Curative Provider Manual

curative

curative

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Section 1 | How to Contact Us

Welcome to Curative, a new kind of health plan with no copays, no deductibles and no out-of-pocket costs, including many generic, brand name and specialty medications.* The full cost-transparency not only means better access to care for your patients, but more time for you to provide high-quality care that you saved from bill collections.

Members must complete a Baseline Visit with **Curative in the first 120 days of enrollment to qualify for $0 copays and deductibles.*

Need help or have a question?

We're here to make health insurance coverage easy. Please reference the key points of contacts for each department. The Provider Reference Guide may be accessed here: https://curative.com/provider-resources. Scroll to General Resources to access this guide.

Section 2 | Our Products

Provider Manual Updates

Curative may periodically update this Provider Manual. We will provide written notice of material changes to any policy or procedure in this Manual as specified in your Agreement with us. We encourage you to contact your **Curative** Provider Representative for any needed clarification on any information.

Regulatory Requirements

Curative complies with all Federal and Regulatory requirements.

Our Plan

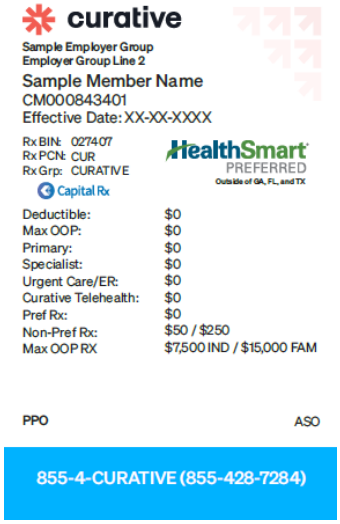
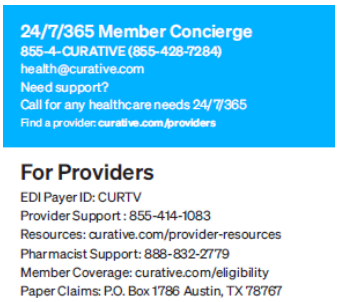
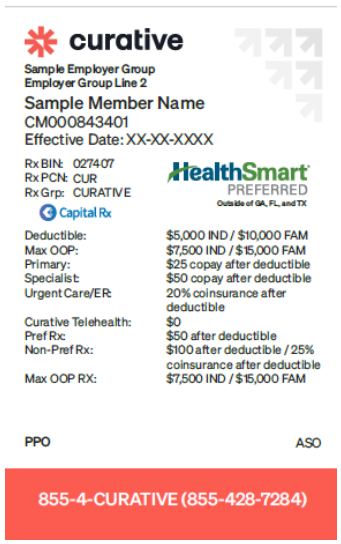
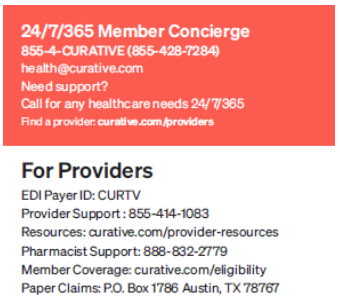
In-Network and Out-of-Network benefits apply to eligible employees and their dependents and services are limited to the allowable amount as determined by **Curative**. All In-Network providers have agreed to accept the **Curative** allowable amount. For Out-of-Network providers, any charges over the allowable amount for services are the patient's responsibility, in addition to the deductible and coinsurance.

If the member completes their Baseline Visit within 120 days of their effective date in the **Curative** Plan, most copays, deductibles and coinsurances will be waived. In-Network providers will receive the **Curative** allowable amount, as defined by the contract. Maximum visits and limitations will continue to apply.

The Baseline Visit is an appointment with a **Curative** Clinician for the Clinical Assessment related to the member's current health status to help them optimize their health care. The Assessment will also include an Evaluation of Preventive recommendations indicated by United States Preventive Services Task Force (USPSTF) and whether immunizations are up to date. The member will be assigned and meet with their Care Navigator for an orientation on the plan benefits, how to access In-Network providers and address any current physician or pharmacy needs.

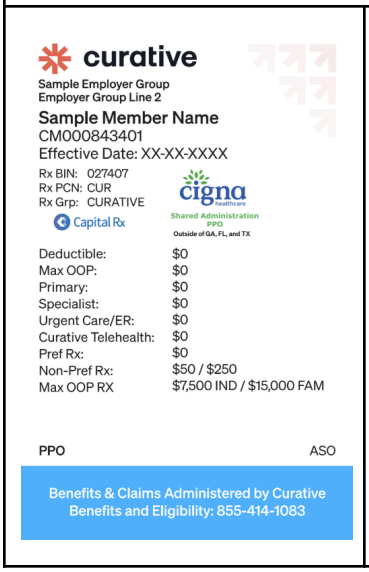
Section 3 | Member Identification Card

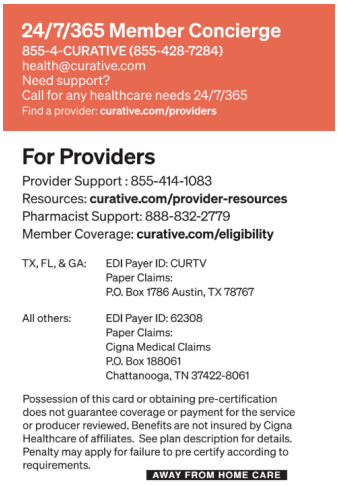
Sample ID Card (Florida, Georgia,Texas)

Baseline Visit Completed - All new **Curative** members will receive a Baseline Complete insurance ID card. Effective 1/1/23, the member will have 120 days from the plan start date to complete the Baseline Visit to be eligible for the full benefits of in-network costs including a $0 deductible and $0 copays.		**Baseline Visit Incomplete -** Effective 1/1/23, if the **Curative** member does not complete the Baseline Visit in 120 days from from the plan start date, a Baseline Incomplete insurance ID card will be sent to the member. The member will be responsible for a $5,000 deductible and respective copay costs.	
			

