



POWERED BY  
**Collective Health**

# Provider Support Manual

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For providers serving members of Providence Health  
Plan Powered by Collective Health

Version 1.4  
Updated 6/1/2026

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# 1. Introduction

## 1.1. Welcome

Welcome to the Provider Support Manual for Providence Health Plan Powered by Collective Health!

While you focus on patient care, Collective Health can help you navigate the administrative side of your patients' health plan. Your commitment to your patients is critical to our shared success, and we look forward to a strong, collaborative relationship.

## 1.2. About Collective Health

### Collective Health

Collective Health is an independent, technology-enabled third-party administrator (TPA) that works with employers and health plan partners, like Providence Health Plan, to administer health benefits.

### How Collective Health supports your office

Collective Health partners with your existing provider network to adjudicate claims and provide administrative support to your office. This includes:

- **Digital resources**
  - Dedicated resources such as this manual and a Payer Space for Providence Health Plan Powered by Collective Health in Availity Essentials.
  - Use your Availity Essentials account to check member eligibility, submit claims, monitor claim status, and view electronic remittance advice (835).
  - You also have access to the Zelis Payments Provider Portal where you can set up electronic funds transfer (EFT), track payments, and view explanation of payment (EOP) documents.
  
- **Personal assistance**
  - The Provider Support Specialist team is happy to help your office learn how to work with Collective Health.

### How Collective Health supports your patients

Members of Providence Health Plan Powered by Collective Health have access to coordinated support that simplifies their healthcare journey, including:

- **Digital resources**
  - Members can access a digital platform called My Collective® (available via mobile app or online) to understand all their health benefits in one convenient place.
  - They also receive a member ID card for Providence Health Plan Powered by Collective Health, which they can access anytime in My Collective.
- **Personal assistance**
  - The Member Advocate and Care Navigation teams support members by answering their coverage questions and guiding them through complex care situations.

## Providence Health Plan Powered by Collective Health

Providence Health Plan Powered by Collective Health is the exclusive partnership between Providence Health Plan and Collective Health, serving as the new TPA for Providence Health Plan's self-funded (ASO) business.

This solution combines Providence's trusted network and service excellence with cutting-edge technology that makes healthcare administration more efficient, transparent, and effective.

The transition to Providence Health Plan Powered by Collective Health began **September 1, 2025**. ASO groups are transitioning on a rolling time frame based on the employer group's effective or renewal date.

To learn more about this change, and for a list of employer group effective dates, please see the list of frequently asked questions for Providence Health Plan providers at [collective.link/PHP-FAQ](https://collective.link/PHP-FAQ).

## 1.3. Purpose of this manual

This Provider Support Manual is your central resource for quickly and efficiently navigating the administrative processes of working with Providence Health Plan Powered by Collective Health.

The primary goal of this resource is to empower your office to quickly handle common tasks by providing step-by-step instructions. While Collective Health is always happy to assist if you need help, our tools are designed to put the control in your hands, reducing your reliance on phone support.

**This manual is strictly an administrative guide.** If there are any inconsistencies between this Provider Support Manual and the official plan documents or your provider agreement, the terms of your agreement will govern and control.

This Provider Support Manual is provided for informational purposes only and does not constitute a contract, guarantee of payment, or promise of coverage. Collective Health is the third-party administrator that administers medical claims on behalf of self-funded plans. All benefits, coverage determinations, and payments are governed solely by the applicable plan documents, which control in the event of any conflict. Prior authorization, utilization management activities, or medical necessity determinations are claims administration functions only and do not guarantee payment. Providers retain sole responsibility for medical decision-making, coding, billing accuracy, and compliance with applicable laws.

## 1.4. How to use this manual

### Who should use this manual

Because a single medical plan can include access to multiple networks, this manual is designed to be used by providers contracted with the following networks:

- Providence Health Plan
- Cigna
- First Choice Health Network
- First Health

### Manual structure

This manual is organized into sections covering key operational areas. Please refer to the Table of Contents for a detailed list of topics. We encourage you to familiarize yourself with all sections relevant to the services your office provides.

### Manual updates

Collective Health is committed to keeping documentation current. This manual is reviewed and updated at least annually. Additional updates may occur throughout the year if administrative processes change.

### Accessing the latest version

#### On-demand access online

1. Log in to Availity Essentials ([apps.availity.com](https://apps.availity.com)).
2. Search for “Providence Health Plan Powered by Collective Health.”
3. Click the Payer Space search result for **Providence Health Powered by Collective Health**.
4. The most recent version of the manual is linked on the **Resources** tab.

#### You'll need an Availity Essentials account for this.

If you don't have one yet, you can register for free at [availity.com/multi-payer-portal-registration](https://availity.com/multi-payer-portal-registration)

## Request a copy

You may also contact the Provider Support Specialist team to get a copy of the current Provider Support Manual sent to your or office via fax. See **section 1.5** for contact information.

## 1.5. Contact us

### Collective Health is here to help

You can accomplish many administrative tasks on your own through Availity Essentials ([apps.availity.com](https://apps.availity.com)) or the Zelis Payments Provider Portal ([provider.zelispayments.com](https://provider.zelispayments.com)).

However, if you need assistance, the Provider Support Specialist team is available to help with most inquiries or to direct you to the appropriate specialist or partner. The Provider Support Specialist team can provide you information over the phone or by faxing it to your office. Emails, chats, and texts are not supported at this time.

#### How to contact the Collective Health Provider Support Specialist team:

Phone: **855-383-3585**

Fax: **833-635-6650**

When you call the phone number above, please be prepared to confirm your NPI – either individual or group – and the zip code associated with that NPI. After confirmation, you'll be offered the following menu options. Depending on your selection, you may need to provide the member's information.

1. Eligibility and Benefits (available 24/7)
2. Claims
3. Payment
4. Medical Authorizations
5. Pharmacy Claims, Benefits or Authorizations
6. Medical Contracting or Credentialing
7. Something Else

### Provider Support Specialist team hours

- Monday – Friday: 8:00 a.m. to 5:00 p.m. PST
- Closed on the following holidays:

New Year's Day

Memorial Day

Thanksgiving Day and the day after

Martin Luther King Jr. Day

Independence Day

Christmas Eve

President's Day

Labor Day

Christmas Day

## 1.6 Directory

The following tables provides the contact information for various partners, allowing you to reach them directly if needed.

### Authorizations

Who to contact	Contact information	Notes
<p><b>Medical authorizations</b></p> <p>Contact either Cigna or American Health Holding via the Provider Support Specialist team phone line.</p>	<p>Phone: <b>855-383-3585</b></p> <ul style="list-style-type: none"> <li>• Select “Medical authorizations.” Then follow the prompts to be connected with the right entity: Cigna or American Health Holding.</li> <li>• For faster service, call the number on the back of the members ID card.</li> </ul>	<p>You can find a list of services that require prior authorization on Collective Health’s website (<a href="https://collectivehealth.com/providers">collectivehealth.com/providers</a>) or in your Availity Essentials account (<a href="https://apps.availity.com">apps.availity.com</a>). See <b>section 3.2</b> for details.</p>
<p><b>Pharmacy authorizations</b></p> <p>Contact the plan’s Pharmacy Benefits Manager (PBM).</p>	<p>Phone: Please call the <b>pharmacist number</b> on the back of the patient’s medical ID card.</p>	<p>This contact is only for medications dispensed at a retail or mail-order pharmacy. For medications administered in a clinic or facility, please use the contact information for medical authorizations instead.</p>

## Claim inquiries

Use these resources if you have questions about the claim submission process, the status of a claim, or the way a claim was processed (adjudication explanation).

Who to contact	Contact information	Notes
<p><b>Medical claims</b></p> <p>Contact Collective Health’s Provider Support Specialist team.</p>	<p>Phone: <b>855-383-3585</b></p> <ul style="list-style-type: none"> <li>• Select “claims.”</li> </ul>	<p>You can check claim status and view remittance advice online in your Availity Essentials account (<a href="https://apps.availity.com">apps.availity.com</a>). See <b>section 4.6</b> for details.</p>
<p><b>Pharmacy claims</b></p> <p>Contact the plan’s Pharmacy Benefits Manager (PBM).</p>	<p>Phone: Please call the <b>pharmacist number</b> on the back of the patient’s medical ID card.</p>	<p>This contact is only for medications dispensed at a retail or mail-order pharmacy. For medications administered in a clinic or facility, please use the contact information for medical claims instead.</p>

## Eligibility and benefits

Who to contact	Contact information	Notes
<p><b>Medical coverage</b></p> <p>Contact Collective Health’s Provider Support Specialist team.</p>	<p>Phone: <b>855-383-3585</b></p> <ul style="list-style-type: none"> <li>• Select “eligibility and benefits.”</li> </ul>	<p>You can check patient eligibility online in your Availity Essentials account (<a href="https://apps.availity.com">apps.availity.com</a>). See <b>section 2.1</b> for details.</p>
<p><b>Pharmacy coverage</b></p> <p>Contact the plan’s Pharmacy Benefits Manager (PBM).</p>	<p>Phone: Please call the <b>pharmacist number</b> on the back of the patient’s medical ID card.</p>	<p>This contact is only for medications dispensed at a retail or mail-order pharmacy. For medications administered in a clinic or facility, please use the contact information for medical coverage instead.</p>

