

April 2026



Operational Updates

Network Health experienced the largest enrollment growth in its history this past January 1—made possible in part by the strong collaboration with our provider partners. Because this growth exceeded expectations, we are currently encountering some short-term operational delays. We appreciate your continued support and patience as we expand staffing to meet this increased demand.

As a reminder, for quicker access to claims status, authorization updates, and practice-related information, we encourage you to use our provider portal. If you are not yet registered and need assistance, please contact your Provider Operations Manager.

Corrected Claim Submission

We have also seen a significant increase in corrected claims. To help ensure timely processing, please include the following.

- **HCFA Claims:** Resubmission Code 7 must be added in Box 22, along with the original claim number
- **UB04 Claims:**
 - Bill type XX7 must be submitted with condition codes D0–D4, D7–D9, or E0
 - Bill type XX8 must be submitted with condition codes D5 or D6
- **Remarks/Notes:** Clearly indicate the correction that is being made

- **Claim Lines:** Providers must include all original claim lines when submitting the corrected claim, we will not accept only the corrected line/lines.

Please note that claims missing the required information will be denied. For additional details, refer to our [Claims Submission Policy](#).

Cardiac Imaging and Cardiac Implantable Devices - New Prior Authorization Requirements Beginning July 1, 2026

To mitigate risks related to our significant membership growth as well as the expansion of our provider network, Network Health is expanding prior authorization requirements.

Effective July 1, 2026, the following services will require prior authorization from EviCore by Evernorth for Network Health members.

- Cardiac Imaging - for our Medicare lines of business (this requirement is already in place for all commercial membership)
- Cardiac Implantable Devices - for all Medicare and Commercial members in all lines of business

EviCore employs board certified specialists, including cardiologists and cardiothoracic surgeons, for peer review of these requests. Peer to peer discussions can be scheduled at your convenience directly with the reviewing physician. EviCore guidelines are evidence-based. As with all services, Network Health will conduct regular review to determine efficacy of the program to evaluate continuation or discontinuation.

If you have questions about requesting authorization, please plan to attend one of our online orientation trainings. The orientation schedule and program training resources will soon be available. Please look for future communications with this information.

CPT and HCPCS Code Updates

Quarterly, the American Medical Association updates Current Procedural Terminology (CPT) codes and the Centers for Medicare and Medicaid Services updates Healthcare Common Procedure Coding System (HCPCS) codes.

There are new codes that will require prior authorization, and these services fall within

our current authorization, experimental and/or genetic review processes. You can find a list of all services requiring prior authorization on [our website](#).

If you have specific questions regarding a service, please contact our customer service or health management teams for assistance. For more information about authorization requirements, forms or services that require review under the experimental and/or genetic process visit the [Provider Authorization Information section of our website](#).

Please forward this information to those within your facility who will need to follow these processes. For prior authorization requests or questions, contact our population health department Monday through Friday; 8 a.m. to 5 p.m.

They can be reached at 920-720-1602 or 866-709-0019.

Language assistance is available for members or practitioners to discuss utilization management issues. Network Health also offers TDD/TTY services for deaf, hard of hearing or speech-impaired individuals. Anyone needing these services should call 711. All callers may leave a message 24 hours a day, seven days a week.

Appointment Access Requirements

As a reminder, as part of our NCQA accreditation, our providers must meet the following appointment access times in order for us to maintain our accreditation. Here are the appointment access standards that must be met.

For Primary Care Services

1. Regular or routine care within 60 days of request
2. Urgent care appointment within 48 hours of request

For Specialist Services

1. Care within 30 days of the request
2. Non-life threatening, urgent appointment within 48 hours of request

For Behavioral Health Services

1. Non-life-threatening emergency within 6 hours of request
2. Urgent care appointment within 48 hours of request
3. Initial visit for routine care within 10 business days of request
4. Follow up appointment for a routine care visit within 30 days of request

Additionally, you must have an answering service, on-call provider, or message to direct patients to the emergency room for after-hours calls.

Provider Resources for New and Existing Providers

- Member's Rights and Responsibilities
- Prior Authorization Requirements
- Payment Policies and Procedures
- Appointment Access Standards (Network Management policy)
- Population Health Standards and Initiatives
- Pharmacy Formulary and Authorization Requirements
- Credentialing Policies and Procedures [You can find all the information here.](#)