ProviderInsight®

Colorado Edition
February 2025

Welcome!

Find medical, dental, and pharmacy information as well as program and plan updates for:

- Commercial
- Select Health Medicare

Select Health

In this Issue

Select Health News and Networks

Select Health 2024: Year in Review

2024 was a challenging yet rewarding year for Select Health and its members. Much of the success we enjoyed last year can be directly attributed to the exceptional work of our network providers. Together, we helped our members live the healthiest lives possible, thus fulfilling the ongoing mission of Select Health.

Major provider milestones of 2024 include:

- Over **13 million** claims were paid.
- Addressed over **12,000** appeals
- Gold-carded over 100 providers resulting in **1,600 fewer preauthorizations.**
- Over **2,500 new contracts** were executed systemwide for greater access to more providers.
- More than 6,000 providers were credentialed or recredentialed.
- All credentialing policies and procedures were transferred to Select Health for **better service.**
- Colorado network expansion **surpassed 19,000 providers.**
- The Musculoskeletal program enrolled **1,300 members**, reaching nearly 3,000 visits.
- We enrolled more than **5,000 members** in our disease management program, with a 58% improvement in depression and a 60% improvement in adherence to statins.
- Our online provider directory accuracy improved from 83% to **95% year over year.**
- The **Quality Provider Program** improved diabetes control by 12% and medication adherence by 5% among participating provider clinics.

These are just some of the many positive outcomes that directly result from our work with network providers. With your help, we can continue in 2025 to ensure that Select Health members get the very best medical care. **Thank you.**

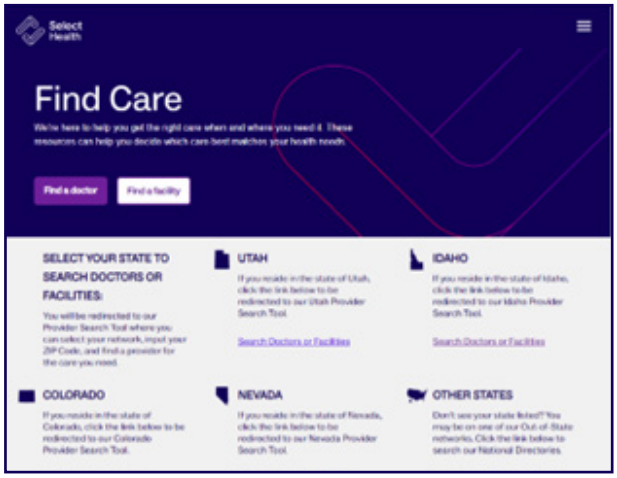
Referral Instructions for Colorado Providers

An important part of properly caring for Select Health members is referring members to other providers who can meet their needs. Since plans in Colorado are EPO for commercial and HMO for Medicare Advantage, it is important that a member's referred care stays within Select Health's network.

There are several options available to providers to make effective in-network referrals, including:

- Check the new **Online Provider Directory** (fastest method – see linked screenshot at right).
- Ask your Provider Relations representative: **COProviderRelations@selecthealth.org.**
- Register for and use the **Provider Benefit Tool**.

Additional questions? Contact your Colorado Provider Representative at **COProviderRelations@selecthealth.org**.



What Makes Select Health Networks Different

We continually invest locally to meet the needs of our members and providers. Here's what makes our Colorado networks different:

- Local provider support teams
- Nationwide plan access
- Top local hospital and health system partnerships
- Both integrated and direct networks
- Continual network development and expansion
- Claims paid quickly and accurately

Visit our **website** to learn more about what we're doing to support Colorado providers.

WORKING WITH YOUR PROVIDER REP TEAM

Select Health's mission is to help people live the healthiest lives possible. We achieve this mission with the important relationships we have with our physicians, clinics, and providers.

Our Colorado provider team is local to you, so you can access personalized support and service when and where you need it. Plus, our phone center teams are available to help you with any concern, like access to our online tools or claims information.

You can get support from the Colorado provider team at **COProviderRelations@selecthealth.org**.

MEET THE TEAM

Carly Stasica, Colorado Provider Development Director

With over 14 years of healthcare experience, Carly's areas of focus include contracting and credentialing, as well as direct work with commercial and government providers to ensure high-quality customer service and easy access to Select Health's suite of online provider tools. Carly is passionate about simplifying the payer experience for provider offices and providers.

Fawn Batliner, Network Engagement Representative

Experienced in maintaining and expanding provider relationships and facilities in the Denver area, Fawn brings a wealth of knowledge to the Select Health Provider Development Team. Fawn will assist in contracting and credentialing efforts, while working to build strong relationships with all Colorado providers. Fawn's extensive provider experience includes operations, clinic administration, relationship development, and practice expansion.

Janet Graves, Network Engagement Representative

With a master's degree in health services administration from Regis University, She brings experience in healthcare leadership within multispecialty clinic operations. Janet is excited to collaborate with clinicians to expand the network and better serve the community.

Sandra Proud, Network Engagement Representative

Sandra graduated from Colorado State University Pueblo and has experience in a variety of roles including market manager, provider relations, and sales. In her current role, she is focused on building relationships as she works with local provider offices.

Provider Tools and Programs At a Glance

Use the information below to quickly manage claims and preauthorization requests as well as to access key programs Select Health offers for supporting providers and their practices. **To sign up for online tools**, fill out a **login application** and **ITSA agreement form**, and email both to **providerwebservices@selecthealth.org**.