## Network inquiries — contracting and credentialing

Who to contact	Contact information	Notes
<p><b>Providence Health Plan</b></p> <p>Medical</p>	<p>Phone: Call your designated Provider Relations representative.</p> <p>Email: <a href="mailto:phpprcontactus@providence.org">phpprcontactus@providence.org</a></p>	
<p><b>Providence Health Plan</b></p> <p>Pharmacy</p>	<p>Email: <a href="mailto:phppharmacycontracting@providence.org">phppharmacycontracting@providence.org</a></p>	
<p><b>Cigna</b></p>	<p>Phone: <b>888-663-8081</b></p>	<p>You can also go online at <a href="http://cignaforhcp.com">cignaforhcp.com</a> for assistance with these types of questions.</p>
<p><b>First Choice Health Network</b></p>	<p>Phone: <b>800-231-6935</b></p> <p>Email: <a href="mailto:providerrelations@fchn.com">providerrelations@fchn.com</a></p>	
<p><b>First Health</b></p>	<p>Phone: <b>800-226-5116</b></p>	

## Network inquiries — disputes related to contract rates (in-network pricing)

Who to contact	Contact information	Notes
<p><b>Providence Health Plan</b></p> <p>Contact Collective Health’s Provider Support Specialist team.</p>	<p>Email: <a href="mailto:provider_reconsiderations@collectivehealth.com">provider_reconsiderations@collectivehealth.com</a></p> <p>Fax: <b>888-227-2351</b></p>	<p>Please include a completed Provider Reconsideration Request form (see <b>appendix A</b>).</p>
<p><b>Cigna</b></p>	<p>Fax: <b>877-804-1443</b></p> <p>Mailing address: <b>Cigna</b> <b>P.O. Box 188061</b> <b>Chattanooga, TN 37422</b></p>	<p>Cigna does not offer a direct phone line for inquiries related to claims pricing.</p>
<p><b>First Choice Health Network</b></p>	<p>Phone: <b>800-467-5281</b></p> <p>Email: <a href="mailto:providerrelations@fchn.com">providerrelations@fchn.com</a></p>	
<p><b>First Health</b></p>	<p>Phone: <b>800-226-5116</b></p>	

## Payment status, set up EFT, reissue explanation of payment (EOP)

Who to contact	Contact information	Notes
<p><b>Zelis</b></p>	<p>Phone: <b>855-383-3585</b></p> <ul style="list-style-type: none"> <li>• Select “payment.”</li> </ul> <p>Email: <a href="mailto:customerservice@zelispayments.com">customerservice@zelispayments.com</a></p>	<p>You can track payment status and access EOPs online in the Zelis Payments Provider Portal (<a href="https://provider.zelispayments.com">provider.zelispayments.com</a>). See <b>section 4.4</b> for details.</p>

### Payment discrepancies, recoupment, void payment

Who to contact	Contact information	Notes
<p>Contact Collective Health’s Provider Support Specialist team.</p>	<p>Phone: <b>855-383-3585</b></p> <ul style="list-style-type: none"> <li>• Select “claims.”</li> </ul> <p>Fax: <b>833-635-6650</b></p>	

### Payment integrity edits

Who to contact	Contact information	Notes
<p><b>Zelis</b></p>	<p>Phone: <b>866-489-9444</b></p> <p>Email:  <b>providerservices.integrity@zelis.com</b></p> <p>Fax: <b>855-250-3338</b></p>	<p>Payment integrity edits on claims can be made by either Zelis or Valenz Health.</p> <p>To learn which entity made the edit, check the explanation of payment or electronic remittance advice, or contact Collective Health’s Provider Support Specialist team at <b>855-383-3585</b> and select “claims.”</p>
<p><b>Valenz Health</b></p>	<p>Phone: <b>866-762-4455</b></p> <p>Email:  <b>billreviewappeals@valenzhealth.com</b></p>	

## 2. Eligibility, benefits, and ID cards

### 2.1. Eligibility and benefits verification

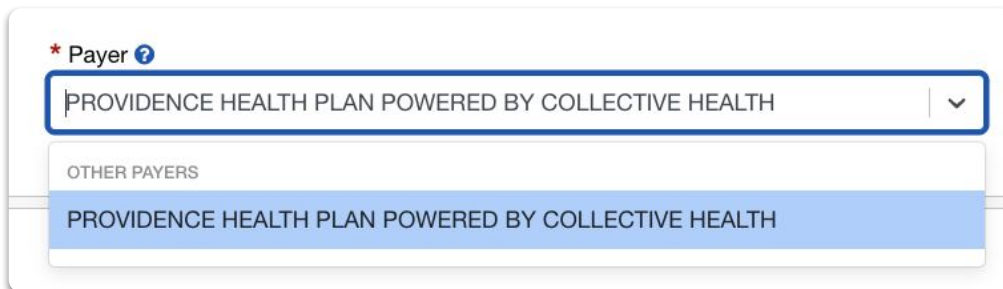
It is crucial to verify your patient's eligibility and benefits before rendering non-emergent services to ensure coverage. Verification helps you confirm active enrollment, understand cost-sharing responsibilities, and identify plan-specific details for your patient.

#### Verify online with Availity Essentials

You'll need an Availity Essentials account for this. If you don't have one yet, you can register for free at [availity.com/multi-payer-portal-registration](https://www.availity.com/multi-payer-portal-registration)

Do not use the ProvLink portal ([phpprovider.providence.org](http://phpprovider.providence.org)) for members on a Providence Health Plan Powered by Collective Health. ProvLink will remain in place only for other Providence Health Plan members (e.g., fully-insured, Medicare).

1. Log in to Availity Essentials ([apps.availity.com](https://apps.availity.com)).
2. Click **Patient Registration** in the top navigation bar.
3. Select the **Eligibility and Benefit Inquiry** app from the drop-down menu.
4. For the payer, select **Providence Health Plan Powered by Collective Health**.



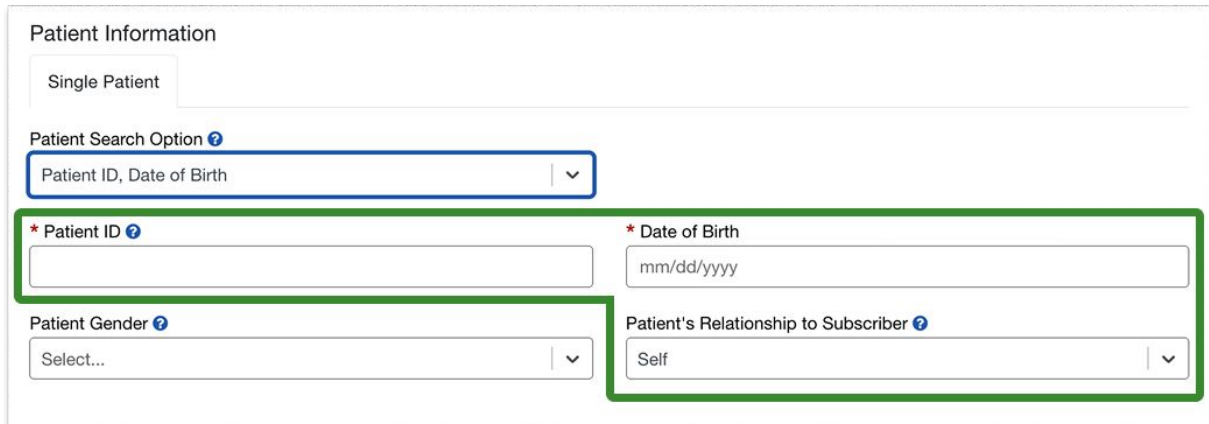
The screenshot shows a web form with a dropdown menu for selecting a payer. The label above the dropdown is "\* Payer" with a help icon. The dropdown is currently open, showing the selected option "PROVIDENCE HEALTH PLAN POWERED BY COLLECTIVE HEALTH" and a list of "OTHER PAYERS" below it. The first option in the "OTHER PAYERS" list is also "PROVIDENCE HEALTH PLAN POWERED BY COLLECTIVE HEALTH".

5. Enter the provider information.

**6.** Enter the patient information.

These instructions will show you how to use the **Patient ID, Date of Birth** search option. If you don't have the patient's ID number, use the **Patient First Name, Patient Last Name, Date of Birth** search option instead.

The fields outlined in green in the image below are **required** on most searches.



The screenshot shows a 'Patient Information' form. At the top, there is a 'Single Patient' button. Below it is a 'Patient Search Option' dropdown menu set to 'Patient ID, Date of Birth'. The form contains several input fields: a text box for '\* Patient ID', a text box for '\* Date of Birth' with a placeholder 'mm/dd/yyyy', a dropdown for 'Patient Gender' set to 'Select...', and a dropdown for 'Patient's Relationship to Subscriber' set to 'Self'. The fields for '\* Patient ID', '\* Date of Birth', 'Patient Gender', and 'Patient's Relationship to Subscriber' are outlined in green to indicate they are required.

**a. Patient ID:**

- i. Enter the "Subscriber ID#" exactly as it appears on the patient's medical ID card.
- ii. You don't need to include the two-digit number under the "Suffix" heading on the ID card.

**b. Date of Birth:**

- i. Add the patient's birthday.
- ii. For shared birthdays (i.e. twins): If multiple family members share the same birthdate, you must uniquely identify the individual by also providing the Patient First Name or Gender in the search parameters.

**c. Patient's Relationship to Subscriber:**

- i. This is a required field that must be changed if the patient is not the subscriber.
- ii. If you select the wrong relationship (e.g., "Self" instead of "Spouse" or "Child"), you will get an error and results will not load for the requested patient.

