimize health disparities.

All contracted Provider Organizations and their downstream providers are required to participate in Oscar's Quality Management and Quality Improvement (QI) Program. Participation includes submission of encounter data, accurate and complete coding, and participation in review of potential quality issues and programs.

QI and Performance Improvement

The purpose of the QI Program is to improve health outcomes of members by providing access to affordable, appropriate and timely healthcare and services, which is routinely measured for compliance with established, evidence based standards. This objective is accomplished by accessing pertinent data, utilizing proven management and measurement methodologies, and continuously evaluating and improving organizational service processes that are either directly or indirectly related to the delivery of care.

The QI Program also provides a framework to evaluate the delivery of healthcare and services provided to members. This framework is based upon the philosophy of continuous quality improvement and includes the following considerations:

- Quality issue identification, oversight, corrective action plan assignment, and follow-up
- Oversight and monitoring of internal programs
- Tracking and trending identified plan and provider issues
- Utilization and medical management plans
- Management of Protected Health Information (PHI)
- Credentialing of practitioners and other providers
- Oversight of delegated entities for quality and medical management
- Disease management
- Case management
- Clinical practice guidelines
- Member Rights and Responsibilities

The responsibility for developing and providing oversight of the QI Program rests with the QI Committee of the Board. In order to foster communication with the practitioner and provider networks, as appropriate, we invite practitioners and designated behavioral healthcare practitioners to collaborate in the planning, design, implementation and review stages of the QI

Program. Any network practitioner may be involved in the design and operation of the QI Program and/or attend and advise through involvement in various clinical subcommittees. If you are interested in collaborating further in the design and operation of the QI Program or attending a subcommittee meeting you can send an email to quality@hioscar.com.

Medical Record Standards

Oscar may perform medical record audits to investigate PQIs or of randomly chosen primary care practitioners.

Practitioners that provide primary care services include the following: family medicine, general medicine, internal medicine, pediatrics and obstetrics/gynecology (when acting as a PCP). This provider manual sets forth the medical record standards criteria used to evaluate performance: applicable to such practitioners.

In general:

1. Accurate Medical records are expected to be readily available to members and the Plan.
2. Medical records are expected to be confidential, abiding by state and federal HIPAA rules. They should be stored securely with access granted to authorized personnel only. Office staff are expected to receive annual training on confidentiality.
3. When deficiencies in medical record keeping are discovered, Oscar will implement corrective action or performance improvement plans with the practitioner.

In the Medical Record:

1. Every page in the record contains the patient name or ID number.
2. Documentation of allergies or No Known Drug Allergies (NKDA) and adverse reactions are prominently displayed in a consistent location.
3. All presenting symptom entries are legible, signed, and dated, including phone entries.
    a. Dictated notes should be signed or initialed to signify review. (If initialed, a signature sheet for initials are noted.)
4. The important diagnoses are summarized and highlighted.
5. A problem list is maintained and updated for significant illnesses and medical conditions.
6. A medication list or reasonable substitute is maintained and updated for chronic and ongoing medications.
7. History and physical exam identifies appropriate subjective and objective information pertinent to the patient's presenting symptoms, and treatment plan is consistent with findings.
8. Past medical history is documented including significant illnesses, accidents, and operations, and prenatal and birth information for pediatric members.
9. Each visit notation includes the following:
    a. Subjective Data: Chief complaint (or reason for visit)
    b. Objective Data: Focused (Problem specific) Physical examination

c. Assessment: Diagnosis or Impression
d. Plan: Treatment plan, goals

10. Laboratory tests and other studies are ordered, as appropriate, with results noted in the medical record. (The clinical reviewer should see documentation of appropriate follow-up recommendations and/or non-compliance to care plan.)
    a. Follow up care is scheduled for abnormal findings
11. Referrals to specialists are clearly documented
12. Follow up report received and acknowledged when referred specialist care was obtained
13. Documentation of Advance Directive or Living Will or Power of Attorney discussion in a prominent part of the medical record for adult patients is encouraged.
14. Should the member decline an Advance Directive, documentation of the member decision shall be documented.
15. Continuity and coordination of care between the PCP, specialty physician(s) (including BH specialty) and/or facilities if there is reference to referral or care provided elsewhere. The clinical reviewer will look for a summary of findings or discharge summary in the medical record. Examples include, but are not limited to, progress notes/reports from consultants, discharge summary following inpatient care or outpatient surgery, physical therapy reports, and home health nursing/provider reports.
16. Age appropriate routine preventive services/risk screenings are consistently noted, i.e. childhood immunizations, adult immunizations, mammograms, pap tests, etc., or the refusal by the patient, parent or legal guardian, of such screenings/immunizations, in the medical record.
17. Appropriate screening and subsequent coordination for ASD.

Quality Data and Reporting

Oscar captures and analyzes data to ensure Oscar programs and providers optimize care, including but not limited to:

- Healthcare Effectiveness Data and Information Set (HEDIS) data to measure performance on areas of care and service
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) data to measure member satisfaction and the experience of care
- Internal data from HRAs and on service utilization, cost, and quality
- Complex case and care management logs and notes
- Practitioner performance and effectiveness of incentives

Oscar does not delegate its QI Program. The Plan does delegate certain QI activities. If plan activities are delegated to an approved entity, the plan will:

- Establish a written delegation agreement outlining the scope of that delegates responsibilities and how they will be monitored by the plan.
- Through a pre-delegation audit and annual oversight audits thereafter, assess the delegates ability to fulfill its responsibilities, including administrative capacity, technical expertise, and budgetary resources.
- Maintain written oversight procedures in place to ensure providers are fulfilling all delegated responsibilities.

