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 15, 2026. A copy of the letter is available online at:

ProvidenceHealthPlan.com/Providers/News-and-Updates

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

Providers should continue to verify member eligibility and coverage before rendering services. While Providence Health Plan will not offer most coverage in 2027, certain employer groups will continue coverage into 2027. As always, providers should verify eligibility and benefits prior to treatment and follow all applicable contractual requirements.

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.

Updated as of 11/16/2026

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

Providers should first verify the member's active eligibility and coverage status. Members can be reassured that their coverage remains active through their plan's applicable coverage end date and that they should continue accessing covered services, seeing their providers, and filling prescriptions as usual while coverage remains in effect.

You can encourage members to review notices they have received for information specific to their coverage.

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

Yes. Existing authorization, referral, and DME processes will remain in place through December 31, 2026, with no changes to current utilization management requirements.

Effective January 1, 2027, prior authorization through EviCore and Carelon will no longer be required for lines of business with active coverage. For members with continued coverage in 2027, CareAdvance prior authoization requirements remain unchanged, and approved authorizations effective in 2027 will continue to be honored.

UPDATE: Should providers continue treating Providence Health Plan members?

Yes, contracted providers should continue providing covered services to Providence Health Plan and Providence Health Assurance members as long as coverage remains active and valid.

While many plans will end December 31, 2026, Providence Health Plan will continue providing coverage for certain employer groups in 2027. Providers should continue verifying member eligibility and benefits before providing services and following applicable contractual requirements.

UPDATE: Will provider contracts or reimbursement arrangements change?

Provider termination notices were mailed on October 15, 2026; however, existing contractual terms, reimbursement arrangements, and billing processes will remain in effect through the applicable termination date of each provider agreement.

Providers should continue operating under their current agreements and follow established billing and reimbursement procedures. Providence Health Plan will continue to process and pay eligible claims in accordance with the terms of the applicable provider contract throughout the transition period.

UPDATE: What happens to claims submitted after the plan termination date?

Providence Health Plan will continue processing and paying eligible claims for covered services, including claims submitted after the plan termination date, in accordance with applicable contractual and regulatory requirements.

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 and groups with existing contracts should continue working with their Provider Relations representatives to add practitioners on a case-by-case basis. Providence Health Plan's no longer accepting new contracts that require full credentialing. The deadline for submission was October 1, 2026.

NEW: Will providers still need to complete recredentialing in 2027?

Effective January 1, 2027, Providence Health Plan has extended recredentialing timelines. Because Providence Health Plan will no longer be operating as an NCQA- or CMS-regulated carrier, the number of providers requiring recredentialing in 2027 will be very limited. Providers with recredentialing requirements will be contacted directly.

Providers should continue to coordinate with their Provider Relations representatives as needed.

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.

Will providers continue to have access to ProvLink in 2027?

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?

Providence Health Plan will ensure claims processing and administration continues 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.

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?

Inpatient Hospital Stays:

For members receiving inpatient hospital care when coverage ends, payment responsibility depends on the type of facility and the member's discharge status.

- If a member is hospitalized in a prospective payment system (PPS) hospital, Providence Health Assurance is responsible for all Part A inpatient hospital services until the member is discharged.
- For all other covered services, payment responsibility will transfer to Original Medicare or the member's new health plan on the effective date of the contract non-renewal or termination.
- If an enrollee is hospitalized 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, through the last day the member was enrolled in the Medicare Advantage plan.

Skilled Nursing Facility (SNF) Stays:

For members receiving Medicare-covered skilled nursing facility care when coverage ends, Providence Health Assurance may continue to have financial responsibility beyond the coverage termination date.

- For Medicare Advantage members receiving care in a SNF, Providence Health Assurance remains financially responsible for covered care through the end of the contract year.
- After that date, members who continue to require SNF care may receive coverage through Original Medicare or another Medicare Advantage plan. If the SNF stay is Medicare-covered, any days used while enrolled in the Medicare Advantage plan will count toward Medicare's 100-day SNF benefit limit.
- Note: This requirement does not apply to stand-alone Prescription Drug Plans.