**7.** Enter the service information.

**a. Benefit / Service Type:**

- i. Use "Health Benefit Plan Coverage - 30" to see every benefit.
- ii. Use "Psychotherapy - A6" to see mental health office visit benefits.

**b. Procedure Code:**

- i. Optional: Enter the relevant CPT or HCPCS procedure code(s). The results will be filtered to show the benefits that apply to the codes.

**8.** Click **submit** to get enrollment and benefit details.

### Viewing your results on Availity Essentials

If a patient has active coverage, your page will look similar to the example below, and you will see a green **Active Coverage** badge under “Member Status.”

**Doe, Jane**  
Street Address  
City, State, ZipCode

[Edit](#) [Print](#) [Feedback](#)

**Member Status**  
Active Coverage

**Date of Birth**  
[Redacted]

**Gender**  
[Redacted]

**Current Plan Effective Date**  
[Redacted]

**Relationship to Subscriber**  
Self

Member ID: [Redacted]

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**Collective Health**

Payer: COLLECTIVE HEALTH

The next section, called **Plan Maximums and Deductibles**, will contain the member’s accumulator data like deductibles and out-of-pocket maximums. You can use the **In Network**, **Out of Network**, and **All Networks** filter buttons to change the view.

FILTER BY NETWORK

Out of Network
In Network
All Networks

#### Plan Maximums and Deductibles

▼ Health Benefit Plan Coverage- 30

Active Coverage

**Group Number:** OA Premium Gold 1500

**Benefit Start Date:** Sep 1, 2025

**Benefit End Date:** Aug 31, 2026

Information / Details	Family
<b>Annual Deductible</b>	<div style="display: flex; align-items: center;"> <span style="background-color: #28a745; color: white; padding: 2px; margin-right: 5px;">In Network</span> <div style="flex-grow: 1;"> <div style="background-color: #28a745; width: 70%; height: 10px; margin-bottom: 5px;"></div> <p>\$3,000 / Calendar Year(s) <span style="float: right;">\$800 Remaining</span></p> <p>-\$2,200 Year to Date</p> </div> </div>
	<div style="display: flex; align-items: center;"> <span style="background-color: #dc3545; color: white; padding: 2px; margin-right: 5px;">Out of Network</span> <div style="flex-grow: 1;"> <div style="background-color: #ccc; width: 100%; height: 10px; margin-bottom: 5px;"></div> <p>\$6,000 / Calendar Year(s) <span style="float: right;">\$6,000 Remaining</span></p> <p>-\$0 Year to Date</p> </div> </div>
<b>Out Of Pocket</b>	<div style="display: flex; align-items: center;"> <span style="background-color: #28a745; color: white; padding: 2px; margin-right: 5px;">In Network</span> <div style="flex-grow: 1;"> <div style="background-color: #28a745; width: 30%; height: 10px; margin-bottom: 5px;"></div> <p>\$12,000 / Calendar Year(s) <span style="float: right;">\$9,310 Remaining</span></p> <p>-\$2,690 Year to Date</p> </div> </div>
	<div style="display: flex; align-items: center;"> <span style="background-color: #dc3545; color: white; padding: 2px; margin-right: 5px;">Out of Network</span> <div style="flex-grow: 1;"> <div style="background-color: #ccc; width: 100%; height: 10px; margin-bottom: 5px;"></div> <p>\$24,000 / Calendar Year(s) <span style="float: right;">\$24,000 Remaining</span></p> <p>-\$0 Year to Date</p> </div> </div>

The next section will show the member’s benefit and cost-sharing information. You can use the same network buttons from the previous section to change the view. Expand a benefit row to see the expected coinsurance, copayments, and any associated limits.

Benefit Information Expand

- ▶ Abortion- 84
- ▼ Acupuncture- 64

Information / Details	Co-Insurance	Co-Payment	Benefit Deductible <sup>?</sup>	Limitations <sup>?</sup>	Authorization <sup>?</sup>
<span>In Network</span>	–	\$25	Refer to: <a href="#">Health Benefit Plan Coverage</a>	–	–
<span>In Network</span>	–	–	Refer to: <a href="#">Health Benefit Plan Coverage</a>	24 Visit(s) / Year(s)	–
<span>Out of Network</span>	–	\$25	Refer to: <a href="#">Health Benefit Plan Coverage</a>	–	–
<span>Out of Network</span>	–	–	Refer to: <a href="#">Health Benefit Plan Coverage</a>	24 Visit(s) / Year(s)	–

- ▶ Air Transportation- 57

## Frequently asked questions

### Why can’t I find the member or their benefits in Avality Essentials?

- Confirm that you have selected the correct payer in Avality Essentials: Providence Health Plan Powered by Collective Health.
- Also confirm that you are using the correct subscriber ID by checking whether the member’s ID card includes “Powered by Collective Health.”
  - If the member’s ID card does not include the “Powered by Collective Health” logo, their claims are not adjudicated by Collective Health, and their benefits will not be available in Avality Essentials. Instead, you may need to use the ProvLink portal to verify eligibility and benefits.

### I have the new subscriber ID. Why am I unable to view the member’s benefit information?

- Ensure the correct option is selected in the “Patient’s Relationship to Subscriber” dropdown in Avality Essentials. It may not appear as required, but selecting the correct patient relationship is important to return accurate eligibility results.

## How can I search for benefit information for mental health office visits in Availity Essentials?

- In the Eligibility & Benefits section, search for “psychotherapy,” which is the industry-standard label for therapy and behavioral health benefits

## Verify eligibility and benefits by phone

Please contact the Collective Health Provider Support Specialist team to verify eligibility and benefits. See **section 1.5** for contact information.

## 2.2. Coordination of benefits verification

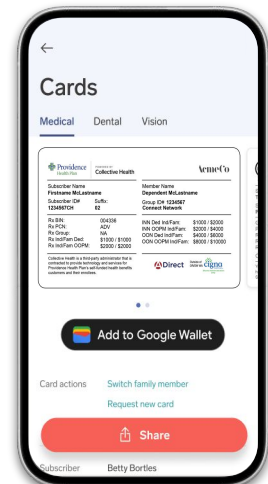
If the member has additional medical coverage, they are responsible for providing this information to both you and Collective Health to ensure accurate coordination of benefits and claims processing.

To verify if a patient has another medical plan on file, please contact Collective Health’s Provider Support Specialist team. See **section 1.5** for contact information.





## 2.3. Medical ID cards

### Medical ID card overview

- All members, including their enrolled dependents, will receive a physical medical ID card.
- The subscriber (primary member) ID number will be the same for all family members on the plan.
- Members can also access a digital copy of their medical ID card in the Collective Health mobile app or in their My Collective account on either:
  - Public Employees Benefits Board (PEBB) members: [pebb-providencehealthplan.collectivehealth.com](https://pebb-providencehealthplan.collectivehealth.com)
  - All other members: [providencehealthplan.collectivehealth.com](https://providencehealthplan.collectivehealth.com)



## Example medical ID card

		POWERED BY <b>Collective Health</b>	
<b>Subscriber Name</b> <b>Firstname McLastname</b>		<b>Member Name</b> <b>Dependent McLastname</b>	
<b>Subscriber ID#</b> <b>1234567CH</b>	<b>Suffix:</b> <b>02</b>	<b>Group ID# 1234567</b> <b>Connect Network</b>	
<b>Rx BIN:</b> 004336 <b>Rx PCN:</b> ADV <b>Rx Group:</b> NA <b>Rx Ind/Fam Ded:</b> \$1000 / \$1000 <b>Rx Ind/Fam OOPM:</b> \$2000 / \$2000	<b>INN Ded Ind/Fam:</b> \$1000 / \$2000 <b>INN OOPM Ind/Fam:</b> \$2000 / \$4000 <b>OON Ded Ind/Fam:</b> \$4000 / \$6000 <b>OON OOPM Ind/Fam:</b> \$8000 / \$10000		
<p>Collective Health is a third-party administrator that is contracted to provide technology and services for Providence Health Plan's self-funded health benefits customers and their enrollees.</p>			
 			

<b>Members</b>	<b>Providers</b>
<b>Member Support:</b> <b>Collective Health</b> <b>800-123-4567</b> <b>providencehealthplan.collectivehealth.com</b>	Precertification must be obtained for services as specified in the member's plan. Please call the number shown below.
<b>Optional buy-up 1</b> <b>800-123-4567</b> <b>Optional buy-up 2</b> <b>800-123-4567</b> <b>Optional buy-up 3</b> <b>800-123-4567</b> <b>Optional buy-up 4</b> <b>800-123-4567</b>	Pre-approval (prior authorization) may be required for some services/drugs.
Carry this card at all times. Before hospital admission or surgery (outside the physician's office) or for other services as specified in your plan, your physician must call for pre-treatment authorization (precertification). Failure to comply may result in reduction of benefits. Emergency hospital admissions must be reported within 48 hours or by the next regular working day following admission (72 hours in some states).	<b>General Provider Inquiries</b> <b>800-123-4567</b> <b>Prior Authorization</b> <b>800-123-4567</b> <b>Pharmacist Inquiries</b> <b>800-123-4567</b> <b>Provider Website</b> <b>apps.availity.com</b>
<b>Notice:</b> Possession of this card or obtaining prior authorization does not guarantee eligibility, coverage, or payment. Please call the number on this card to verify eligibility.	<b>Providers in the PHP service area including MH/SUD within OR/WA send claims to:</b> PO Box 23055 Tampa, FL 33623 Payer ID #36481 <b>All other claims send to:</b> Cigna, P.O. Box 188061 Chattanooga, TN 37422-8061 Payer ID #62308 <b>Benefits are not insured by Cigna Healthcare or affiliates</b>

# 3. Authorization and utilization management

## 3.1. Overview and provider responsibility

Our utilization management (UM) program is designed to ensure members receive care that is medically necessary, appropriate, and cost-effective under the terms of their health benefits plan. This section outlines the requirements and procedures for prior authorization, post-service authorization, benefit level exceptions, and other utilization management activities.

