In an effort to give providers more information regarding our authorization processes, Network Health has developed timeframes for submitting authorization requests.

<table>
<thead>
<tr>
<th>Service Requested</th>
<th>Provider Timeframe for Submitting Authorization Request to Network Health</th>
<th>Maximum Regulatory Turnaround Time</th>
<th>Network Health’s Usual Turnaround Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Urgent or emergent acute hospital admissions for commercial and Medicare</td>
<td>Within one business day of admission or concurrent needs</td>
<td>One business day within receipt of request for commercial. 30 calendar days for Medicare.</td>
<td>One business day within receipt of request for commercial. Five business days for Medicare.</td>
</tr>
<tr>
<td>• All inpatient concurrent reviews</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Skilled-nursing facility (SNF) admission or readmission</td>
<td>At least one business day before admission or readmission to the SNF; no later than within one business day after admission with documentation to substantiate reasoning for the post-admission request. Within one business day of concurrent needs</td>
<td>14 calendar days within receipt of request</td>
<td>One business day within receipt of request</td>
</tr>
<tr>
<td>• All SNF concurrent reviews</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Elective inpatient procedures on the Medicare Inpatient Only List*see below</td>
<td>At least seven calendar days prior to scheduled admission or procedure</td>
<td>14 calendar days within receipt of request</td>
<td>Five business days within receipt of request</td>
</tr>
<tr>
<td>• Elective procedures or admissions that are not on the Medicare Inpatient Only list (inpatient, outpatient or ambulatory, including but not limited to advanced imaging studies, spine surgical procedures, interventional pain management, joint surgeries and all ambulatory cardiac diagnostics, and radiation oncology requested through eviCore)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please submit all authorization requests to Network Health’s utilization department via fax or phone.

Fax 920-720-1916 920-720-1903
Telephone 920-720-1602 920-720-1600

*see below
- Durable medical equipment, orthotics or prosthetics
  - Within seven calendar days of the first date of service or equipment being provided

- Home care services
  - New Requests: Within seven calendar days of the initial evaluation
  - Extensions: Within seven calendar days of re-evaluation or re-certification period

- Acupuncture (commercial members only)
  - New Requests: Within seven calendar days of the first treatment
  - Extensions: Prior to exhaustion of approved dates of service or approved number of units

- Chemotherapy notification (Medicare members only)
  - At least within seven calendar days of the first treatment

When an authorization request is approved, providers receive written notification of the approval including an authorization identification number(s). An authorization approval identification number is needed to process associated claims, but is not a guarantee of payment of such claims. Please ensure you have an authorization identification number on file prior to submitting any claims for services that require authorization.

If an authorization request submitted before a service is not approved (i.e. is denied), written notification is sent to the member and the provider. If the member chooses to proceed with the service, the member may be responsible for paying the associated claim(s). Providers also receive written notification when post-service (retrospective) authorization requests are not approved.

Network Health provides case management services for members needing assistance with transition of care upon discharge. The staff providing case management services are independent from the utilization management staff, therefore please ensure all authorization requests are made through the utilization management department via the above process (notifying Network Health of a member’s discharge date is not considered a request for authorization).

*If a request for urgent or emergent acute hospital inpatient services or an elective procedure on the Medicare Inpatient Only List isn’t made within the above referenced timeframes, but is made within one business day of discharge or completion of the procedure, Network Health will review the request for medical necessity. eviCore will review requests submitted to them if the request is made within three business days of the study’s completion, clinical criteria are satisfied and is clinically urgent, this includes CPT code changes and/or updates.

When an authorization request is received after a service is rendered, the request is considered a retrospective authorization request. Network Health’s turn-around timeframe goal for retrospective requests is 14 calendar days. The maximum regulatory timeframe for a health plan to make a retrospective determination is 30 days. When retrospective service requests do not meet medical necessity criteria, the provider is at financial risk. In order to limit your risk, please attempt to submit authorization requests prior to performing the service.

Exceptions are made to the above timeframes when providers submit documentation of circumstances occurring outside of their control which prevented them from requesting authorization within those timeframes.

Unless noted in the list the required time frames are for both commercial and Medicare products.