Sample ID Card (Outside Florida, Georgia, Texas)

Baseline Visit Completed - All new **Curative** members will receive a Baseline Complete insurance ID card. Effective 1/1/23, the member will have 120 days from the plan start date to complete the Baseline Visit to be eligible for the full benefits of in-network costs including a $0 deductible and $0 copays.	**Baseline Visit Incomplete -** Effective 1/1/23, if the **Curative** member does not complete the Baseline Visit in 120 days from from the plan start date, a Baseline Incomplete insurance ID card will be sent to the member. The member will be responsible for a $5,000 deductible and respective copay costs.





Eligibility Verification

All participating providers are responsible for verifying a member's eligibility at each and every visit. Providers can verify member verification through one of the methods below:

- Availity Essentials: www.availity.com
  Eligibility and Benefits Verification

  - Real-time eligibility lookup for **Curative** members

  OR

- Navigate to **Curative** https://curative.com/eligibility
  - Enter the Member ID, Last name, DOB
  - Click 'See Coverage'
  - You'll see the member's coverage dates, basic copays and deductible information

Please note for both methods:

- Last name and member ID must match the ID card exactly.
- Birth date must be accurate.

Section 4 | Prior Authorization and Notification

Curative Clinical Care Management (CCM) includes the following services:

- Prior Authorization of certain services is required.
- Notification only of certain services is required.
- Concurrent review of members in hospitals, SNF, and LTAC.

Access to the services requiring the above listed levels of authorization, notification and/or concurrent review may be accessed at https://curative.com/provider-resources. To initiate an authorization request or notification, we encourage providers and facilities to use the electronic portal available at: https://curative.com/pa/med.

Any time you have Clinical Care Management questions and/or concerns regarding a **Curative** member, we encourage you to call us at 855-414-1083. The Clinical Care Management department maintains a toll-free fax line 24 hours daily. The fax number is 877-942-4448.

Prior Authorization Process

- **Review Criteria Source**: Prior authorization requests are reviewed utilizing decision guidelines based on reasonable evidence. **Curative** uses MCG (formerly Milliman Care Guidelines) which is a national approved care guidelines entity to perform prior authorization.

- **Contact Information**: The Clinical Care Coordinators may receive prior authorization requests via the electronic portal at https://curative.com/pa/med, telephone, fax, or HIPAA secure encrypted email from the provider's office. The guidelines are applied and the services are authorized by the Clinical Care Coordinator, or referred to the Medical Director or Physician Reviewer for approval.

- **Peer Review:** The peer reviewer reviews all cases where the potential for denial is possible. As required by state law, in any instances where the medical necessity or appropriateness of the requested service is questioned, the Medical Director or Peer Reviewer will make every reasonable effort to contact the requesting provider in order to afford him/her the opportunity to discuss the plan of treatment and the clinical basis for the decision, prior to a final determination.

- **Adverse Determination:** Any Adverse Determinations will follow established policies prior to final determination and communications of the Adverse Determination to the member and providers.

- **Prior authorization Numbers**: **Curative** will provide prior authorization numbers that fully comply with the format for federal and state requirements and currently utilizes ANSI ASC X12 837 claim form format.

Timeframes for Provider Prior Authorization Requests and Notifications

Service Type	Timeframe
Elective admissions	Prior Authorization required three (3) days prior to the scheduled admission date
Outpatient services that require prior authorization	Prior Authorization requests three (3) business days prior to the outpatient service date
Non-Elective (emergent) inpatient admissions	Notification within one (1) business day of admission
Newborn admissions	Notification within one (1) business day
Inpatient admissions, facility transfers, or changes in level of care	Notification within one (1) business day
Organ transplant initial evaluation	Prior Authorization requested at least thirty (30) days prior to the initial evaluation for organ transplant services
Clinical trials services	Prior Authorization required at least thirty (30) days prior to receiving clinical trial services

The following timeframes are required of the ordering provider for prior authorization and notification. If a provider fails to follow these established prior authorization and notification requirements, the prior authorization request may be reclassified as a retrospective review which will extend the amount of time **Curative** has to respond to a prior authorization request. Please note that the member cannot be held responsible for the provider's failure to notify **Curative** in accordance with the notification requirements.

Notification

Prior Authorization for medical necessity of services does not guarantee the network level of benefits. Even if approved by **Curative**, non-network providers paid at the **Curative** allowable amount may balance bill for charges in excess of this amount. The member is responsible for these charges, which can be significant.

Certain services, such as emergency admissions, maternity admissions, only require notification to **Curative**. Prior Authorization and Notification Requirements may be accessed at https://curative.com/provider-resources.

Prior Authorization and Notification Contact Number

- **Curative** Electronic Preauthorization Portal: https://curative.com/pa/med
- To check the status of Preauthorization: https://curative.com/pa/status
- Clinical Care Management: Fax 877-942-4448

Prior Authorization Form: Curative accepts the Texas Standard Prior Authorization Request Form in lieu of the **Curative** Prior Authorization Form.
The **Curative** Prior Authorization form may be accessed at https://curative.com/priorauth.

Concurrent Review

Curative performs concurrent review and discharge planning on inpatient admissions and observations, consistent with health plan benefits. **Curative** will work closely with the attending physician and hospital discharge planners to coordinate the use of home health care and other health care alternatives, which may decrease a hospital's length of stay.

Disease Management

Disease Management is available for qualifying members identified with high-risk diseases, such as diabetes, COPD, and other conditions as identified.

Case Management

Case Management is available for members with high-risk issues, non-compliance, or multiple acute disease processes. **Curative's** Case Management utilizes close monitoring, patient / family education to achieve patient acceptance and compliance. Case Management encourages the interventions of other health care providers, social services and other resources as indicated. The Case Manager works closely with the physician and the alternative care providers to assist the patient and family in understanding the care needs and limitations of the patient. If a Provider identifies a member that may be a candidate for Case Management services, please notify our Clinical Case Management Department by contacting Provider Services at 855-414-1083.

Discharge Planning

Discharge Planning is available to provide assistance to any member being discharged while assuring quality and continuity of care. **Curative** evaluates and assists in identifying the patient's needs for transition from the acute hospital to home or to the most appropriate setting and is coordinated with the patient and their family, Case Manager, and attending physician working as a team to identify the needs of the member.