### Prior authorization (PA)

PA involves the professional medical review of services before a patient receives care to determine things like:

- Medical necessity
- Appropriate length of stay
- Appropriate level of care

This review makes it possible for health benefits plans to manage costs by controlling for services that are unnecessary or beyond the member's true needs.

### Post-service authorization (PSA)

A PSA may be necessary when a service that required PA was rendered without one. The claim for such a service will be denied until authorization is received.

### Benefit level exception (BLE)

An in-network provider can request a BLE when they need to refer a member to an out-of-network provider or facility for specialized care. With an approved BLE, the member's in-network benefits will apply to services from the referred out-of-network provider. This can be useful when an in-network provider is inaccessible or unable to render the care a member needs.

## American Health Holding

Collective Health partners with American Health Holding to provide utilization management services.

### Provider responsibility

It is the rendering provider's responsibility to obtain PA for services that require it before services are rendered, unless otherwise specified (such as in emergencies). Failure to obtain PA may lead to claim denial, non-payment, or reduced payment.

For durable medical equipment (DME), the supplier is considered the rendering provider. The DME supplier is responsible for obtaining PA before supplying items to the member.

## 3.2. Prior authorization (PA)

### 3.2.1. How to check if PA is required

#### Option 1: Reference the PA code lists

- PA code lists are available on the [PA requirements and instructions document](#).

#### Option 2: Call the PA line

- Call the Prior Authorization phone number on the back of the patient's medical ID card.

#### **FAQ: Do I need to request PA for physical therapy, occupational, or advanced imaging?**

Prior authorization through EviCore (PT/OT) and Carelon (advanced imaging) is **no longer required** following the transition to Providence Health Plan Powered by Collective Health.

### 3.2.2. How to submit a request for PA

#### Option 1: Use the instructions document to determine where to submit your request

- Directions are available on the [PA requirements and instructions document](#) to determine how to submit your request to American Health Holding or Cigna, including PA requests for durable medical equipment (DME).
- If you're referring a member to an out-of-network provider, and you also need to request in-network benefits for out-of-network services, please use the benefit level exception (BLE) form in **section 3.4.1**, and follow these instructions:.

- **If you submit your PA to American Health Holding:** You should submit both requests together. Place the BLE form as the first page of your fax for efficient processing
- **If you submit your PA to Cigna:** Send your PA request to Cigna according to their standard procedures, and send your BLE request to American Health Holding.

### Option 2: Submit a PA request over the phone

- For faster service, please refer to the Prior Authorization phone number on the back of the patient's medical ID card.
- Otherwise please call **855-383-3585** and select “Medical Authorizations”.
  - Follow the prompts to be connected with the right entity to submit your request, which will be either American Health Holding or Cigna.

#### **FAQ: Will previous PAs be honored with the switch to Collective Health, or do I need to submit new ones?**

PAs, single case agreements, and gap exceptions (benefit level exceptions) issued by Providence Health Plan before the employer group transition date will be honored as issued for the duration of their original approval period.

A new Providence Health Plan Powered by Collective Health member ID does not require a new approval letter. No resubmission is required unless the original approval has expired.

#### **FAQ: How are existing authorizations handled for the June 1, 2026 durable medical equipment transition to Integra?**

Active PA approvals issued before June 1, 2026, will be honored for the entire duration of the original approval period. You do not need to resubmit active approvals unless the original approval has expired.

### 3.2.3. Turnaround times

#### **Requests submitted to American Health Holding**

American Health Holding will review requests and issue a determination within the following time frames:

#### ERISA time frames

- **Prior authorization requests:**
  - Standard: No later than five business days after the request was received.
  - Urgent: As soon as possible, but no later than 72 hours after the request was received.

- **Post-service authorization requests:**
  - No more than 30 calendar days after receipt of the request.

#### Non-ERISA Oregon time frames

- **Standard:** Within 2 business days of receiving the original request.
  - If your request is missing any necessary information, American Health Holding will request more information within 2 business days of receiving the original request. You have a 45 calendar day window to reply.
    - If you reply, the turnaround time is 2 business days after receipt of your response.
    - If you do not reply, the turnaround time is 2 business days after your 45 calendar day window has lapsed.
- **Urgent:** Within 3 calendar days\* of receiving the original request.
  - If your request is missing any necessary information, American Health Holding will request more information within 1 calendar day\*\* of receiving the original request. You have a 2 calendar day window to reply.
    - If you reply, the turnaround time is 2 calendar days<sup>†</sup> after receipt of your response.
    - If you do not reply, the turnaround time is 2 calendar days after your 2 calendar day window has lapsed.

\* For Public Employees Benefits Board (PEBB) plans: 72 hours.

\*\* For PEBB plans: 24 hours.

† For PEBB plans: 48 hours.

If any necessary information is missing from your request, delays in these timelines may occur. American Health Holding will send notifications and determinations to you by fax.

#### **Requests submitted to Cigna**

If you submitted a request to Cigna, then please contact Cigna for information about their turnaround times. Phone: **855-229-8599**.

### **3.2.4. Concurrent review process**

Concurrent review happens when American Health Holding monitors the medical necessity of an episode of care during a course of treatment.

These reviews are conducted by phone or fax follow-up to ensure that discharge and treatment milestones are reached. Concurrent review is performed for inpatient as well as outpatient care.

American Health Holding will notify your office by phone or fax before the last approved service date. This notification will specify the clinical information required for concurrent review (e.g. progress notes, therapy notes, and current treatment and discharge plans) and instructions for submission.

### 3.2.5. Request for clinical information notification

#### Requests submitted to American Health Holding

When a PA request is received with insufficient clinical information to make a determination, American Health Holding will notify your office by fax, mail, or phone. This notification will specify the additional information needed to complete the request. The decision-making timeline (as outlined in **section 3.2.3.**) will be paused until the requested information is submitted.

You have at least **45 calendar days** from the date of the notification to submit the required information.

- If the information is received within the 45-day timeframe, then the review of your request will resume. The determination timeframe restarts on the day the missing information was received. See **section 3.2.3.** for the turnaround times.
- If the requested information is not received within the 45-day timeframe, the PA may be denied. You may refer to the request letter for next steps, including appeals.

#### Requests submitted to Cigna

If your authorization request was submitted to Cigna, then they will contact you if any information is missing.

### 3.2.6. Utilization management guidelines

#### Requests submitted to American Health Holding

American Health Holding utilizes evidence-based clinical practice guidelines, criteria, and protocols derived from peer-reviewed scientific literature and expert consensus including designate health plan medical policies and Milliman Care Guidelines. All UM decisions are based solely on the appropriateness of care and service, and are conducted by licensed healthcare professionals like RNs and physicians.

For more details about what clinical criteria American Health Holding uses to make determinations, please see either of the following resources:

- The [PA requirements and instructions document](#).
- The “Services Requiring Prior Authorization” information on the [Provider Resources and Support](#) webpage.

If you need more information about how a specific UM determination was made please call **855-383-3585** and select “Medical Authorizations.”

### Requests submitted to Cigna

If you submitted a request to Cigna, then please contact Cigna for information about their guidelines. Phone: **855-229-8599**.

### 3.2.7. PA appeals and provider reconsiderations

When a PA request is denied, you will receive a determination letter. The letter describes how to dispute the decision, and it should be your primary resource for appeal instructions. However if you do not have the letter, please call **855-383-3585** and select “Medical Authorizations.”

## 3.3. How to submit a post-service authorization request

Please follow the submission instructions in **section 3.2**.

## 3.4. Benefit level exceptions (BLE)

### 3.4.1. How to initiate a BLE request

If you're an in-network provider referring a member to an out-of-network provider for specialized care, you can request a new BLE, or an extension of an existing one, by following these steps:

- 1. Check the prior authorization list:** Before submitting your request, use the instructions in Section 3.2 to see if the services also require prior authorization (PA) – which is also called a clinical medical necessity review.
- 2. Download and complete the form:** [Network Benefit Level Exception Request](#)  
You must include the specific procedure codes (CPT or HCPCS), diagnosis codes (ICD-10), and place of service code (a two-digit code). **Without these codes, your request may be denied.**
- 3. Fax the form to American Health Holding:** **844-545-1622**  
If you're also submitting a PA request to American Health Holding for clinical medical necessity review, please use the instructions in **section 3.2.2** and put the BLE form as the **first page** of your fax.

### 3.4.2. How to check the status of a BLE request

To check the status of a BLE request, please contact Collective Health's Provider Support Specialist team. See **section 1.5** for contact information.

### 3.4.3. What to expect after your submit a BLE request

1. American Health Holding will forward your BLE request to Collective Health for review. You usually **won't** be notified this happens, but it typically occurs within 1 day of the date you submit your request.
2. If you also submitted a PA request to American Health Holding per **section 3.2.2**, they will begin reviewing your request.
3. American Health Holding will send you a letter with the determination of your PA request (if applicable).
4. Collective Health will send you a letter with the determination of your BLE request. Please refer to the turnaround times below to learn how quickly this can happen after you submit the form.