Delegated organizations and providers must provide quality metrics for review by the QI Committee, including but not limited to periodic reporting of:

- Complex case management summary
- Utilization management (UM)
- Performance improvement initiatives, findings, and corrective action

Preventive Health and Wellness Initiatives

Oscar's goal is to meet and exceed all the highest clinical and customer quality standards and reporting requirements, specifically the utilization and quality measures of HEDIS the CAHPS survey.

Clinical Practice and Preventive Health Guidelines

Clinical practice guidelines, preventive health guidelines, and other internal criteria provide direction and standards for preventive, acute, and chronic care health services relevant to Oscar's enrolled membership. Clinical practice guidelines are reviewed against UM criteria and member education materials to ensure consistency and alignment with appropriate medical recommendations.

Oscar is committed to the philosophy that evidence-based guidelines are effective in improving health outcomes. Oscar compiled a list of recognized resources that promulgate evidence-based clinical practice guidelines. All providers are strongly encouraged to consult and implement the following guidelines in their provision of healthcare services to Oscar members.

Preventive Care Guidelines

US Preventive Services Task Force: The U.S. Preventive Services Task Force (USPSTF) issues recommendations on screening, counseling, and preventive medication topics and includes clinical considerations for each topic. Includes guidelines for adults 20-64 and 65+ years as well as children 2-19 years.

uspreventiveservicestaskforce.org/

Advisory Committee on Immunization Practices (AICP): Medical and public health experts who develop recommendations on the use of vaccines in the civilian population of the United States. The recommendations stand as public health guidance for safe use of vaccines and related biological products. Includes guidelines for children under 24 months.

cdc.gov/vaccines/hcp/acip-recs/index.html

The American College of Obstetricians and Gynecologists (ACOG): Decision support resources grounded in scientific evidence from the premier professional organization dedicated to the improvement of women's health.

https://www.acog.org/Clinical-Guidance-and-Publications/Search-Clinical-Guidance

American Academy of Pediatrics: Evidence-based decision-making tools for managing common pediatric conditions. Includes guidelines for children from birth to 19 years.

https://pediatrics.aappublications.org/current_policy

Acute/Chronic Medical Condition Guidelines

American College of Cardiology: Framework of evidence-based clinical statements and guidelines developed by leaders in the field of cardiovascular medicine.

acc.org/guidelines

American Diabetes Association: Standards, guidelines and clinical practice recommendations for healthcare professionals who care for people with diabetes.

https://professional.diabetes.org/content-page/practice-guidelines-resources

American College of Physicians: American College of Physicians resource for clinical practice guidelines addressing screening, diagnosis and treatment of diseases relevant to internal medicine and its subspecialties.

acponline.org/clinical-information/guidelines

Behavioral Health Guidelines

Professional Resources for Behavioral Health: Optum is the contracted Managed Behavioral Healthcare Organization for Oscar. They provide best practice guidelines for the screening, diagnosis and treatment of mental health conditions and substance use disorders.

https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/bpg.html

Population Health Management

Oscar offers a variety of programs designed to keep members healthy, improve clinical outcomes across settings, support members with emerging clinical risk and support members with multiple chronic illnesses. These programs cover a range of areas such as Prevention and Screening, Concierge Case management, Discharge Planning and Complex Case Management. Our Complex Case Management (CCM) program supports Oscar members in managing chronic conditions, and assists them in minimizing barriers and navigating the healthcare system. Enrollment into Oscar's CCM program involves a comprehensive assessment of the member's condition, determination of available benefits and resources, and development and implementation of a case management plan with performance goals, monitoring and follow-up. Depending on the needs of your patient they may qualify for a number of Oscar's Population Health Programs. To refer an Oscar member or obtain more information on Oscar's Population Health programs, call 1-855-OSCAR-55 or click here.

Health Management and Education

Oscar engages in health education to equip members with tools and resources to stay healthy, improve knowledge about chronic conditions and their treatment, learn behaviors for better self-management, and promote prevention and early detection of illnesses. Education efforts include telephonic outreach, targeted online content, member engagement through Oscar's mobile app and website, and other tactics. We evaluate outcomes using several mechanisms, including but not limited to HEDIS measures, utilization statistics, pharmacy data, and program participant surveys.

Member and Provider Satisfaction

Member satisfaction is a high priority and may be assessed through several sources and methods, including but not limited to satisfaction surveys and appeal records. Member complaints and appeals are assessed by reason category, provider, region, and delivery system.

Provider satisfaction may be assessed by satisfaction surveys, provider services complaints, and direct feedback offered by Provider Organizations. Satisfaction issues are categorized and assessed by severity and prevalence of the issue. Issues not meeting standards or performance benchmarks are identified and a Corrective Action Plan (CAP) for resolution and correction is implemented.

Potential Quality Issues

DEFINITIONS

Potential Quality Issue (PQI): is a suspected deviation from provider performance, clinical care, or outcome of care which requires further investigation to determine if an actual quality of care issue exists.

Quality of Care (QOC) Issue: is a confirmed adverse variation from expected clinician performance, clinical care, or outcome of care, as determined through the PQI process.

Quality of Service (QOS) Issue: is a confirmed adverse variation that causes dissatisfaction and a poor experience in the delivery of healthcare services.