Management of Members With Special Circumstances

Some members may require services that fall outside of the ordinary scope of Clinical Care Management or Clinical Case Management. Under these special circumstances, **Curative** may identify the member's special circumstances which include, but are not limited to, an individual who has a disability, acute condition, or life-threatening illness and will gather the facts of the case and forward to the Medical Director who will develop a plan of action to assist the member with special circumstances.

Curative Care Navigation

Care navigators can help members and providers with Prior Authorization submissions, escalations, status updates, and to help answer questions around the process. Additionally, our Care Navigators can connect members/providers with our Clinical Care Management team and help with unique and complex situations.

Care Navigators can respond to members and providers via email and text usually within 4 hours, sometimes sooner.

Section 5 | Adverse Determinations of Prior Authorizations

Contact Information

If you have questions and/or require clarification regarding an adverse determination and/or the appeal process, please do not hesitate to contact **Curative's** Provider Services Department at:

- **Provider Services** 855-414-1083

Adverse Determination

An **Adverse Determination** is an instance where **Curative** is questioning the medical necessity or appropriateness or the experimental or investigational nature of health care services.

All **Curative** Prior Authorization requests will be reviewed for medical necessity. Requests for services may be denied for the following reasons:

- Not medically indicated (Adverse Determination).
- Services are considered experimental or investigative (Adverse Determination).
- Services can be safely provided in an alternative setting or level of care (Adverse Determination).
- Services rendered were not determined to meet the definition of emergency care (Adverse Determination).

Adverse Determinations may only be issued by the Medical Director or Physician Reviewer. All requests for services that do not meet the predetermined criteria are forwarded to the Medical Director or Physician Reviewer for consideration. The Medical Director will make every reasonable effort to discuss the case with the requesting physician prior to issuing an Adverse Determination.

Administrative Denials may be issued by the Clinical Care Coordinators which relate to cases, such as an employee is not eligible, or benefits are not a covered service.

Notification of Determinations

Provider Notification: The requesting provider shall be notified via phone call or electronic transmission within three (3) calendar days of the determination. For Adverse Determinations, a written notification will also be provided no later than the third (3rd) working day after the date of the request. If related to an acquired brain injury, provider notification will be via phone call.

Such communications will include the following:

- A clear and concise statement of the specific medical or contractual reasons for the resolution shall be sent to the requesting provider and include a request for further information or action.
- The information regarding the appeal process and the right to appeal the decision, including instructions and how to file a complaint to **Curative**.

Member Notification: Members will be notified of the denial of services via the United States Postal Service. Notification will include a description of the procedure for filing a complaint and for filing an appeal. It will include a notice to the member of the member's right to appeal an adverse determination to an IRO and of the procedures to obtain that review, including a copy of the form prescribed by the Texas Department Insurance.

Curative will use the following notifications:

Hospitalization

If a patient is hospitalized at the time of the adverse determination, **Curative** will notify the Provider of record:

- Within twenty-four (24) hours by phone or electronic transmission,
- Will follow with a letter within three (3) working days to notify the member and the provider of record of this determination.
- The letter shall state that benefits will be terminated at a stated date and time after notification.
- The notification letter will also inform you as to the right of appeal and the process to follow.

Medical (No Hospitalization)

If the patient is not hospitalized at the time of the adverse determination, **Curative** will notify the member and the provider of the record within three (3) calendar days in writing.

Post Stabilization

If the adverse determination is related to denying post stabilization care subsequent to emergency treatment as requested by a treating physician or other health care provider, **Curative** shall provide the notice to the treating physician or other health care provider no later than one (1) hour after the time of the request followed by a letter within three (3) working days to all parties.

Retrospective Review

If an adverse determination is related to a retrospective review, **Curative** will notify the provider of record and the member within a reasonable period, but not later than thirty (30) days after the date on which the claim was received.

Adverse Determinations Appeal

A member, a person acting on behalf of the member, or the member's provider may appeal an adverse determination of a prior authorization request orally or in writing. All appeals of an adverse determination will be processed within set time frames and must fulfill the requirements as follows:

- All appeals must be submitted to **Curative** orally or in writing.
- The appealing party will be allowed a minimum of one hundred eighty (180) days after the date of issuance of written notification of an adverse determination to file an appeal.
- In a circumstance involving a member's life-threatening condition, the member is entitled to an expedited appeal or an immediate appeal to an IRO and is not required to comply with procedures for an internal review by **Curative**.
- **Curative** may not require exhaustion of internal appeals prior to external review if:
    - **Curative** fails to meet its internal appeal process timelines as above, or
    - The claimant with an urgent care situation files an external review before exhausting **Curative's** internal appeal process.
- Within five (5) working days from the receipt of the appeal, **Curative** will send an acknowledgment letter to the patient or a person acting on the patient's behalf and the patient's physician or other health care provider.
- Appeal decisions will be made by a physician who has not previously reviewed the case.
- Once a determination of an appeal is made, written notice will be sent to all relevant parties of the determination of the appeal as soon as practicable, but not later than the thirtieth (30^{th}) calendar day, after the date **Curative** receives the appeal.
- If an appeal is denied and, within ten (10) working days from the denial, the provider sets forth in writing good cause for having a particular type of specialty provider review the case, the denial will be reviewed by a health care provider in the same or similar specialty that typically manages the medical or specialty condition, procedure, or treatment under discussion. The specialty review must be completed within fifteen (15) working days of receipt of the request.
- After **Curative** has reviewed the appeal of the adverse determination, a letter will be sent to the member or an individual acting on behalf of the member, and the provider of record, explaining the resolution of the appeal.

If you disagree with a prior authorization (PA) denial, you may submit an appeal on behalf of your patient, our member. An appeal must be submitted within 180 days of the PA denial. Please include a copy of the original denial, a claim form, and other supporting documentation.

Curative Health Plan
Attn: Appeals Coordinator
PO Box 1786
Austin TX 78767

Curative will consider the appeal request and issue a written decision to you within 30 days of receipt of the appeal request. Your appeal will be reviewed by a claims representative not involved with the initial decision.