### 3.4.4. Turnaround times

#### Standard BLE requests

- **ERISA plans:** 15 business days
- **Non-ERISA Oregon plans:** 2 business days

#### Urgent BLE requests

- **All plans:** 72 hours
- Note: A BLE only qualifies as urgent if the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the claimant's ability to regain maximum function, or in the opinion of a physician with knowledge of the claimant's medical condition would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

### **3.4.5. What to expect if the BLE is approved**

When a health benefits plan approves a BLE for an out-of-network provider:

- Claims from the out-of-network provider will be covered at in-network cost sharing rates for the services and timeline specified.
- Charges in excess of the allowed amount will not be covered, and the member may be balance billed.

# 4. Claims, payment, and reconciliation

## 4.1. Claim processing and payment overview

### How do claims and payments work at Collective Health?

1. Your office submits a claim to Collective Health's payer ID (see **section 4.3** for details).
2. Accepted claims are ingested into Collective Health's system, priced according to fee schedules, and adjudicated to apply benefits based on the patient's health benefits plan design.
3. Every day, adjudicated claims are sent in a daily 835 batch file to Collective Health's payment partner, Zelis ZAPP. **Claims are typically paid within 14–21 calendar days of this step.**
4. Every Monday, Collective Health requests funds from the sponsor of the patient's health benefits plan for all claims processed during the previous week.
5. Every Friday, Zelis ZAPP releases payment for all claims that have been funded by the plan sponsor. Depending on your preferred payment method, you may receive funds from Zelis ZAPP by:
  - a. Paper check
  - b. Direct deposit through an automated clearing house
  - c. Virtual card
6. Every week, Zelis ZAPP sends out explanation of payment statements for the claims paid during the previous week.
7. At the end of the fiscal year, Zelis ZAPP is responsible for generating and furnishing any required 1099 documents to your office for tax purposes.

The process and timeline described above is just an example. Several factors may affect actual payment timelines, including claim completeness, complexity, pending prior authorizations, and coordination of benefits investigations.

## How are payments issued?

### Payment method options

- Collective Health partners with Zelis ZAPP to issue payments.
- By enrolling with Zelis ZAPP, you can receive payments through electronic funds transfer methods like virtual card or direct deposit through an automated clearing house.
  - See **section 4.4** for enrollment instructions.
- Otherwise, the default payment method is paper check.

### Exception for Intel Health for Life Centers (HFLC)

Due to Intel's arrangement with HFLC clinics, Collective Health will not issue payments to HFLC providers. However, HFLC providers can still access explanation of payment (EOP) documents by enrolling in Zelis ZAPP.

### Payment aggregation

- Payments will be aggregated across the standard weekly payment cycle. This means a single check or electronic fund transfer may contain payments and adjustments across multiple patients and multiple services from claims that were processed over the previous week.
- The details of which claim transactions were included in a payment will be listed on the remittance advice (electronic remittance advice and explanation of payment).

### Currency

- All payments are made in U.S. dollars.

## 4.2. Claim submission requirements

### Submit one claim, per patient, per encounter

Submit one paper claim form, or one electronic claim submission, per patient for services rendered on a single date of service, or for a single inpatient stay, unless specific billing guidelines dictate otherwise.

### Timely filing requirements

Claims must be received by Collective Health within the specified timely filing limits.

### Initial claim submission

- Under usual circumstances, claim shall be submitted within sixty (60) days of the date of service, and in no case later than twelve (12) months from the date of service.

- In cases of coordination of benefits, a claim shall be submitted no later than 12 months after a different insurer (a) denied the claim in whole or in part; or (b) requested a refund of an erroneous payment made on the claim.
- If a claim relates to an inpatient stay, the date the patient was admitted counts as the date the patient received the healthcare service for claims purposes.

### Corrected claims

- Requests for corrected claims must be received within 1 year from the date of the original explanation of payment or remittance advice.

### Consequences of late filing

- Claims received after the timely filing limit may be denied.
- Providers may not bill the plan or member for services denied due to late filing, except under specific circumstances outlined by the plan or applicable law.

### Required electronic claim formats

Collective Health accepts claims in the current HIPAA-mandated ANSI ASC X12N formats:

- **For professional claims:** 837P (005010X222A1)
- **For institutional claims:** 837I (005010X223A2)

### Required paper claim formats

Required claim forms:

- **For professional claims:** CMS-1500
- **For institutional claims:** UB-04

Guidance for completing forms:

- Use officially printed forms. Photocopies may not be accepted.
- Claim information must be typed or printed legibly in black ink.
- Do not use staples, highlights, or correction fluid/tape.

### Required information on claims

The following information is generally required for complete claim processing:

Category	Required information on claims	
<b>Patient information</b>	<ul style="list-style-type: none"> <li>● Full name (as it appears on the member ID card)</li> <li>● Member ID number</li> <li>● Date of birth</li> </ul>	<ul style="list-style-type: none"> <li>● Gender</li> <li>● Relationship to subscriber</li> <li>● Address</li> <li>● Patient account number or control number</li> </ul>
<b>Subscriber information (if different from the patient)</b>	<ul style="list-style-type: none"> <li>● Full name</li> <li>● Member ID number</li> <li>● Date of birth</li> </ul>	
<b>Payer information</b>	<ul style="list-style-type: none"> <li>● Please refer to the payer name and payer ID on the back of the patient’s medical ID card or in <b>section 4.3</b>.</li> </ul>	
<b>Billing provider information</b>	<ul style="list-style-type: none"> <li>● Name</li> <li>● Address</li> <li>● Phone number</li> </ul>	<ul style="list-style-type: none"> <li>● National Provider Identifier</li> <li>● Tax Identification Number</li> </ul>
<b>Rendering provider information (if different from the billing provider)</b>	<ul style="list-style-type: none"> <li>● Name</li> <li>● National Provider Identifier</li> </ul>	
<b>Service information</b>	<ul style="list-style-type: none"> <li>● Date(s) of service</li> <li>● Place of service code(s)</li> <li>● CPT®/HCPCS procedure code(s) with appropriate modifiers</li> <li>● Diagnosis code(s) (ICD-10-CM) coded to the highest level of specificity; linked to each procedure code for professional claim submissions</li> <li>● Units of service</li> </ul>	<ul style="list-style-type: none"> <li>● Billed charges for each service line</li> <li>● Total billed charges for the claim</li> <li>● Prior authorization number (if applicable)</li> <li>● For services rendered in a facility:               <ul style="list-style-type: none"> <li>○ Facility name</li> <li>○ Facility address</li> <li>○ Facility National Provider Identifier</li> </ul> </li> </ul> <p><b><i>Continued on next page.</i></b></p>

Category	Required information on claims
<p><b>Service information (continued)</b></p>	<ul style="list-style-type: none"> <li>● For inpatient claims:           <ul style="list-style-type: none"> <li>○ Admission date</li> <li>○ Discharge date</li> <li>○ Type of bill</li> <li>○ Admission type</li> <li>○ Admission source</li> <li>○ Discharge status</li> <li>○ Revenue codes</li> <li>○ Value and condition codes (as applicable)</li> </ul> </li> </ul>
<p><b>Coordination of benefits information</b></p> <p>Always submit the claim to the primary payer first, <b>wait for it to be processed</b>, and then submit a separate claim to the secondary plan.</p>	<ul style="list-style-type: none"> <li>● Other insurance carrier name</li> <li>● Other insurance address</li> <li>● Other insurance policy number</li> <li>● Primary payer payment details (if Collective Health is the secondary payer, or any other non-primary payer). When submitting a secondary claim electronically, this must be documented in Loop 2320 “Other Subscriber Information” on the 837 EDI where:           <ul style="list-style-type: none"> <li>○ <b>Required:</b> SBR01 indicates the payer responsibility sequence (e.g. P = primary, S = secondary, T = tertiary, U = unknown)</li> <li>○ <b>Preferred:</b> SBR03 indicates plan name, if known</li> <li>○ <b>Required:</b> SBR09 indicates insurance code type (e.g. CI = Commercial, MA = Medicare Part A, MB = Medicare Part B, MC = Medicaid, VA = Veterans’ Affairs Plan, WC = Workers’ Compensation Health Claim)</li> <li>○ <b>Required if primary plan already applied benefits:</b> CAS segment indicates any patient cost-sharing details applied by the primary plan</li> <li>○ <b>Required if primary plan already applied benefits:</b> AMT segment indicates any primary plan payment details</li> </ul> </li> </ul>

This list is not exhaustive. For more information, please refer to the following standards:

- National Uniform Claim Committee’s (NUCC) 1500 Claim Form Instruction Manual
- National Uniform Billing Committee’s (NUBC) UB-04 Data Specifications Manual

Incomplete or inaccurate claims may be rejected or denied, leading to processing delays. Please see **section 1.5** to get support.

## 4.3. Claim submission instructions

For the most direct claim submission instructions, please refer to the back of the patient’s medical ID card. However, you can also use the instructions in this section based on that state where care was rendered.