Clinician or Provider: is any individual or entity engaged in the delivery of healthcare services licensed or certified by the State to engage in that activity, if licensure or certification is required by State law or regulation.

Corrective Action Plan (CAP): is a plan approved by the appropriate quality improvement committee to help ensure that a related quality issue does not occur in the future. CAPs contain clearly stated goals and timeframes for completion.

PROCESS

Oscar has a systematic method for the identification, reporting, and processing of PQIs, to determine opportunities for improvement in the provision of care and services to Oscar members and to direct actions for improvement based upon the frequency and severity of the PQI.

It is our policy to accept a PQI referral through a variety of sources. These include but are not limited to: Internal referrals from Grievances and Appeals; a Plan member; a Plan provider; a Plan staff member; an affiliate.

All PQIs which are identified will be tracked in the PQI log for the purposes of monitoring patterns to identify any potential trends or any significant sentinel events.

All information obtained during and used in a quality of care investigation will be held in strict confidence, according to the Plan confidentiality policies and in accordance with all relevant State and Federal Peer Review Laws and regulations.

A designated medical professional reviews all referred PQIs to identify whether a true Quality of Care or Quality of Service issue exists after which the case will be assigned a severity score. Some cases will be referred to the Peer Review and Credentialing Subcommittee based on our policy. Based on review by the Peer Review and Credentialing Subcommittee, a provider may be placed on a CAP or may be required to submit a CAP. The CAP will request follow-up and evidence from the provider in question to demonstrate that the corrective actions have been implemented as specified.

All PQI outcomes are trended on a continuous 36 months' basis. Any identifiable trends, regardless of outcome to the member, will be referred to the Quality Improvement Committee on a quarterly basis for potential action or educational opportunities.

REPORTING

To report a PQI, you may complete and fax the PQI Referral Form linked below and included in the Forms section at the end of this Manual. You may also report a PQI by completing this electronic PQI Referral Form. Either form can be submitted anonymously.

RELATED FORM:

PQI Referral Form (fax)

Pharmacy Services

Overview

Oscar contracts with CVS/caremark to provide and coordinate the outpatient prescription drug benefit. CVS/caremark, on behalf of Oscar, is responsible for managing the pharmacy network, formulary, and all aspects of the outpatient prescription drug benefit, including any related medication management programs, approvals, denials and appeals. CVS/caremark adjudicates prescription claims at the point of sale.

Drug Formulary

The Oscar formulary is a dynamic document. Medications on Oscar's formulary generally remain consistent throughout any coverage year, but new medications and generics that become available are evaluated by Oscar's Pharmacy and Therapeutics (P&T) Committee and individual medications may be added to or removed from the formulary.

To access the drug formulary, click here

To initiate a drug authorization, click here

Related Form:

Oscar Drug Prior Authorization Form

Access to Care

Overview

Oscar is dedicated to providing access to high quality providers and strives to ensure strong network coverage for all Oscar members' needs. Oscar will work with members and providers to ensure members have access to appropriate, timely, and continuous care.

Practitioners may freely communicate with patients about all treatment options, regardless of benefit coverage limitations.

Provider Directory Discrepancies

Participating providers must notify Oscar of any change to the provider's name, address, telephone number, business structure, or tax identification number within ten business days after making the change.

Availability of Providers

Oscar offers healthcare plans as a healthcare Service Organization (HCSO). Members are not required to designate a specific PCP and can see any in-network PCP they wish. Members do not need a referral to see a specialist. The list of in-network providers and facilities by state can be found on the Oscar website.

Members do not have out-of-network benefits (except for network exceptions, i.e., an emergency). To create a streamlined experience and protect Oscar members from unanticipated costs, the following may be grounds for a provider's termination from the Oscar network:

- No admitting privileges to an in-network hospital. Providers are required to report if they lose their admitting privileges and must show best efforts to regain them,
- Admitting members to out-of-network hospitals,
- Performing procedures at out-of-network facilities, and/or
- Referrals to out-of-network providers (including laboratories)

Availability Standards

Oscar expects to offer access for scheduling appointments with an in-network practitioner, mental health professional, and specialist for medical/surgical services, per any Arizona law and NCQA guidelines. Oscar has adopted quantifiable and measurable appointment availability standards consistent with state regulations and NCQA guidelines, including timeliness of appointments for preventive care, routine primary care, specialty care, urgent care, emergency care, after hours care, and waiting time in the provider office.

The following outlines Oscar's appointment availability standards:

Activity	Standard
Preventive care appointments with PCPs	60 days of request (sooner if necessary, for the enrollee to be immunized on schedule)
Routine-care appointments with PCPs	15 days of request (or sooner if medically necessary)
Appointments with Specialists (including high impact and high volume specialists)	60 days of request (or sooner if medically necessary)
Urgent care services	Seven days per week

Non-emergency inpatient care from a contracted facility	In a timely manner as medically necessary
Services from a contracted physician or practitioner in a contracted facility, including emergency inpatient care	In a timely manner as medically necessary
Care for non-life threatening behavioral health emergency	6 hours of request
Urgent behavioral health appointment with or without prior authorization	48 hours of request
Initial visit for routine behavioral health appointment	10 business days of request
Follow up routine behavioral health appointment with a physician	15 business days of request
Follow up routine behavioral health appointment with a non-physician	10 business days of request
Non-urgent appointments for ancillary services (for diagnosis or treatment of injury, illness, or other health condition e.g. lab work or diagnostic testing, such as mammogram or MRI, and treatment of an illness or injury, such as physical therapy.)	During normal business hours or sooner if medically necessary
Emergency Care	Immediate access to the nearest receiving center based on prudent layperson and reasonable person definitions. No prior authorization required.