Adverse Determinations Expedited Appeal Process

Curative provides a method for expedited appeals for emergency care denials, care for life-threatening conditions denials, and/or continued stays for hospitalized member denials.

- Expedited appeals will be reviewed by a specialist who has not previously reviewed the case and is of the same or similar specialty, as would manage the member condition under review. In addition, the specialist reviewer may interview the member, an individual acting on behalf of the member, or the provider to make a decision.
- The expedited appeal will be completed based on the immediacy of the condition and not later than one (1) working day for the date all the information necessary to complete the appeal is received and communicated by phone. A letter will always follow up oral notification of the expedited appeal decision within three (3) working days from the date of the decision.
- All correspondence with the appealing party/parties will be in writing and signed by the Medical Director or designee.
- In any circumstance involving a member's life-threatening condition, the member is entitled to an immediate appeal to an independent review organization and is not required to comply with procedures for an internal review or expedited appeal.

Specialty Review Appeals for Adverse Determinations

A provider of record may request that a particular type of specialist review an adverse determination by providing a good cause explanation for such request.

Section 6 | Member Complaints and Appeals

Member Complaints

If you or your patient, our member, are dissatisfied with any aspect of the operation of **Curative**, including but not limited to dissatisfaction with plan administration, you may either file a complaint.

When **Curative** is notified of a complaint, orally or in writing, we will send a letter acknowledging the date we received the complaint not later than the fifth business day after the date of receipt of the complaint. If the complaint was received orally, **Curative** will enclose a Complaint Form clearly stating that the Complaint Form must be returned to us for prompt resolution. After receipt of the written Complaint or Complaint Form, we will investigate and send a letter with our resolution within 30 calendar days.

A complaint expressing dissatisfaction with an adverse determination constitutes an appeal of that adverse determination and will be processed according to the appeals process stated in *Section 5: Adverse Determinations of this Provider Manual*. A complaint concerning ongoing emergencies or denial of continued stay for hospitalization will be resolved in one business day of receipt of the complaint. The investigation and resolution shall be concluded in accordance with the medical immediacy of the case.

Complaints should be directed to **Curative** Provider Services at 855-414-1083 or in writing to:

Curative Health Plan
ATTN: Provider Appeals
P.O. Box 1786
Austin, Texas 78767

Member Appeals Process

A provider may file an appeal, for themselves or on behalf of their patient, our member.

Curative provides an appeal process for a provider who is not satisfied with the resolution of the complaint. The appeals process allows a provider to appear before a **Curative** Appeal Panel. Appeals must be made in writing and submitted to the following address:

Curative Health Plan
ATTN: Provider Appeals
P.O. Box 1786
Austin, Texas 78767

Curative will send an acknowledgment letter to the member not later than the 5th business day after the date the written request for appeal is received and will complete the appeals process not later than the 30th calendar day after the date the written request for appeal is received.

Contact Information

If you have questions and/or require clarification regarding a complaint and/or the appeal process, please do not hesitate to contact **Curative's** Provider Services Department.

Provider Services 855-414-1083
P.O. Box 1786
Austin, TX 78767

Section 7 | Claims Processing and Payment

We work hard to ensure that your claims are processed timely and accurately. To be paid promptly for the services you provide, please follow these procedures:

- Claims must be submitted within 95 days from the date of service or date of discharge, unless otherwise specified in your Provider Agreement.
- Additional time will be available when Curative is the secondary payor for a claim when Coordination of Benefits (COB) applies.
- To check member eligibility:
  - Availity Essentials: www.availity.com
    Eligibility and Benefits Verification
    - Real-time eligibility lookup for **Curative** members
    - View covered services, co-payments, coinsurance, and deductibles
    - Check plan-specific coverage and benefit limitations

  OR

  - Navigate to **Curative** https://curative.com/eligibility
    - Enter the Member ID, Last name, DOB
    - Click 'See Coverage'
    - You'll see the member's coverage dates, basic copays and deductible information
- When applicable, providers must obtain prior authorization or notify Curative for planned procedures and services. Refer to **Section 4.0 – Utilization Management and Prior Authorization** for complete instructions and authorization lists.

  To ensure prompt and accurate processing, all claims must be submitted completely, accurately, and in compliance with Curative's billing requirements.

Claim Preparation Requirements:

Use the **HIPAA-compliant 837 electronic format** or the appropriate paper form (CMS-1500 for professional, UB-04 for institutional claims).

Include all required data elements:

- Member ID (as shown on the Curative ID card)

- ➔ Rendering/servicing provider NPI
- ➔ Billing/pay-to provider NPI and Tax ID (TIN)
- ➔ ICD-10 diagnosis code(s) and CPT/HCPCS procedure code(s)
- ➔ Dates of service and billed amount
- ➔ Place of service code
- ➔ **The servicing location address must be reported in Box 32** of the CMS-1500 (or the corresponding field on the UB-04).
- ➔ "Pay-To" address must be accurate in Box 33.
- ➔ **For any claim that includes drugs, list the NDC code, quantity, and dosage provided.**
- ➔ Ensure **Assignment of Benefits** is marked "Yes" or "No."
- ➔ **Facilities may submit interim billings** for extended inpatient or long-term services, when applicable and consistent with contract terms.
- ➔ All claims must be legible, complete, and contain all service lines related to that encounter.
- ➔ Claims must be submitted within **95 days** of the date of service or discharge unless otherwise specified in your Provider Agreement.

Prompt Payment of Claims

Curative complies with all applicable state and federal prompt payment requirements. A claim is considered processed timely if it has been paid, pended for review, or denied within the timeframes established under applicable statutes and regulations, including those issued by the Texas Department of Insurance (TDI).

To ensure your claims are processed promptly and qualify as "clean claims," please ensure that:

- Claims are submitted either electronically or on paper (if permitted by applicable law).
- Each claim is complete, legible, and accurate, with all required fields populated and all supporting documentation attached.
- Claims include valid member identification, provider NPI, diagnosis and procedure codes, dates of service, billed amounts, and servicing location.
- Claims that require prior authorization, coordination of benefits, or medical records include all relevant documentation at the time of submission.

Curative considers a claim “clean” when it can be processed without the need for additional information from the provider, member, or a third party.

