Providence Health Plan | Providence Health Assurance

Providence Health Plan Transition FAQ

For Providers

Will providers receive a termination letter?

Yes. Provider termination letters were mailed to all contracted providers on October 15th. A copy of the letter is available here:

ProvidenceHealthPlan.com/Providers/News-and-Updates

How will providers know which members are eligible for services after December 31, 2026?

Providers should continue to verify the member's eligibility and coverage status prior to providing services.

To confirm active coverage for:

- Providence Health Plan members, please check member eligibility through ProvLink.
- Providence Health Plan Powered by Collective Health members, please check member eligibility through Availity.

How will members learn about changes to their coverage?

Members will receive information about any changes to their coverage at the appropriate time, based on their plan. If a member has questions about their specific coverage or notice, please direct them to the Customer Service number on their member ID card.

What should providers tell members who are concerned about losing coverage?

Providers should first verify the member's active eligibility and coverage status. Based on a member's current, active coverage, providers can reassure members that there are no immediate changes to their coverage, benefits, or access to care. Members should continue seeing their providers, accessing services, and filling prescriptions as they do

today. Coverage end dates and transition details may vary by plan, so members should refer to their plan-specific notices for the most accurate information. If a member has questions about their specific coverage or notice, please direct them to the Customer Service number on their member ID card.

Additional information regarding future coverage options will be communicated directly to members as it becomes available.

Will prior authorizations, referrals, or DME approvals still be honored?

Yes. You should continue following existing authorization, referral, and DME processes. At this time, there are no changes to current utilization management requirements. Providence Health Plan will continue to meet its regulatory, contractual, and operational obligations throughout the transition and will communicate any future changes well in advance.

Should providers continue treating Providence Health Plan members?

Yes, as a contracted provider with Providence Health Plan, providers must continue delivering services to Providence Health Plan and Providence Health Assurance members as long as coverage remains active and valid. Nothing about this announcement changes provider obligations or member access to covered services in 2026.

Will provider contracts or reimbursement arrangements change?

There are no changes to provider contracts or reimbursement arrangements currently. You should continue to operate under existing agreements and follow current billing and reimbursement processes. Any future updates will be communicated directly to affected providers.

What happens to claims submitted after December 31, 2026 for 2026 dates of service?

Providence Health Plan will continue to maintain the necessary operations and support required to process claims and fulfill all contractual and regulatory obligations. Providers should continue submitting claims through normal channels and follow existing processes. If any future changes to claims submission, processing, or support become necessary, we will communicate those updates in advance and provide guidance.

How will member appeals and provider reconsiderations be handled? Will timely filing guidelines change?

At this time, member appeals, provider reconsiderations, and timely filing requirements remain unchanged and will continue to be administered according to existing policies and processes. Providers should continue following current appeal, reconsideration, and filing procedures. If any changes are made in the future, we will communicate them in advance and provide updated guidance.

Should I still send new providers to be credentialed?

Practitioners/groups with existing contracts should continue to work with their Provider Relations representatives to add practitioners on a case-by-case basis. New contracts requiring full credentialing will not be accepted after October 1, 2026.

Are there changes to who I contact in 2027 (Customer Service, Health Care Services, Provider Relations, etc.)?

At this time, there are no changes to provider support contacts. Please continue using the same Customer Service, Health Care Services, and Provider Relations contacts you use today. If any changes are made in the future, we will communicate them in advance and provide updated contact information.

How long will I have access to the Provider Portal, Provlink?

ProvLink will remain available to providers and continue to function as it does today. If there are any future changes to ProvLink access, record availability, or related processes, we will communicate those updates in advance.

How will Providence Health Plan assist with Collective Health pricing issues and claim runout for 2027?

Collective Health will remain responsible for claims processing and administration throughout the applicable claims runout period for each self-funded (ASO) group. At this time, there are no changes to existing processes or escalation pathways. Please continue working with your current Collective Health and Providence Health Plan contacts as you do today. If any changes are made to support models, escalation procedures, or points of contact, we will communicate those updates in advance.

Will the CareAdvance tool on ProvLink still be used for Prior Authorization requests in 2027 for those plans continuing in 2027?

CareAdvance will remain available to providers and continue to function as it does today. If there are any future changes to Prior Authorization submission, we will communicate those updates in advance.

Is the claims address or payor ID going to change?

At this time, there are no changes to claims submission processes. Please continue submitting claims using the same addresses and payor IDs you use today. If any changes are made in the future, we will communicate them in advance and provide updated instructions.

What are Providence Health Assurance's obligations related to continuity of care for Medicare Advantage enrollees?

CMS requires that if an enrollee is hospitalized in a prospective payment system (PPS) hospital, Providence Health Assurance is responsible for all Part A inpatient hospital services until the enrollee is discharged, in accordance with the regulation (42 CFR § 422.318). Original Medicare or the enrollee's new plan will assume payment responsibility for all other covered services on the effective date of contract non-renewal/termination. If an enrollee is in a non-PPS hospital, Providence Health Assurance is responsible for the covered charges through the last day of the contract or, for contracts reducing their service area, the last day that the Medicare Advantage member was enrolled in the MA plan.

With respect to Medicare members receiving care in a skilled nursing facility (SNF), Providence Health Assurance will be financially liable for care through the end of the contract year. After that date, members continuing in a SNF may receive coverage through either original Medicare or another MA plan. If the SNF stay is Medicare-covered, the number of days of the enrollee's SNF stay while enrolled in a MA plan will be counted toward the 100-day limit. (This requirement does not apply to stand-alone Prescription Drug Plans (PDPs.)