Authorizing an Out-of-Network Provider

If it is determined that Oscar does not have an in-network provider accessible or available with the appropriate training and experience needed to timely treat a member's condition, Oscar will approve an out-of-network authorization as a network exception. Requests for out-of-network authorization may be made by the member or an in-network provider.

Please note: approvals will not be made on the basis of convenience for either a member or a provider, and Oscar may not approve the particular out-of-network provider requested. If Oscar approves the authorization, all services performed by the out-of-network provider shall be subject to a treatment plan approved by Oscar in consultation with the member, the member's PCP, and the out-of-network provider. Before any services are rendered, Oscar will negotiate a single case agreement outlining the services authorized and reimbursement rate(s) for such services. In the event that Oscar does not approve an authorization as a network exception, any services rendered by the out-of-network provider will not be covered or reimbursed.

Transitional Care

Oscar understands that when providers leave the network or are terminated from the plan, members may require coverage for a period of time to ensure continuity of treatment.

As such, members who are being treated by a provider whose contracted status has been terminated may be able to continue ongoing treatment for covered services for up to 90 days after the effective date of termination. In addition, pregnant members in their second or third trimester may be able to continue care with a former in-network provider through delivery and any postpartum care directly related to the delivery.

Please note: members must contact Member Services to request this continuity of care and it must be authorized prior to service. Formerly in-network providers must agree to accept as payment the negotiated fee that was in effect just prior to the termination. Additionally, the provider must agree to provide Oscar with necessary medical information related to the member's care and adhere to Oscar's policies and procedures, including those for assuring quality of care, obtaining preauthorization, and authorization.

If a provider was terminated by Oscar due to fraud, imminent harm to patients or final disciplinary action by a state board or agency that impairs the provider's ability to practice, continued treatment with that provider is not available.

Credentialing

Overview

The Oscar network credentialing process is designed to provide initial and ongoing assessment of the provider's ability to render specific patient care and treatment within limits defined by licensure, certification and/or accreditation.

Oscar performs or provides oversight for all aspects of the credentialing process, including primary source verification of provider information and identification of potentially problematic providers.

Re-credentialing of providers occurs every three (3) years. Information from Quality Management (QM), Utilization Management (UM), Member Services, and Appeals & Grievances is considered at the time of re-credentialing. Provider status and performance is continuously monitored between re-credentialing cycles by Oscar or its delegated entity. Ongoing monitoring of reports by regulatory agencies of sanctions, limitations on licensure, and complaints are also performed between re-credentialing cycles.

All providers that meet requirements are referred to the Medical Director for review and final approval. The Medical Director has the authority to refer any providers for further review to the Credentialing and Peer Review Committee for final approval. If a reportable quality issue or trend is identified, the Credentialing and Peer Review Committee takes appropriate action in

accordance with Oscar's policies and procedures. Oscar providers have the right to a formal fair hearing and appeal if Oscar decides to alter the conditions of a practitioner's participation based on quality and/or service issues.

Oscar complies with applicable state and federal requirements and NCQA standards in credentialing and recredentialing its providers. Providers must maintain good standing with state and federal regulatory and licensing bodies.

Practitioner Rights

All practitioners have the right to:

- Review the information Oscar obtains from outside sources (e.g., malpractice insurance carriers, state licensing boards) to support their credentialing applications.
- Correct erroneous information from outside sources within 30 days of identification.
- Check the status of their credentialing or recredentialing application here.
- Practitioners with questions on their credentialing application or status may also reach out to Provider Relations at 1-855-OSCAR-55 or Credentialing at credentialing@hioscar.com.

If the Peer Review and Credentialing Committee makes a Professional Competence, Conduct, Business, or Administrative Decision with regard to a Participating LIP's participation status and the Peer Review and Credentialing Committee offers such Participating LIP an opportunity to appeal the recommendation, the Peer Review and Credentialing Committee will provide the Participating LIP notice of the Peer Review and Credentialing Committee's recommendation, that: (i) states the specific criteria, facts and circumstances that the Peer Review and Credentialing Committee considered in making its recommendation; (ii) specifies the proposed effective date of its recommendation; (iii) summarizes the basis for the Peer Review and Credentialing Committee's recommendation; (iv) describes the Participating LIP's right to request a hearing or meeting to appeal the recommendation; (v) sets forth the time limit within which to request such a hearing/meeting; and (vi) generally describes the appeal process and summarizes the Participating LIP's rights during the hearing/meeting. These rights to appeal apply exclusively to Participating LIP and Organizational Providers. An Applicant who does not have a Participation Agreement in place with Oscar at the time of application has no appeal rights under this Plan.

Practitioner Obligations

A Participating LIP has the obligation to continually update his/her CAQH application with the most current information available with respect to all information and to notify Oscar immediately upon the occurrence of those events. Failure to so update the CAQH application or to provide such notification to Oscar will constitute grounds for denial of the recredentialing application and termination of Participating LIP's participation status. A participating provider shall notify Oscar of any change in the provider's name, address, telephone number, business

structure, or tax ID within ten business days after making the change, per Arizona state regulations.