### 4.3.1. Services rendered by certain partners

Provider name	Claim submission information
Durable medical equipment (DME) through Integra	<p>For dates of service on or after June 1, 2026, submit DME claims directly to Integra.</p> <p><b>Payer information</b></p> <ul style="list-style-type: none"> <li>• Oregon members: Que Payer ID 4907</li> <li>• Washington members: Que Payer ID 4908</li> </ul> <p><b>Electronic submission</b></p> <ul style="list-style-type: none"> <li>• Submit claims with Integra’s billing platform, Que.</li> <li>• Review Integra’s <a href="#">Introduction to Que Manual</a> and complete the EDI testing process before your first claim submission.</li> </ul>
Galileo, Omada, and TruHearing	<p><b>Payer information</b></p> <ul style="list-style-type: none"> <li>• Payer name: Collective Health</li> <li>• Payer ID: 36479</li> </ul> <p><b>Electronic submission</b></p> <ul style="list-style-type: none"> <li>• Please submit electronic claims through Availity Essentials (see <b>section 4.3.5</b> for instructions) or any clearinghouse with a connection to Optum.</li> </ul> <p><b>Paper claim submission</b></p> <ul style="list-style-type: none"> <li>• Collective Health PO Box 23055 Tampa, FL 33623</li> </ul>
Progyny	Submit claims directly to Progyny.

### 4.3.2. Services rendered in Oregon or Washington

#### Payer information

- Payer name: Providence Health Plan Powered by Collective Health
- Payer ID: 36481

#### Electronic submission

- Please submit electronic claims through Availity Essentials (see **section 4.3.5** for instructions) or any clearinghouse with a connection to Optum.


#### Paper claim submission



- Collective Health  
PO Box 23055  
Tampa, FL 33623

### 4.3.3. Services rendered in any other state

Use the tables on the next two pages to learn how to submit your claim. The instructions depend on which wrap network is on the patient’s medical plan. Please review the following information carefully to find the right steps for you.

A wrap network offers patients a way to receive coverage outside of the standard Providence Health Plan service area in Oregon and Washington.

Wrap network	Claim submission information
<p><b>Cigna</b></p> <p>If the patient's plan includes this wrap network, then the following logo will be on the front of their medical ID card:</p> 	<p><b>Intel Health for Life Centers</b></p> <p><b>Payer information</b></p> <ul style="list-style-type: none"> <li>• Payer name: Providence Health Plan Powered by Collective Health</li> <li>• Payer ID: 36481</li> </ul> <p><b>Electronic submission</b></p> <ul style="list-style-type: none"> <li>• Please submit electronic claims through Availity Essentials (see <b>section 4.3.5</b> for instructions) or any clearinghouse with a connection to Optum.</li> </ul> <p><b>Paper claim submission</b></p> <ul style="list-style-type: none"> <li>• Collective Health PO Box 23055 Tampa, FL 33623</li> </ul>

Wrap network	Claim submission information
<p><b>Cigna (continued)</b></p>	<p><b>All other providers</b></p> <p><b>Payer information</b></p> <ul style="list-style-type: none"> <li>• Payer name: Cigna</li> <li>• Payer ID: 62308</li> </ul> <p><b>Paper claim submission</b></p> <ul style="list-style-type: none"> <li>• Cigna PO Box 188061 Chattanooga, TN 37422-8061</li> </ul>
<p><b>First Choice Health Network + First Health</b></p> <p>If the patient's plan includes these wrap networks, then the following logos will be on the back of their medical ID card:</p>  	<p><b>Services rendered in Alaska, Idaho, or Montana</b></p> <p><b>Payer information</b></p> <ul style="list-style-type: none"> <li>• <b>Payer name:</b> First Choice Health Network</li> <li>• <b>Payer ID:</b> 91131</li> </ul> <p><b>Paper claim submission</b></p> <ul style="list-style-type: none"> <li>• First Choice Health Network PO Box 2289 Seattle, WA 98111-2289</li> </ul>
	<p><b>Services rendered in any other state</b></p> <p><b>Payer information</b></p> <ul style="list-style-type: none"> <li>• <b>Payer name:</b> Providence Health Plan Powered by Collective Health</li> <li>• <b>Payer ID:</b> 36481</li> </ul> <p><b>Electronic submission</b></p> <ul style="list-style-type: none"> <li>• Please submit electronic claims through Availity Essentials (see <b>section 4.3.5</b> for instructions) or any clearinghouse with a connection to Optum.</li> <li>• <b>If you are contracted with First Health</b>, then you should not submit claims electronically. Please use the paper claims mailing address instead.</li> </ul> <p><b>Paper claim submission</b></p> <ul style="list-style-type: none"> <li>• Collective Health PO Box 23055 Tampa, FL 33623</li> </ul>

#### 4.3.4. Coordination of benefits and dual coverage

When a member has coverage under multiple plans, the submission process depends on which plan is the primary or secondary payer. You must effectively treat the primary and secondary coverage as two separate transactions. This applies to all coordination of benefits scenarios, even if both plans are administered by Providence Health Plan or Providence Health Plan Powered by Collective Health.

1. **Submit to the primary plan first:** You must always submit the claim to the primary payer first.
2. **Wait for processing:** Do not submit the secondary claim until the primary claim has been fully adjudicated. Primary and secondary benefits cannot be processed simultaneously on a single claim submission.
3. **Submit to the secondary plan:** Once you have the explanation of payment from the primary payer, submit a separate claim to the secondary payer.
  - a. You must include the primary plan's payment details on the secondary claim. See **section 4.2** for the specific coordination of benefits information that is required.

##### Important note on dual coverage

In the past, you may have been able to submit primary and secondary claims at the same time for members with dual Providence Health Plan coverage. **This process has changed.** Please follow the submission process outlined on the previous page. Claims submitted to the secondary payer without the primary plan's payment information will be denied.

#### 4.3.5. Submitting claims and attachments through Availity Essentials

You'll need an Availity Essentials account for this part. If you do not have an account yet, you can register as a healthcare provider for free at [www.availity.com/essentials-portal-registration](http://www.availity.com/essentials-portal-registration). See **section 4.3.7.** if you need help using Availity Essentials.

Providers can submit electronic claims through Availity Essentials in two ways:

1. Direct data entry form (recommended if you need to include attachments)
2. Batch EDI file uploads (recommended for high volume)

**See the next page for detailed instructions.**

**Option 1: Submit a claim on a direct data entry form**

This method uses digital claim forms within Availity Essentials, similar to filling out a paper CMS-1500 or UB-04 form.

1. Log in to your Availity Essentials account: [apps.availity.com](https://apps.availity.com)
2. Click **Claims & Payments** in the top navigation bar.
3. Select the **Claims & Encounters** application.
4. Enter the correct payer name based on **sections 4.3.1.** and **4.3.2.**
5. Enter all required claim information and **submit** the claim.

**Need to attach a file?**

You can attach up to ten files of supporting documentation before you submit the claim. Above the service line fields, click **Add Additional Claim Information** and select **Attachments** from the drop-down menu. You can attach the following types of files:

- |        |            |        |
|--------|------------|--------|
| • CSV  | • MS EXCEL | • PNG  |
| • GIF  | • MS PPT   | • TIFF |
| • JPG  | • MS WORD  | • TXT  |
| • JSON | • PDF      | • XML  |

**Option 2: Submit claims by uploading batch EDI files**

If your office or billing service works with large volumes, you can upload ANSI X12 EDI transactions in Availity Essentials.

1. Log in to your Availity Essentials account: [apps.availity.com](https://apps.availity.com)
2. Click **Claims & Payments** in the top navigation bar.
3. Select the **Send & Receive EDI Files** application.
4. Select the **SendFiles** folder and click **Upload**.
5. Browse for and select your file, then click **Submit**.

**4.3.6. Tracking claim status**

**How to check if your claim was accepted**

If you submit a claim through Availity Essentials, then you can verify if your claim was accepted by using the following steps:

1. Log in to your Availity Essentials account: [apps.availity.com](https://apps.availity.com)
2. Click **Claims & Payments** in the top navigation bar.
3. Select the **Claim Status** application.
4. Select the payer who received the claim (reference sections **4.3.1.** and **4.3.2.**)
5. Fill out required fields and **submit** to review the status summary page.

**4.3.7. Get help with Availity Essentials**

Availity Essentials resource	How to access it
Register as a healthcare provider for a free Availity Essentials account.	<a href="https://www.availity.com/multi-payer-portal-registration">www.availity.com/multi-payer-portal-registration</a>
Availity Essentials Provider Help Center	Log in to your Availity Essentials account > <b>Help &amp; Training</b> > <b>Find Help</b> .
Availity Essentials training and demo videos	Log in to your Availity Essentials account > <b>Help &amp; Training</b> > <b>Get Trained</b> .

Availity Essentials resource (cont.)	How to access it (cont.)
Contact Availity Customer Support	Log in to your Availity Essentials account > <b>Help &amp; Training</b> > <b>Availity Support</b> . <a href="http://www.availity.com/customer-support">www.availity.com/customer-support</a>

## 4.4. Payment with electronic funds transfer (EFT)

Collective Health strongly encourages electronic funds transfer (EFT) as it is the fastest and most secure way to manage your payments and claim reconciliation. EFT options include:

- **Automated clearing house (ACH):** Direct deposit of claim funds into your bank account.
- **Virtual Credit Card:** A single-use credit card number used for payment.

### Benefits of EFT payments

Opting for EFT provides several significant benefits to your practice, including:

- **Faster cash flow:** EFT provides faster access to funds compared to paper checks.
- **Reduced administrative work:** You'll benefit from reduced paperwork and streamlined bank reconciliation.
- **Security:** EFT reduces the risk of lost or stolen checks.