Availity Essentials – Claims Management

Website: www.availity.com

Availity Essentials is Curative’s preferred electronic platform for claims management, eligibility verification, and remittance tracking. Providers can submit, correct, and monitor claims in real time, ensuring accuracy and timely payment.

Claims Submission

Claim Type	Supported Format	Form Reference
Professional	837P	CMS - 1500
Institutional	837I	UB - 04

Claims must be submitted within 95 days of the date of service or discharge unless otherwise stated in your Provider Agreement.

Claim Status Inquiry

Use the **Claim Status** tool in the “Claims & Payments” menu to verify claim receipt and processing status.

Search Options:

- Member ID or Last Name
- Claim Number
- Date(s) of Service
- Rendering or Billing NPI

Displayed Results Include:

- Claim received date
- Current status (Accepted, In Process, Paid, Denied, or Returned)
- Payment date and amount
- Denial or rejection reason codes

Corrected and Re-submitted Claims

- Review rejection reasons in Availity and correct before re-submission.

- Post-adjudication denials should be submitted using the **Reconsideration** or **Appeal** form found at curative.com/providers.
- Do **not** mark a claim as "Corrected" when submitting an appeal or reconsideration.

Remittance and Payment Reconciliation

Use the **Remittance Viewer** in Availity to review ERA and EOP data. (Must be signed up for these services to obtain these items). https://curative.com/electronic-claims-processing

Features Include:

- View and download ERAs and EOPs
- Search by Check/EFT Number, Claim Number, or Date
- Match ERA data to bank deposits for reconciliation

Error Resolution

Availity provides a **Claim Errors** report identifying missing or invalid data. Correct these errors prior to re-submission to prevent delays.

Provider Support

Availity Client Services
Phone: **1-800-282-4548**
Hours: Monday–Friday, 7:00 a.m.–8:00 p.m. (ET)

Electronic and Paper Claim Submission

Electronic Claims

Providers are strongly encouraged to submit claims electronically.

Requirements:

- Use the HIPAA-compliant 837P/837I format.
- Curative utilizes **TriZetto** as the primary clearinghouse but also accepts claims through **Optum** and **Availity**.

Electronic Claims
Providers choosing electronic submission must use the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") compliant 837 electronic format, or a CMS-1500 and/or UB-04, or their successors. **Curative** utilizes TriZetto as an allowable clearinghouse. Providers should submit an Electronic Funds Transfer Form found at https://curative.com/electronic-claims-processing to initiate EFT. Because most clearinghouses can exchange data with one another, providers will be required to work with their existing clearinghouse to

establish Electronic Remittance Advice (ERA) with **Curative**. Please contact Provider Relations if assistance is needed.

Clearinghouse	Payer ID	Contact Information
TriZetto **www.trizettoprovider.com**	**CURTV (Professional Claims)** **CURTV (Institutional Claims)**	**Phone: 1-800-556-2231** **Email: physiciansupport@cognizant.com**
Optum	**CURTV (Professional Claims)** **CURTV (Institutional Claims)**	**https://customerconnect.optum.com/payerlist**
Availity	**CURTV (Professional Claims)** **CURTV (Institutional Claims)**	**Phone: 1-800-282-4548** **www.availity.com**

Paper Claims
Paper claims can be submitted to the address on the member Identification Card noted below:

Curative Health Plan

% Paper Claims
P.O. Box 1786
Austin, Texas 78767

Electronic Payment Methods (EFT/ERA)

Curative offers the ability to receive claims payments and send remittance advices electronically. Both options offer benefits over paper transactions. The EFT form can be accessed from our Provider Relations Representative.

- **Electronic Funds Transfer (EFT)**
  Electronic Funds Transfer (EFT) is the electronic exchange of claims payments. It is safe, secure and quicker than paper check payments. EFT allows payments to be deposited electronically directly into a bank account once a claims payment is released. There is no need to manually deposit checks.
  https://curative.com/electronic-claims-processing

- **Electronic Remittance Advice (ERA)**

Electronic Remittance Advice (ERA) enables you to receive claims payment information electronically. ERA files are transmitted in the HIPAA mandated ASC X12 835 5010 A1 format. ERA allows providers to post claims remittances electronically to your billing software vendor or clearinghouse to automate manual processes. Contact Provider Relations for enrollment assistance.

Voided and Reissued Checks

In the event a check has not been received, providers should call Provider Services. Curative will verify the current address for the provider and verified if cashed. Curative may also reissue a check if we have mailed to the wrong address and or are 45 days or older.

Note: Curative issues payments in accordance with verified provider information maintained in our directory and contract records. Providers are responsible for ensuring that their **"Pay To"** address is accurately listed on the CMS-1500 or UB-04 claim form and that a current, valid W-9 is on file. Payments will be mailed only to the verified address associated with the approved W-9 and contracting records on file.

Correcting or Voiding Claims

Please submit corrected claims as outlined below within 95 calendar days from the date the Explanation of Payment (EOP) is issued. Claims adjustments must clearly indicate that they are corrected and/or voided and should have the original claim number listed on them. Providers can find the Payer Claim Control Number, (also known as claims number) on the EOP. Corrected claims received after 95 days will be denied.

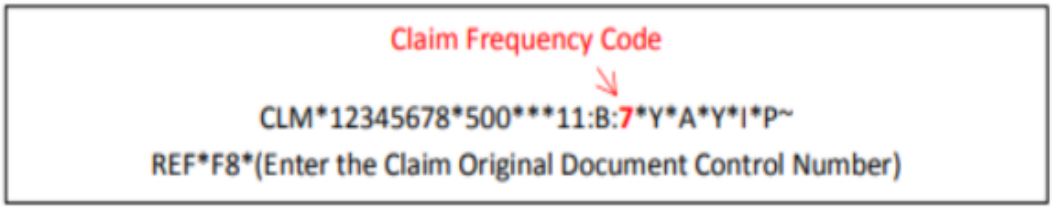
As set forth in the provider agreement, providers cannot bill members for covered services submitted beyond the timely filing limit.

All claims submitted should have all lines pertaining to that claim populated and should not be filed with only the line items that need to be corrected. Providers who do not follow this process will have claims denied as duplicate.