Credentialing Delegation and Oversight

Oscar may delegate credentialing activities to contracted Provider Organizations that have administrative capacity to provide such services and meet delegation requirements as demonstrated in a pre-delegation review.

Oscar performs, and requires delegated entities to perform, ongoing internal audits to ensure the credentialing status of its providers remains current at all times. Audits include validation of licensure, malpractice, DEA, OIG and other sanctions, and current status of applicable certification and/or accreditation.

Non-Discrimination Policy

Oscar conducts monitoring, at least annually, to ensure that discriminatory decisions are not made. Monitoring practice includes annual audits of practitioner complaints for evidence of alleged discrimination.

Information submitted to the Credentialing Committee for approval, denial, or termination does not designate a provider's race, ethnic/national identity, gender, age, sexual orientation, types of procedures performed, or payor sources.

Member Grievances

Overview

Oscar has a process for timely hearing and resolution of member grievances in accordance with regulatory guidelines. The Sr. Manager of Grievances and Appeals has primary responsibility for Oscar's grievance system and processing of grievances is not delegated to any other entity. Oscar performs ongoing review and analysis of grievances in order to track and trend issues. Analyses are reviewed by the Quality Management Committee and the Continuous Quality Improvement Committee, and recommendations are made to improve plan policies and procedures.

Filing a Member Grievance

Oscar provides assistance as needed to members filing grievances and maintains a toll-free number for the filing of grievances. Grievance forms and a description of the grievance procedure are made available on the Oscar website (hioscar.com/forms).

Members may submit grievances via mail, fax, online, or email for up to 2 years for post-service denials, 60 days for pre-service requests in regards to informal reconsideration. A Formal appeal request may be submitted 180 days from the informal reconsideration denial following any incident or action that is the subject of the member's dissatisfaction. Grievance Forms will be

provided promptly upon request. Members can also call Oscar's customer service line to get help in filling out a form. A written record is made for each grievance received by Oscar including the date received, the plan representative recording the grievance, a summary or other document describing the grievance, and its disposition.

Oscar's grievance system addresses the linguistic and cultural needs of its member population as well as the needs of members with disabilities. Oscar ensures there is no discrimination against an enrollee or subscriber (including cancellation of the contract) on the grounds that the complainant filed a grievance. Grievances will be addressed and resolved according to state regulations.

Related Form:

Member Grievance Form

Provider Inquiries and Disputes

Overview

Provider inquiry

Providers who would like to make a claims inquiry may contact Oscar via phone, web, email, fax, or letter sent to the address specified on the EOP. Inquiries leading to the submission of adjusted claims or late submissions will be reviewed according to the timelines established in the claims submission section.

Provider dispute

A provider wishing to submit a payment dispute may do so using Oscar's Dispute Resolution Form or other written format submitted by mail, through Oscar's electronic provider portal, or via fax within **90 calendar days** of a claim processing decision. A copy of the Dispute Resolution Form can be found in the forms section of this manual and on Oscar's website. This submission will trigger Oscar's Dispute Resolution Process. Once the dispute form is received, Oscar will send an acknowledgement letter to the provider. Oscar will resolve or seek additional information needed to resolve disputes within **60 calendar days**. If Oscar requests additional information to resolve a dispute, the provider has **30 calendar days** to respond. Upon receipt of all required information, Oscar will then seek to resolve the dispute within **60 calendar days**.

At any time during the Dispute Resolution Process either party may request a meet and confer by telephone, and if the meet and confer isn't effective either party may submit the Dispute to Binding Arbitration.

Dispute Resolution Form and other related communications may be mailed to:

Oscar Health Plan, Inc.
P.O. Box 52146
Phoenix AZ, 85072–2146

Related Form:

Provider Dispute Resolution Form

Fraud, Waste, and Abuse (FWA)

Overview

Oscar takes Fraud, Waste and Abuse (FWA) very seriously. Oscar's Special Investigations Unit (SIU) is tasked with the detection, prevention, and investigation of FWA in the delivery of healthcare services.

Fraud, Waste, and Abuse are improper actions that result in inappropriate and unnecessary spending. Fraud is distinguished from waste or abuse in that it is committed when one knowingly or willfully makes a material misrepresentation or omission with the intent to defraud and obtain a benefit. Waste refers to overutilization, extravagant, careless or needless expenditure of healthcare benefits or services often caused by disorganization or a misuse of resources. Abuse describes practices that are inconsistent, or outside the bounds of generally accepted practices in the industry, which result in unnecessary services and payment.

Detection

Oscar uses a number of sources as well as proactive and reactive processes to detect FWA, including but not limited to: hotline reports, internal employee escalation, external industry sources, pre-payment and post-payment claim review, claim edits, and data analysis. Any report, regardless of source, may result in an investigation.

Prevention and Investigation

As part of its prevention and investigative efforts, Oscar's SIU may initiate investigations which may include but are not limited to an audit of a provider's records. Prepayment review may be applied to the claims of a provider or member for whom there is a basis to suggest inappropriate billing or services may be occuring. Post-payment review may be conducted when there is a basis to suggest inappropriate billing or services relating to a provider or member after claims have previously been processed and paid.