### How to set up EFT payments

Collective Health contracts with **Zelis Advanced Payments Platform (ZAPP)** to process payments. Enroll with with Zelis to set up electronic payment. Providers that are not enrolled will receive payment by paper check by default.

- Online: [collectivehealth.epayment.center/Registration](http://collectivehealth.epayment.center/Registration)
- Phone: **855-774-4392**

### Where to view and track EFT payments

You can track EFT payment status and access electronic remittance advice in the **Zelis Payments Provider Portal**.

- Online: [provider.zelispayments.com](https://provider.zelispayments.com)

### Zelis Payment Provider Portal best practices and troubleshooting

Browsers	Devices	Getting help
<ul style="list-style-type: none"> <li>• For best results, use the latest version of Google Chrome.</li> <li>• The portal does not work on Safari.</li> <li>• If the portal isn't functioning, clearing your browsing history, cache, and cookies may help.</li> <li>• Turn off pop-up blockers.</li> </ul>	<ul style="list-style-type: none"> <li>• Access the portal on a computer for best results.</li> <li>• The portal does not function on mobile devices.</li> </ul>	<ul style="list-style-type: none"> <li>• The Help and Resources page of the portal offers information about Zelis, alongside useful resources to help you navigate the portal. Including:               <ul style="list-style-type: none"> <li>○ Learning Center</li> <li>○ Submit a Request</li> </ul> </li> <li>• Need assistance? Please see <b>section 1.6</b> for Zelis's contact information.</li> </ul>

## 4.5. Payment with paper checks

You'll receive payment in the form of a paper check if you either:

- Select the paper check option when registering for the payment portal (see **section 4.4** for registration instructions)
- Don't register for the payment portal

### Paper check mailing address

Checks are mailed to the billing address on file for your practice based on the information in your claim:

- **837 EDI:** Loop 2010AA NM1 billing provider information segment
  - If a "pay-to" address is included in the 837 EDI, then checks will be mailed there instead.
- **CMS-1500 form:** Box 33
- **UB-04 form:** Field (FL) 1

## Lost or stolen checks

If you believe a check payment has been lost or stolen, please contact Collective Health to request that the check be voided and reissued. See **section 1.5** for contact information.

## Stale-dated checks

Checks issued on behalf of Collective Health are valid for a specific period - 180 days.

- If a check has not been cashed within approximately **four (4) months** from the issue date, Collective Health will send an affidavit letter to the provider address on file.
- If a check has not been cashed within approximately **six (6) months** from the issue date, Collective Health will attempt to reissue the payment to the provider address on file.
- It is important to cash checks promptly. Here's what happens to checks that remain uncashed:
  - ERISA plans: Checks that remain uncashed for a period of **12 months or more** from the date of issue will be forfeited and returned to the plan.
  - Non-ERISA plans: The process for uncashed check will follow the laws of the state that has jurisdiction over the plan. Funds may be escheated (turned over) to the state.

## 4.6. Understanding remittance advice

You'll receive remittance advice, also known as the explanation of payment, after Collective Health processes your claim and a payment decision has been finalized. Remittance advice gives your billing staff every detail they need to reconcile the payment you receive with the claims your office submitted.

### Remittance advice is available in two formats

- **Electronic remittance advice**, in an 835 file, is created when payment is made through electronic funds transfer. You can access electronic remittance advice through Availity ([apps.availity.com](https://apps.availity.com)) and your Zelis Payment Provider Portal ([provider.zelispayments.com](https://provider.zelispayments.com)).
- **Explanation of payment** documents are included with paper checks in the mail. This is the default method if you aren't registered for electronic funds transfer. You can also view and download explanations of payment documents in your Zelis Payment Provider Portal ([provider.zelispayments.com](https://provider.zelispayments.com)) in PDF, CSV, or Excel format.

## Aggregation

Remittance advice can contain information about all the claim transactions that Collective Health made in the last payment cycle. That means a single remittance advice may contain information for multiple patients and multiple dates of service.

## Adjustment reason codes and denial explanations

Collective Health follows the X12 standards on remittance advice. The codes will indicate the reason why the billed charges were adjusted and who is financially responsible for the adjustments.

- Claim Adjustment Reason Codes: [x12.org/codes/claim-adjustment-reason-codes](https://x12.org/codes/claim-adjustment-reason-codes)
- Remittance Advice Remark Codes: [x12.org/codes/remittance-advice-remark-codes](https://x12.org/codes/remittance-advice-remark-codes)

## Capitation payments

If capitation payment applies to a claim, the remittance advice will include the reason code: **CO24**. In capitation arrangements that cover only specific procedures, the remittance advice may have multiple line items, some paid under the capitation agreement and others paid on a fee-for-service basis.

If capitation payment applies to a claim, the remittance advice will show a zero dollar payment and will state the service is subject to capitation. Then separately, on a monthly basis, a provider with a capitation arrangement will receive a separate explanation of payment with the actual payment calculations for their enrolled capitated subscribers.

## 4.7. Appeals and provider reconsiderations

### 4.7.1. Disputes related to authorizations

- See **section 3.2.7** to learn how to dispute denied requests for prior authorization or post-service authorization.

### 4.7.2. Provider reconsiderations

You have the right to dispute certain decisions as outlined in your network contract. This is known as a provider reconsideration request.

A provider reconsideration request is different from a patient's right to appeal benefit determinations under their health benefits plan. However, you can also request an appeal on the patient's behalf if they authorize you to do so. Please see **section 4.7.3** for information about appealing on a patient's behalf.

### Timely filing requirements for provider reconsiderations

Please refer to your network contract to learn about timely filing requirements.

## How to submit a provider reconsideration request

The instructions for submitting requests vary depending on what type of decision you want to dispute:

- **How to dispute contracts, network participation, or credentialing**
  - Please refer to your network provider contract or online network account. You can also contact your network relations team using the network contact information in **section 1.6**.
- **How to dispute contract rates (in-network pricing)**
  - Providers who are contracted with **Providence Health Plan**:
    1. Complete the Provider Reconsideration Request Form (see **appendix A**).
    2. Submit the form and any supporting documents to Collective Health using the instructions on the form.
  - Providers who are contracted with **Cigna, First Choice Health Network, or First Health**:
    - i. Please refer to your network provider contract or online network account. You can also contact your network relations team using the directory information in **section 1.6**.
- **Any other type of dispute**
  - Collective Health can review provider reconsideration requests for disputes related to claims, benefits decisions, or payments. Your request may be forwarded to one of Collective Health's third-party partners if they were responsible for the original decision.
    3. Complete the Provider Reconsideration Request Form (see **appendix A**).
    4. Submit the form and any supporting documents to Collective Health using the instructions on the form.

### 4.7.3. Appeal on behalf of a patient

Collective Health reviews appeals related to determinations related to claim outcomes or benefit determinations. Common examples include:

- Services excluded by the plan
- Cost sharing (i.e. copay, coinsurance, deductible)
- In-network vs. out-of-network benefit level

### Timely filing requirements for appeals

- You must submit your appeal to Collective Health within 180 days of receiving the adverse benefit determination on the remittance advice.

### Required information for appeals

1. Complete the Appointment of Authorized Representative Form (see **appendix B**).
2. Complete the Request for Internal Appeal Form (see **appendix C**).
3. Include any documents or other information that support your appeal, such as relevant excerpts of medical records.

### Where to submit an appeal

- Fax: **888-974-0998**
- Mailing address:  
**ATTN: Member Appeals Team**  
**Collective Health**  
**1557 W Innovation Way, Suite 300**  
**Lehi, UT 84043**

### Turnaround times for appeals

- **Standard appeals:**
  - For ERISA plans: 60 days from the date Collective Health receives the appeal.
  - For non-ERISA plans: 30 days from the date Collective Health receives the appeal.
- **Urgent appeals (pre-service only):** If the standard turnaround time will negatively impact the patient's access to care, then Collective Health will make a determination as quickly as possible.
  - To request an urgent appeal, you must include the reason for the urgency within the completed appeal form.
  - Urgent requests are generally only honored if the timeliness of a pre-service determination affects the member's immediate access to care. Collective Health reserves the right to determine that a case does not warrant an expedited review.

## 4.8. Overpayments, recoupments, and offsets

Collective Health is committed to accurate claim payments. We have a process in place to identify and recover funds that were incorrectly paid due to issues like billing errors, incorrect coordination of benefits, or duplicate payments. The recovery of these funds is known as **overpayment recovery** or **recoupment**.

## Identification

Overpayments are often identified through Collective Health's standard claim adjudication processes or internal reviews. They may also be identified by you, the provider, or the employer group.

## New remittance advice

When an overpayment is identified, you will receive updated remittance advice, including electronic remittance advice (ERA, or 835) and an explanation of payment (EOP) document.

The new remittance advice will show two separate claim transactions:

- 1. Reversal of the original payment**

First, you will see the payment with all negative dollar amounts. This is how we reverse the original determination on the claim that led to the overpayment.

- 2. The adjusted payment**

Next, you will see the new payment with adjusted dollar amounts and payment codes explaining the adjudication reasons.

## Request for repayment

You will also receive a letter in the mail requesting a refund. The letter will include all details you need to identify the related claim and payment such as the subscriber name, patient name, member ID, date(s) of service, claim number(s), and the overpayment amount. It will also explain how long you have to respond to the notice or to submit payment.