Electronic

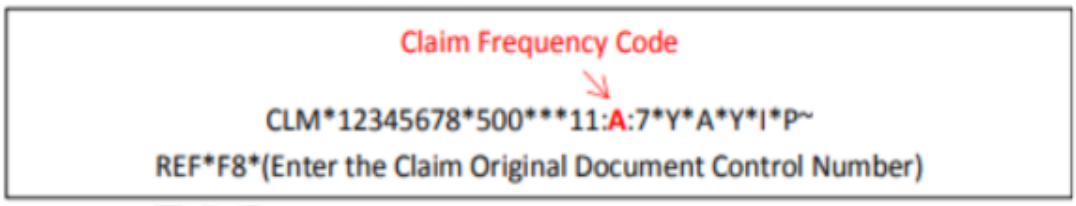
Professional Claims (837p)

- ➔ Enter Frequency code *7* for all corrections, in Loop 2300 Segment CLM05-3
- ➔ Enter the original claim number on the 2300 loop in the REF *8* to void, in Loop 2300 Segment CLM05-3



Institutional Claims (837I)

- ➔ Enter Frequency code *5* for late charge(s) including only the additional late charges that were not included in the original claim.
- ➔ Submit with the last character of the Type of Bill as *7*, to indicate Frequency Code *7* for corrections. This code is not used in lieu of charges. A value of *A* indicates an institutional claim.
- ➔ Type of Bill as *8*, to indicate Frequency Code *8* to voiced or cancelled claims.



Paper
Submit a corrected paper claim to:
Curative Health Plan
% Paper Claims
PO Box 1786
Austin, Texas 78767

Professional claims

- ➔ Enter original claims number, must be typed in field 22 (CMS-1500 Claim Form) entering *7* for all correctionsEnter original claims number, must be typed in field 22 (CMS-1500 Claim Form) entering *8* for all voided, or cancelled claims.

Institutional Claims

- ➔ Submit with last character of the Type of Bill as *5*, for late charge(s) including only the additional late charges that were not included in the original claim.
- ➔ Submit with last character of the Type of Bill as *7*, must be typed in field 4 (UB-04 Claim Form) entering *8* for all voided or cancelled claims

Duplicate Claim

Please avoid submitting a duplicate claim when:

- ➔ **A claim that has not yet been paid.** For electronic claims, the reports received by a provider's office will indicate if a claim is in process or if action is needed by the provider. If the claim is in process, resubmitting will not speed payment but will in fact delay payment as the duplicate is researched. Effectively using the reports generated and/or the Availity website for claim status will make filing additional claims unnecessary in most cases. The Availity website can also be used for claim status regarding paper submitted claims.

- ➔ **Payment that has been received but not posted to show the claim is paid.** It is important to process all reports and checks promptly once they reach the provider's office.

- ➔ **A claim that was rejected, with additional information requested by Curative.** If a claim is rejected requesting additional information, another copy of the claim along with the information requested is not required. Curative already has the claim copy on file so when submitting the requested information, please include a copy of the original request. (Note: If a claim is rejected needing corrected information on the claim itself, then a corrected claim copy will need to be submitted.)

Overpayments

We will inform you in writing of an overpaid claim within 180 days of the date of payment and you will have 45 calendar days (unless otherwise indicated in your Agreement) from receipt of notice to refund the money back to us. If your payment is not received by that time, we may offset the overpayment against future claim payments, or in accordance with the terms of your Agreement.. *For further details, please refer to your **Curative Provider Agreement**.*

All overpayment refunds should be sent to the address below. In the case that you identified an overpayment and are refunding the amount, please provide sufficient documentation (Member ID, Date of Service, Claim Number, Overpayment Amount and Reason for Overpayment, if known) to enable us to research the overpayment.

Curative Health Plan
Attn: Refunds
PO Box 1786
Austin TX 78767

Payment Policy

Curative administers provider reimbursement in accordance with this Manual and the applicable Payment Policies available in the Provider Resources section of the Curative.com website. Curative may update its Payment Policies at any time by posting revised versions on the website. When required by applicable state law, Curative will provide advance notice of such updates to providers through the website.

Coordination of Benefits and Subrogation

Coordination of Benefits
Curative shall coordinate payment with the terms of a member's benefit plan and applicable state and federal laws. Providers shall bill primary insurers for items and services they provide to a member before they submit claims for the same items or services to **Curative** (when **Curative** is secondary). Any balance due after receipt of payment from the primary payer should be submitted to **Curative**. The claim must include information verifying the payment amount received from the primary. If Medicare is the primary payer, we will use the Medicare Allowed Amount.

Subrogation
In the event if one of our members is injured by the act of a third party, **Curative** reserves the right to recover payments for items or services provided to that member to the extent permitted by applicable laws. Providers shall cooperate in our effort to recover reimbursement from the responsible third party. Upon receiving payment from the responsible party, the provider shall refund the amount of payment up to the amount paid by the third party for the items or services involved.

Charging Members for Non-Covered Services

When the service the provider is furnishing is not covered by **Curative** and the provider has informed the member that the service is non-covered before providing the service, the provider may bill the member.

A service may be non-covered for one of three reasons:

1. It is excluded from **Curative** coverage.

2. It would be covered by **Curative**, but it exceeds a benefit limit, such as a limited number of occupational therapy visits.

3. If the services have been deemed to not be medically necessary or experimental, it may be considered a non-covered service. If a provider has documentation that **Curative** has denied a request for prior authorization because the service is not medically necessary or is considered experimental, the provider may bill the member if the provider has informed the member prior to delivering the service that will not be covered by **Curative** and the patient has agreed to pay.

Section 8 | Provider Claim Reconsiderations or Arbitration

Claim Reconsideration

A **Claim Reconsideration must be submitted prior to filing a formal appeal.** Providers have up to **90 days** from the date of the original **Explanation of Payment (EOP) or Electronic Remittance Advice (ERA)** to submit a reconsideration, unless otherwise specified in the provider agreement.