Pre and postpay claims payment reviews entail a thorough review of submitted claims, and review of available, and when needed requested information, to determine whether the data submitted on the claim is accurately and appropriately supported. At times these reviews may be conducted at the provider's location. Information requested or reviewed onsite may include but is not limited to: medical records, billing statements, evidence of member cost share collection, invoices, administration records, test results, nursing notes, audit logs, providers orders, lab requisitions, certificates of medical necessity as well as the medical record

documentation that supports each of these. Providers are responsible to ensure that their available documentation fully supports the data, and medical necessity of the procedures, services, and supplies, submitted on the claim. This includes, but is not limited to, compliance with the most stringent medical record documentation standards that would apply, and Medicare's Medical Record Documentation standards in the absence of others, as well as compliance with national coding and billing standards (i.e. CPT®, HCPCS, ICD-10). These reviews may result in full denial of the claim or specific claim lines if documentation is insufficient or does not substantiate data submitted. Records that contain cloned documentation, conflicting information or other such irregularities may be disallowed for reimbursement.

Additionally, a post-payment review may involve a sampling and extrapolation methodology, where allowed, or may require the provider to cooperate in the performance of a self-audit to resolve identified issues. Investigations may involve review of contemporaneous treatment records as well as interviews with associated parties including members and providers.

Resolution

Based on the findings of an investigation, SIU may pursue corrective actions including but not limited to: provider placement or continuation on pre-payment review, provider education, recovery of overpaid funds including claims offsets, repayment demands, legal action, termination of contract, and reporting to state and federal regulators and/or law enforcement.

Reporting Fraud, Waste, and Abuse

If providers or Provider Organizations suspect potential FWA relating to Oscar in any form, they must report it to Oscar immediately. To report, you can contact Oscar's SIU in the following ways:

- Compliance Hotline: 1-844-392-7589
- Online Portal: http://hioscar.ethicspoint.com/
- Mail: Oscar Health Plan, Inc., Special Investigations Unit, 75 Varick Street, 5th Floor, New York, NY 10013
- Email: fraud@hioscar.com

Please call the Compliance Hotline at 1-844-392-7589 or submit through the Online Portal to report any general compliance-related concerns (including reporting violations of law, regulations, policies, or procedures) and questions about Oscar's Compliance Program, or to seek advice about how to handle compliance-related situations at work. All calls are treated confidentially, and callers can remain anonymous if they so choose. Callers may be asked whether they are willing to identify themselves so that an issue may be followed up with the caller after the call ends. Reports through Oscar's Compliance Hotline may remain anonymous. Retaliation against anyone who raises a concern is prohibited.

FORMS

AUTHORIZATION REQUEST FORM

Authorization request form

*To request an authorization complete this form, attach relevant clinical info, and fax it to **844-965-9053.***

What is this form for?
- ✔ Pre-service, in-network medical auths that are reviewed by Oscar (not partner) staff
- ✔ Concurrent or post-service auth for ER to inpatient admission

What is this form not for? *(for any of these, call 855-OSCAR-55 or visit provider.hioscar.com)*
- ✘ Requests where the physician or facility is out of network
- ✘ Auth for services reviewed by one of our partners, or to find out what requires auth
- ✘ Help finding an in-network provider or facility

Request submitted by (and how we can reach you)

Your name (first & last)	Phone & ext.	Fax

Patient

Name (first & last)	DOB	ID #
		OSC

Physician

Name (first & last)	NPI	TIN

Service Type (please select one)

- ◯ Non-Surgical Ambulatory Services
- ◯ Vendor Provided Services
- ◯ Elective Surgical Procedures
- ◯ Emergent Admissions
- ◯ Transportation
- ◯ Long Term Acute Care Facility
- ◯ Specialized Facility Stays
- ◯ Other

Place of Service (please select one)

- ◯ Ambulatory Surgical Center
- ◯ Inpatient - General Acute
- ◯ Skilled Nursing Facility
- ◯ Acute Rehabilitation Facility
- ◯ Home
- ◯ Office
- ◯ Observation Care
- ◯ Outpatient Hospital

Facility (if applicable)

Facility name & address	NPI	TIN

Dates

Request is (check one): ◯ Pre-service ◯ Concurrent ◯ Post-service

Service start or admit date	Service end or discharge date

Service

Include units and/or visits (if applicable)

Procedure code(s) CPT/HCPCS/Revenue	
Diagnosis code(s) ICD-10	

Notes (include your request # if for an existing case)**:**

Fax this form to **844-965-9053 -** include clinical information for fastest response

◯ Please select if expedited (urgent) processing required

CMS-1500 CLAIM FORM

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA — PICA

CARRIER

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT™S NAME (Last Name, First Name, Middle Initial)

3. PATIENT™S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT™S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED™S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED™S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT™S CONDITION RELATED TO:

11. INSURED™S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO ***If yes***, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED™S OR AUTHORIZED PERSON™S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15.OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

71b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D.PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1											NPI	
2											NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

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.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license #, or SSN) of the primary individual rendering each service is reported in the designated section.For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWCP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1197. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

[Oscar Drug Prior Authorization Form]

MEMBER GRIEVANCE FORM

Oscar Grievance Form

Completion of this form is optional. However, we encourage the form's return to assist in resolving your grievance. To file a grievance, you or your authorized representative may contact our Member Services Department using the telephone number displayed on the member ID card or submit a letter in writing to the address listed below. Oscar will mail a written response within 30 calendar days from the date of receipt.