## Timeframe

Please refer to the overpayment notice from Collective Health for details about how long you have to respond to the notice or to submit payment.

## How to repay Collective Health

Collective Health accepts refunds by check only. Here is how to resolve the overpayment:

- **Required Documentation:** To ensure proper and timely processing, please include either:
  - A copy of the overpayment notification letter from Collective Health.
  - A detailed written explanation outlining the cause of the overpayment (only include this if you identified the overpayment with your own internal audit.)

- **Make checks payable to:** The plan sponsor.
  - This is usually the employer of the subscriber of the benefits plan. Their logo is in the upper right corner of the patient's medical ID card.
  - Do not make checks payable to Collective Health or Providence Health Plan.
- **Mailing address:**
  - **Collective Health**  
**PO BOX 840222**  
**Los Angeles, CA 90084-0222**

## Uncashed or pending overpayments

You will also receive a letter in the mail requesting a refund. The letter will include all details you need to identify the related claim and payment such as the subscriber name, patient name, member ID, date(s) of service, claim number(s), and the overpayment amount. It will also explain how long you have to respond to the notice or to submit payment.

## Future offsets policy

Collective Health will not offset underpayments against overpayments, or vice versa, at this time. Please send repayments by check.

## Overpayment determination disputes

You can appeal the overpayment determination using the instructions in **section 4.7**. If the overpayment was the result of a prior authorization decision, see **section 3.2.7** for appeal instructions.

# 5. Appendix

The appendix contains the forms and documents needed to complete some of the administrative tasks listed in this manual.

## **Digital forms**

A direct link to a digital version of each form will be available above the corresponding page in the appendix. These PDF forms are often easier to complete on a computer.

Digital form: [collective.link/php-prr](https://collective.link/php-prr)

# Provider Reconsideration Request



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Collective Health

Please use the form below to submit your reconsideration request. To ensure thorough review, all fields must be completed. Please attach any relevant documents and include specific supporting information for the reviewer's consideration. You will receive an acknowledgement of receipt via fax within 7 calendar days, and a determination will be provided within 30 calendar days for requests eligible for review.

Submission Options	
<b>Fax:</b> 888-227-2351  <b>Email:</b> provider_reconsiderations@collectivehealth.com	<b>Mail:</b> ATTN: Provider Reconsiderations Collective Health 1557 W Innovation Way, Suite 300 Lehi, UT 84043
Provider Details	
Billing Provider/Clinic Name:	Billing Provider/Clinic NPI:
Phone:	Fax:
Mailing Address:	
Dispute Details *	
<p><i>* Complete <b>one</b> form per dispute type. One form may cover multiple claims for multiple members if the provider and dispute type are identical. Use separate forms for different billing providers or dispute types.</i></p> <p><i>For disputes regarding Prior Authorization or Medical Necessity, please follow the instructions provided on your determination letter.</i></p>	
Dispute Type: <input type="checkbox"/> Claim / Benefit Decision <input type="checkbox"/> Payment Dispute <input type="checkbox"/> Amended Reconsideration <input type="checkbox"/> Other _____	
Description of Dispute:	

Digital form: [collective.link/php-prr](https://collective.link/php-prr)

# Provider Reconsideration Request



POWERED BY  
Collective Health

This sheet is provided for your convenience. You may attach your own sheet as long as the following fields are provided.

#	Patient Full Name	Date of Birth	Subscriber ID	Claim ID	Date(s) of Service	Expected Outcome
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						

Providence Health Plan Powered by Collective Health | Provider Support (855) 383-3585

Digital form: [collective.link/php-rep](https://collective.link/php-rep)



POWERED BY  
**Collective Health**

Collective Health  
1557 W Innovation Way, Suite  
300 Lehi, UT 84043

**AUTHORIZED REPRESENTATIVE FORM – COMMERCIAL APPEALS & GRIEVANCES**

**Member Information:** (Please provide the following information)

<b>First Name:</b>	<b>Last Name:</b>
<b>Address:</b>	<b>City &amp; State:</b>
<b>Phone (with area code):</b>	<b>Email:</b>
<b>Date of Birth (mm/dd/yyyy):</b>	<b>Member ID #</b>

I appoint

Print Name of Representative (Individual)	Mailing Address	Relationship
to act on my behalf as my authorized representative for the purpose of requesting an appeal for coverage, payment of a claim or to file a complaint on my behalf.		

**Member Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Authorization to Release Health Information for Appeals, Claims or Grievances**

By signing above, I understand and agree to the following:

- I authorize Providence Health Plan Powered by Collective Health and its subsidiaries to disclose to the above named representative any information relevant to my grievance, claim or appeal, including, but not limited to, medical records and coverage information.
- My Authorized Representative may exhaust my formal appeal rights and will receive all communication regarding any such appeal or grievance in lieu of me.
- This authorization shall begin the date I sign this form and will remain in effect until my administrative appeals are exhausted, and no longer than 12 months.
- I understand that I may revoke or cancel this authorization at any time by sending Providence Health Plan Powered by Collective Health a written cancellation statement at the mailing address listed below. My cancellation of this authorization will not affect any action Providence Health Plan Powered by Collective Health took before it received my request.

Specific authorization is required to release medical and financial information concerning the health care information listed below. By initialing, I authorize release of the information related to my appeal, claim or grievance relating to examination, testing, diagnosis or treatment for the following forms of sensitive information:

\_\_\_\_\_ Alcohol/Drug/Substance Use Disorder  
Initials

\_\_\_\_\_ Mental Health  
Initials

\_\_\_\_\_ HIV/STD/STI/AIDS  
Initials

\_\_\_\_\_ Maternity/Pregnancy (Reproductive Care-Health)  
Initials

\_\_\_\_\_ Genetic Information  
Initials

- Note: To parents/legal guardians of minors: state laws may prohibit Providence Health Plan Powered by Collective Health from acting on your request about Sensitive Information without written authorization from the minor member. (Both Representative and minor must sign).

**Representative Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Submit this completed form to Providence Health Plan Powered by Collective Health: Appeal & Grievances, 1557 W Innovation Way, Suite 300 Lehi, UT 84043

Digital form: [collective.link/php-appeal](https://collective.link/php-appeal)

## Request for Internal Appeal Form



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**Collective Health**

You have the right to appeal adverse benefit determinations. These may include:

- Determinations of ineligibility to participate in the plan
- Determinations that certain services are not covered
- Rescission of coverage
- Determinations that certain treatments are not medically necessary
- Termination of your membership in this plan

You must submit your appeal within 180 days of the adverse benefit determination.

### Patient Information

_____	_____
Patient Name	Patient DOB
_____	_____
Subscriber Name	Subscriber ID

### Services in dispute

_____	<input type="radio"/> Yes	When: _____	<input type="radio"/> No
Claim Number (if applicable)	Have you already received these services?		
_____	_____		
Provider Name	Provider Address		

Please state the reason you believe the decision was incorrect (you may also attach a letter of explanation):

In addition to this form, please submit any additional supporting documentation. This may include:

- A letter or prescription from your doctor
- A receipt for money you paid
- Relevant excerpts of medical records

_____	_____
Signature	Date (mm/dd/yyyy)

I am the:  Patient/Subscriber  Parent/Legal Guardian  Authorized Representation

\*If you are a third party, a provider, or you are submitting this on behalf of a family member for whom you do not have full PHI authorization, please also fill out the appointment of authorized representative form attached.

## 6. Revision history

Version	Revision date	Summary of changes
1.0	12/01/2025	Initial release
1.1	03/10/2026	<p>Section 1</p> <ul style="list-style-type: none"> <li>- Added disclaimer about the purpose of this manual.</li> </ul> <p>Section 2</p> <ul style="list-style-type: none"> <li>- Added details and FAQs about how to perform an eligibility and benefit search in Availity Essentials.</li> </ul> <p>Section 4</p> <ul style="list-style-type: none"> <li>- Expanded claim submission instructions.</li> <li>- Added instructions for members with COB and dual coverage.</li> <li>- Updated appeal review timelines.</li> </ul> <p>Section 5</p> <ul style="list-style-type: none"> <li>- Updated the Authorized Representative form.</li> </ul>
1.2	04/01/2026	<p>Section 2</p> <ul style="list-style-type: none"> <li>- Added instructions for searching for benefits by a specific procedure code in Availity Essentials.</li> </ul> <p>Section 4</p> <ul style="list-style-type: none"> <li>- Updated estimated claim payment timeline.</li> <li>- Added patient account number to the table of required information on claims.</li> <li>- Updated phone number and website for registering with Zelis for EFT payments.</li> </ul>
1.3	05/08/2026	<p>Section 1</p> <ul style="list-style-type: none"> <li>- New contact information for contract rate disputes.</li> </ul> <p>Section 3</p> <ul style="list-style-type: none"> <li>- Added subsection numbers for easier navigation of prior authorization topics.</li> </ul> <p>Section 4</p> <ul style="list-style-type: none"> <li>- Updated provider reconsideration information.</li> </ul>

Version	Revision date	Summary of changes
1.3 (cont.)	05/08/2026	Section 5 - Updated the provider reconsideration request forms.
1.4	06/01/2026	Section 1 - Updated contact information for the Collective Health Provider Support Specialist team.  Section 3 - Added information and instructions for benefit level exception (BLE) requests. - Added information about the transition to Integra for durable medical equipment (DME).  Section 4 - Updated claim submission instructions for certain partners, including Integra for DME claims.