A claim reconsideration is appropriate when you believe that a claim was not processed correctly or are disputing concerns such as **underpayment, timely filing denials, missing information, or coordination of benefits.** Use Curative's **Claim Reconsideration Form,** available on our website https://curative.com/provider-resources**,** and to submit requests via the designated email address provided on the form. Submissions by mail are accepted but may result in longer processing times.

Medical records are **not typically required** for a reconsideration request unless the dispute involves a **code audit, code edit, or authorization-related denial.** In such cases, supporting medical documentation must be included. Failure to provide required records will result in the original denial being upheld.

Claim Appeals

If you disagree with the outcome of a **Claim Reconsideration** or payment adjustment, you may file **one formal Claim Appeal** within **90 calendar days** from the date of the reconsideration determination or adjustment, unless a different timeframe is specified in your Provider Agreement.

A **Claim Appeal** is appropriate when disputing **clinical determinations**, such as **medical necessity, level of care, or authorization denials**, or when you have additional documentation that was not previously reviewed during the reconsideration process.

Your appeal submission must include:

- **A copy of the original Explanation of Payment (EOP) or Electronic Remittance Advice (ERA)**
- A **detailed written explanation** of the reason for your appeal
- All relevant **supporting documentation** (e.g., medical records, reconsideration determination, correspondence, authorizations)

Providers should use Curative's **Appeal Form**, available on our website https://curative.com/provider-resources**,** and to submit requests via the designated **email address** provided on the form. Submissions by mail are accepted but may result in longer processing times.

Incomplete or untimely appeal submissions may be returned without review.

***PREFERRED METHOD by EMAIL**: providercustomerservice@curative.com*
***Please enter in Subject line:** Claim Reconsideration **or** Claim Appeal [Your Claim Number]*

Curative Health Plan
Attn: Claim Reconsiderations
PO Box 1786
Austin TX 78767

Curative Health Plan
Attn: Claim Appeals
PO Box 1786
Austin TX 78767

Medical Records

When submitting medical records to support a claim, appeal, or clinical review, please include the following to ensure accurate routing and timely processing:

- Member ID
- Claim number (if applicable)
- Date(s) of service
- Reason for submission (e.g., medical necessity, coding clarification, prior authorization review, appeal)

Attach all relevant correspondence or supporting documentation—such as provider letters, requests from Curative, or formal review notices—to ensure the submission is properly indexed and linked to the corresponding claim.

Important:
Curative does not process unsolicited medical records or clinical documentation that has not been specifically requested by Curative or submitted as part of a defined claim reconsideration or appeal process. Unsolicited medical records will not be reviewed and may be returned or securely discarded in accordance with Curative's privacy and data retention policies.

Arbitration

If either party remains dissatisfied after following the claims dispute resolution procedures in this section, an arbitration proceeding may be filed unless otherwise stated in your Agreement with **Curative.** In the event that arbitration becomes necessary, such arbitration shall be initiated by providing written notice to other party. The shared fees and costs of arbitration (fee of the independent arbitrator, etc.) will be shared equally between the parties or as indicated in the Agreement. Each party shall be responsible for the payment of that party's specific fees and costs (e.g. the party's own attorney's fees, the fees of the party selected arbitrator, etc.) and any costs associated with conducting the non-binding mediation or arbitration that the party chooses to incur (e.g. expert witness fees, depositions, etc.).

Section 9 | Credentialing

Introduction

Curative requires participating Providers to be initially credentialed and recredentialed every thirty-six (36) months throughout their tenure treating Curative members. Credentialing and Recredentialing applies to contracted physicians, institutional providers and other allied health practitioners as defined by state or federal law/regulation.

Contact Information

If you have questions and/or require clarification regarding credentialing or recredentialing, please do not hesitate to contact **Curative's** Credentialing Department: credentialing@curative.com.

Credentialing
P.O. Box 1786
Austin, TX 78767

Non-Discrimination

Curative will not discriminate against any applicant for participation in its network on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran, or marital status or any unlawful basis not specifically mentioned herein.

Credentialing Committee

Curative's Credentialing Committee is a standing committee and is responsible for administering the Credentialing Plan on behalf of **Curative**.

Curative's Credentialing Committee is a peer review body and makes decisions to accept, retain, deny or terminate a network contracted Provider. The number of voting members present constitutes a quorum.

Curative's Medical Director, or a designee, will chair the Credentialing Committee. All members of the committee are in network, credentialed **Curative** Providers. The Chair may appoint additional providers, as deemed necessary to form broad based knowledge for peer review. In addition, other Provider specialists may be consulted as needed to complete a provider's credentialing and/or recredentialing review.

Providers

Curative credentialing and recredentialing includes, but not limited to the following providers:

- Medical Doctors (MD)
- Doctors of Osteopathic Medicine (DO),

- Doctors of Podiatry (DPM),
- Psychiatrists and other physicians
- Doctoral or master's-level psychologists who are state certified or licensed
- Master's-level clinical social workers who are state certified or licensed
- Oral Surgeons (OMS),
- Speech Therapists (ST), Occupational Therapists (OT) and Physical Therapists (PT),
- Independently contracted Pathologists and Radiologists,
- Independently contracted Telemedicine practitioners, and
- Institutional Providers listed in the organization's network directories including, but not limited to, Hospitals, Skilled Nursing Facilities, Rehabilitation Facilities, Free Standing Surgery, Behavioral Health Facilities, Laboratories and Radiology facilities.

Curative practitioners have the right to review information submitted to support their credentialing application. This could include information obtained from any outside source with the exception of references, recommendations or other peer-review protected information. They also have the right to correct erroneous information from another source by submitting a request in writing (including email) within sixty (60) calendar days to the **Curative** credentialing representative.

This written request is added to the credentialing file and verified by credentialing personnel with date and signature. With direction from the Medical Director, or designee and within ten (10) calendar days the practitioner will be notified of receipt of the correction request along with the accepted correction.

Curative practitioners are also notified of their rights to receive the status of their credentialing or Recredentialing application upon request in writing (including email).