1. Member Information

Member Name: ______________________________ Member ID #: OSC________________

Home Address: ____

City: ______________________________ State: __________ Zip: ____________

Home Phone Number: ________________________ Date of Birth ____________________

2. Complainant Information (if different from Member)

*If you are **not** the Member, please provide **your** information here.*

Your Name: ____

Company: ____

Relationship to Member:

❑ Parent ❑ Spouse ❑ Other: ______________________________

Your Mailing Address: ____

City: ______________________________ State: __________ Zip: ____________

Your Phone Number: ______________________ Your Fax Number: ____________________

3. Please describe the nature of your grievance below (please use additional pages if necessary). Add any facts your feel should be considered in the review of your grievance. As a reminder, please attach any supporting documentation you have.

If your grievance involves a claim, please additionally provide the following (if available):

Claim ID(s): ______________________________ Date(s) of Service: ____________________

Provider(s) and/or Facility Name(s): ____

4. Did you speak with an Oscar representative about this issue?

___NO ___YES - If yes, please provide the name of the individual that you spoke to and the date:

Name of Rep(s): ________________________________ Date(s): ____________________

If no, you may be able to resolve your issue immediately by contacting Oscar at 1-855-672-2755 or

help@hioscar.com.

5. Authorization (if submitted by someone other than the Member)

Please note that Oscar is unable to share a Member's Personal Health Information (PHI) without the express written permission of the Member via a HIPAA authorization form. Please contact Oscar or visit hioscar.com/forms to get a copy of the HIPAA authorization form, which must be completed and signed by the Member.

Has the Member(s) signed a HIPAA authorization form authorizing you to speak on the Member's behalf?

___ NO ___YES

If we do not have a HIPAA authorization on file, the written response for a grievance filed by a non-authorized party will be mailed to the Member.

Would you like us to send the response to you instead? ___ NO ___YES

If YES, Oscar will contact the Member to request they authorize you to receive this information.

6. Signature and Submission

I acknowledge that the information contained within this form is accurate to the best of my knowledge. I have provided complete and accurate information upon which to base an investigation of the circumstances surrounding the issue. I agree to cooperate and provide any additional information necessary and/or appropriate related to this grievance. My failure to do so may result in Oscar closing the investigation related to this matter.

Signature ____ Date ____________

Name (Printed): ____

Please submit this completed form (Attn: Grievances) to one of the following:

By mail:
Oscar Insurance
Attn: Grievances
P.O. Box 52146
Phoenix AZ, 85072

By email:
help@hioscar.com
Attn: Grievances

By fax:
888-977-2062
Attn: Grievances

PQI REFERRAL FORM

Potential Quality Issue (PQI) Referral Form

DIRECTIONS: To report a potential quality issue, fax to Quality Improvement 888.732.0625

Member Information			
Member First and Last Name:		*Date of Birth (mm/dd/yyyy)*	
Member ID # if available:		*Gender:*	
Provider Information			
Provider (facility) or Practitioner of Concern (if applicable):			
Contracted ☐ Non-Contracted ☐ Unsure		*contracted, indicate Facility/Provider ID #*	
Facility or Location Where Care Was Rendered			
PQI Indicator Category (check all that apply)			
_____ Access and/or availability _____ Assessment/Treatment/Diagnosis _____ Communications/Conduct _____ Continuity of Care _____ Other		____ Pharmacy/UM Authorization ____ Readmission/UM ____ Safety ____ Surgical Services ____ Unexpected Death	
Date of PQI Occurrence:	_____/______/______	Date PQI Identified:	______/______/______
Describe Incident or Concern (Please be as specific as possible, include witnesses if applicable)			
Reported by (Optional):			
Name/Title:		Phone #:	
Organization:		Date Submitted:	

PROVIDER DISPUTE RESOLUTION FORM

Provider Dispute Resolution Form - **Arizona**

Instructions

If you have not previously addressed this issue with Oscar, please call 855-OSCAR-55 to speak with a representative. This matter should undergo a preliminary review before filing a dispute.

Filling out this completed form will constitute a provider initiating a formal Dispute with Oscar and will trigger Oscar's Dispute Resolution Process.

Please complete this form and mail to:

Oscar Health Plan, Inc.
P.O. Box 52146
Phoenix, AZ 85072-2146

Please call Oscar at 855-OSCAR-55 if you want to check on the status of your dispute.

Provider Information - Fill out all fields.

Provider Type

- ○ Physician
- ○ Anxilliary
- ○ Hospital
- ○ Ambulatory Surgical Center
- ○ Ambulance
- ○ Home Health
- ○ Rehabilitation Center
- ○ Durable Medical Equipment
- ○ Assisted Living Facility
- ○ Other (Please specify): ______________________________

Provider Name	Provider NPI	Provider Tax ID Number

Provider Address	Suite/FL #	City	County	State	Zip code

Phone	Fax	Email address

Dispute Type - Choose one.

Dispute Type

- ○ Contracted rate
- ○ Timely filing
- ○ Benefits decision
- ○ Out-of-network review
- ○ Claims messages
- ○ Prompt payment
- ○ Health plan refund request
- ○ Request for additional information
- ○ Other (Please specify): ______________________________

Disputed Claim Information - Include the following information about the claim in dispute.

Patient Name	Patient's Oscar ID Number	Claim ID

Dates of service

Dispute Description

○ Check here if supporting documentation is enclosed.

Please be specific about how you would like this be resolved:

UB-04 CLAIM FORM

oscar

UB-04 Claim Form

1	2	3a PAT. CNTL #		4 TYPE OF BILL
		b. MED. REC. #		
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM / THROUGH	7

8 PATIENT NAME	a	9 PATIENT ADDRESS	a			
b		b		c	d	e

10 BIRTHDATE	11 SEX	ADMISSION 12 DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	CONDITION CODES 18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30

	31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37	
a																a
b																b

38		39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a						
	b						
	c						
	d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1									1
2									2
3									3
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20									20
21									21
22									22
23		***PAGE ____ OF ____***	***CREATION DATE***		***TOTALS***				23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI		
A							57		A
B							OTHER		B
C							PRV ID		C

	58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
A						A
B						B
C						C

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
A				A
B				B
C				C

66 DX	67	A	B	C	D	E	F	G	H	68
	I	J	K	L	M	N	O	P	Q	

69 ADMIT DX		70 PATIENT REASON DX	a	b	c	71 PPS CODE		72 ECI	a	b	c	73

74 PRINCIPAL PROCEDURE CODE / DATE	a. OTHER PROCEDURE CODE / DATE	b. OTHER PROCEDURE CODE / DATE	75
c. OTHER PROCEDURE CODE / DATE	d. OTHER PROCEDURE CODE / DATE	e. OTHER PROCEDURE CODE / DATE	

76 ATTENDING	NPI	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

80 REMARKS	81CC		
	a		
	b		
	c		
	d		

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997

NUBC™ National Uniform Billing Committee

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

UB-04 NOTICE: **THE SUBMITTER OF THIS FORM UNDERSTANDS THAT MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION AS REQUESTED BY THIS FORM, MAY SERVE AS THE BASIS FOR CIVIL MONETARTY PENALTIES AND ASSESSMENTS AND MAY UPON CONVICTION INCLUDE FINES AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW(S).**

Submission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete. That the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts. The following certifications or verifications apply where pertinent to this Bill:

1. If third party benefits are indicated, the appropriate assignments by the insured /beneficiary and signature of the patient or parent or a legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the patient or the patient's legal representative.
2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.
3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.
4. For Religious Non-Medical facilities, verifications and if necessary re-certifications of the patient's need for services are on file.
5. Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal Law and Regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 through 1086, 32 CFR 199) and any other applicable contract regulations, is on file.
6. The provider of care submitter acknowledges that the bill is in conformance with the Civil Rights Act of 1964 as amended. Records adequately describing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.
7. For Medicare Purposes: If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance which is responsible to pay for the services for which this Medicare claim is made.
8. For Medicaid purposes: The submitter understands that because payment and satisfaction of this claim will be from Federal and State funds, any false statements, documents, or concealment of a material fact are subject to prosecution under applicable Federal or State Laws.
9. For TRICARE Purposes:
   (a) The information on the face of this claim is true, accurate and complete to the best of the submitter's knowledge and belief, and services were medically necessary and appropriate for the health of the patient;

   (b) The patient has represented that by a reported residential address outside a military medical treatment facility catchment area he or she does not live within the catchment area of a U.S. military medical treatment facility, or if the patient resides within a catchment area of such a facility, a copy of Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;

   (c) The patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverage, and that all such coverage is identified on the face of the claim except that coverage which is exclusively supplemental payments to TRICARE-determined benefits;

   (d) The amount billed to TRICARE has been billed after all such coverage have been billed and paid excluding Medicaid, and the amount billed to TRICARE is that remaining claimed against TRICARE benefits;

   (e) The beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,

   (f) Any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent employees, but excluding contract surgeons or other personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.

   (g) Based on 42 United States Code 1395cc(a)(1)(j) all providers participating in Medicare must also participate in TRICARE for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987; and

   (h) If TRICARE benefits are to be paid in a participating status, the submitter of this claim agrees to submit this claim to the appropriate TRICARE claims processor. The provider of care submitter also agrees to accept the TRICARE determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. The provider of care will accept the TRICARE-determined reasonable charge even if it is less than the billed amount, and also agrees to accept the amount paid by TRICARE combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. The provider of care submitter will not attempt to collect from the patient (or his or her parent or guardian) amounts over the TRICARE determined reasonable charge. TRICARE will make any benefits payable directly to the provider of care, if the provider of care is a participating provider.

ONE PAGE APPEAL FORM

Oscar Appeal Form

If you (or someone acting on your behalf or your provider of record) would like to file an appeal of a denied authorization request related to medical necessity issued by Oscar, this form can be completed and submitted to Oscar. While it is not required to complete this form in order for your appeal request to be accepted, it may help Oscar in processing your request. If you have any questions or would like to request more information, you or your doctor can call us at 1-855-672-2755 (855-OSCAR-55), or message us in the Oscar app or at hioscar.com.

Member Information	
Name (first and last):	Oscar ID#:
DOB (mm/dd/yyyy):	Phone Number:
Address:	Name & relationship to member of person acting on member's behalf (if applicable):

Summary of Denied Authorization Request	
Service(s) Denied:	Date(s) of Service:
This appeal is related to a: ❒ Pre-service request ❒ Post-service request ❒ Concurrent request	Provider Name:
This appeal request should be considered URGENT: ❒ Yes ❒ No	Case Number (MEDREV-XXXXX):

Please use this space to explain your appeal request, and the disagreement with Oscar's decision:

Appealing party's signature:	Today's date (mm/dd/yyyy):

Please fax this form along with supporting clinical information to 844-965-9054.

APPENDIX

REIMBURSEMENT POLICIES

Please visit https://provider.hioscar.com/resources/arizona/appendix/ to view Oscar's reimbursement policies.