Initial Credentialing

Curative requires each applicant to use the Council for Affordable Quality Healthcare's (CAQH) ProView for initial credentialing and recredentialing. This free online service allows each applicant to fill out a single application which meets the needs of multiple organizations. At initial application, each provider must supply their National Practitioner Identification number and their CAQH ProviderID number to initiate the credentialing process. The CAQH attestation must not be older than sixty (60) days. Institutional providers must complete the **Curative** Institutional Provider Onboarding Form.

Primary Source Verification

Curative will verify elements related to an applicants' regulatory authority to practice, relevant training, experience and competency from applicable sources during the credentialing process.

Credentialing information is verified, whenever possible, through acceptable primary source entities or other designated method. Primary Source Verification Results are obtained for state licensure to practice, education or training, board certification, NPI number and hospital affiliations. Verification received from secondary sources includes DEA Registration, work history and professional liability coverage history.

National Practitioner Data Bank: The history of state and federal professional board sanctions and professional liability claims that resulted in paid judgments by or on behalf of a provider is obtained from the National Practitioner Data Bank.

All verifications must be current and verified within one twenty (120) calendar days prior to the Credentialing Committee making its credentialing decision.

Recredentialing

Curative's network providers are required to recredential at least every thirty-six (36) months. **Curative'**s recredentialing process is identical to that for initial credentialing and is consistent with Health Plan accreditation standards and applicable state requirements. Through the use of the CAQH Provider ID, **Curative** will automatically initiate a provider's recredentialing cycle no later than sixty (60) days prior to the end of the thirty-six month recredentialing cycle

If **Curative** is unable to receive the recredentialing information within thirty (30) days of their recredentialing due date, a notification letter is sent notifying the provider will be terminated. Providers terminated for failure to return recredentialing documents may re-apply after 30 calendar days from the effective date of termination, but the provider is treated as a new applicant for credentialing.

Recredentialing Application

All individual practitioners applying for recredentialing must complete the Texas Standardized Credentialing Application (TSCA) or provide their up to date CAQH number. The TSCA includes a current, signed attestation by the applicant. By signing the attestation, the applicant acknowledges that omissions or nondisclosure of information may result in denial or termination. Presentation to the credentialing committee includes information regarding substantial omissions of information regarding areas including:

- Work history covering at least five (5) years.
- Limitations in ability to perform the essential functions of the position.
- History of loss of license and felony convictions.
- History of loss or limitation of privileges, sanctions, or other disciplinary activity.
- Current professional liability insurance coverage.
- Lack of present illegal drug use.
- Signed attestation confirming correctness and completeness of the application.

The attestation date on the credentialing application is within 180 calendar days prior to the date the credentialing committee makes an eligibility decision. Institutional Providers will also be recredentialed every three years.

Delegated Credentialing

Curative may delegate authority to perform the function of provider and institutional credentialing and Recredentialing to contracted groups. Even when credentialing and Recredentialing is delegated, **Curative** retains the responsibility of credentialing and Recredentialing contracted providers. **Curative** reserves the right to decline or terminate providers credentialed or recredentialed by delegates.

Appeal of Credentialing or Recredentialing Determination

If the Credentialing Committee recommends acceptance with restrictions or the denial of an initial or recredentialing application, the provider shall be entitled to appeal the recommendation. An appeal will be heard by the Appeals Committee. If the applicant chooses to appeal, the applicant must request a hearing in writing and the request must be received by **Curative** within thirty (30) days of the date **Curative** gave notice of its decision to the applicant.

Provider Performance Monitoring

Curative monitors network providers to encourage the provision of safe, quality care to **Curative** members between providers credentialing cycles. **Curative** has an on-going monitoring process to determine providers' performance between periods of credentialing and recredentialing.

Provider Data Demographics

Federal provider directory regulations require **Curative** and providers to work together to maintain accurate provider directory lists. It is required by law for you and **Curative** to keep your information current and to confirm its accuracy every ninety (90) days. However, **Curative** may require confirmation upon request as well. We include provider data information in our directories to help patients find care. Being in our directories allows new patients to find out if you are accepting new patients, where you are located and how to reach you. In addition, by making sure we have your current information, we can send you timely communications and reminders. Remember to notify us of your data changes in accordance with state, federal and contractual requirements and guidelines.

Section 10 | Confidentiality

Curative Confidentiality / HIPAA Policy is based on the premise that adherence to the highest standards of ethical conduct is consistent with the goals and objectives of the organization. Consistent with this premise is the critical importance of maintaining confidentiality of the activities of the organization.

Information related to individual medical records of patients, provider credentialing / Recredentialing files, contract terms / rate arrangements and other sensitive issues are managed with the utmost respect for the confidential nature by all board, committee members and staff and in full compliance with Health Information Portability and Accountability Act (HIPAA) and other privacy regulations.

All Provider information obtained and/or documentation created during the credentialing and recredentialing process is treated in a confidential manner. **Curative** complies with HIPAA guidelines regarding the release of credentials information to third parties. **Curative** employees and committee members attending credentialing committees sign confidentiality agreements and are responsible to maintain confidentiality of credentialing and Recredentialing activities.

Section 11 | Fraud, Waste, and Abuse (FWA)

Curative is committed to preventing, detecting, and correcting Fraud, Waste, and Abuse (FWA). Providers must comply with all applicable laws, contractual requirements, and accepted billing and coding standards, including CPT®, HCPCS, ICD-10, and NCCI guidelines.

Fraud is an intentional act to obtain improper payment. *Waste* is unnecessary utilization resulting in excess cost. *Abuse* is billing or service practices inconsistent with accepted standards that result in improper payment.

Providers are responsible for submitting accurate claims, maintaining supporting medical records, implementing controls to prevent FWA, and cooperating with audits, reviews, and investigations.

Identified overpayments may be recovered through refunds, claim adjustments, or offsets as permitted by law. Confirmed FWA may result in corrective action, recoupment, payment suspension, termination, and referral to regulatory or law enforcement authorities. Reports of suspected FWA made in good faith are protected from retaliation.

FWA Audit failure denials: You are required to submit, or provide access to, medical records upon our request. Failure to do so in a timely manner may result in an audit failure denial, creating an overpayment. Overpayments created as a result of a failure to provide access to requested medical records will be subject to recoupment in accordance with applicable state regulations.