Claims

1. Verify Select Health member eligibility by:
   - Checking **member ID cards**, or
   - Using the **Provider Benefit Tool,** our online tool for quickly viewing member eligibility and claims information
2. Submit claims using one of the following:
   - **Electronic Data Interchange (EDI) transactions:** Contact the Select Health EDI Team:

     edi@selecthealth.org
     800-538-5099
   - Send via U.S. mail to:

     P.O. Box 30192
     Salt Lake City, UT 84130
     (for Commercial/Medicaid/CHIP)

     P.O. Box 30196
     Salt Lake City, UT 84130
     (for Medicare claims ONLY)
3. Monitor claim status in the **Provider Benefit Tool**.

Preauthorization

For services and procedures requiring preauthorization, use one of the following to submit requests:

1. Select Health's secure online preauthorization tools:
   - **CareAffiliate®:** Our online tool for submitting requests and checking status saves time for your practice (some requests qualify for auto-approval).
   - **PromptPA:** An online preauthorization tool for medications and durable medical equipment. For assistance with PromptPA, contact Select Health Pharmacy Services:
     - **800-442-3129** (for Commercial, PBM)
     - **855-442-9988** (for Medicare)
2. Send a request form via email. **Preauthorization forms** must be submitted via email if not using CareAffiliate or PromptPA as follows:
   - Commercial: **commercialUMintake@imail.org**
   - Medicare: **medicareUMintake@imail.org**

Programs

Quality Provider Program (QPP):
QPP is an outpatient care delivery model that offers patients a collaborative relationship with a team of providers. This team-based healthcare delivery model is led by a healthcare practitioner and provides comprehensive and continuous patient care for enhancing health outcomes and patient satisfaction.

Learn more: Visit us online or contact us at **qualityprovider@selecthealth.org**.

Pharmacy & Therapeutics:
Find online information on formularies, pharmacy tools, and other valuable resources. Or, call our dedicated phone line for pharmacists and physicians **(800-442-3129)**, with pharmacists on staff who can answer your questions.

Behavioral Health:
Visit the Behavioral Health area of our website to access a variety of behavioral health tools and resources for:

- Credentialing
- Mental Health Integration
- Opioid Prescribing
- Zero Suicide

Questions about compliance? Contact your Provider Relations representative at COProviderRelations@selecthealth.org.

Compliance Matters

Compliance requirements center on ensuring:

- Accurate provider demographic information
- Equal access for those with disabilities
- Fraud, waste, and abuse training attestations

Contact your Provider Relations representative if you have questions or have **not** previously provided a preferred email address needed for these required attestations:

1. PROVIDER DEMOGRAPHIC INFORMATION ATTESTATION

Per **CMS and the Consolidated Appropriations Act**, practitioners are required quarterly to attest and update their demographic information.

Select Health provides for these attestations via a quarterly Qualtrics survey sent to your email inbox.

Effective **July 1, 2025**, if a provider offers telehealth services, it will be indicated in the provider directory. **Learn more**.

2. EQUAL ACCESS FOR THOSE WITH DISABILITIES

When you update your information In your quarterly demographic attestation, please update accommodations for those with disabilities along with your clinic location to specify whether your location is meeting the ADA standards.

Per **CMS (42 CFR 438.206a), the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act**, these standards require healthcare providers to provide individuals with disabilities full and equal access to their healthcare services and facilities.

Learn more about these standards.

3. FRAUD/WASTE/ABUSE (FWA) TRAINING ATTESTATIONS

Per **CMS Medicare Managed Care Manual Ch. 21 (50.3.2)**, practitioners who see patients **on Medicare** are required to:

- Participate in FWA training
- Attest that compliant training has been completed in the first 90 days of contract/hire date and annually thereafter. Access the **online attestation form**.

NOTE: Using the previously required, CMS-issued content is no longer mandatory; however, **this training** is still available as an option.

In addition, Select Health offers access to trainings encouraged by regulatory bodies:

1. CULTURAL SENSITIVITY TRAINING

Per **NCQA (QI, Element E, Factor 2)** and **CMS (42 CFR 438.10)**, practitioners are required to complete cultural competency/sensitivity training.

Select Health offers a **brief, online training** that complies with this requirement in the education area of our website.

2. QUALIFIED MEDICARE BENEFICIARIES (QMBs)

This Centers for Medicare and Medicaid Services (CMS) program helps low-income Medicare beneficiaries by:

- Paying for their premiums, deductibles, copayments, and coinsurance
- Prohibiting billing for Medicare A/B deductibles and cost sharing
- Not discriminating against or refusing service because they are protected from paying cost sharing.

Learn more about **CMS requirements for QMBs.**

Quality Improvement Programs

Quality Provider Plus Program (QPP) Updates

SAVE THE DATE!
The Quality Provider Program spring Gather & Grow Conference will be held on **May 7, 2025**. The focus for this conference will be hypertension measures with additional sessions on using the Quality Data Corrections tool, allowable corrections, and how to supercharge your online tool use. **Stay tuned for details!**

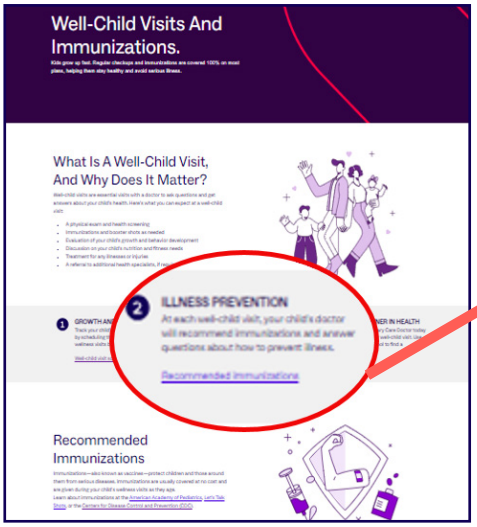
2025 UPDATED PROGRAM MATERIALS NOW ONLINE.
Check out new 2025 program materials for **primary care measures**.

Focus on Child and Adolescent Immunizations

Update on the Quality Provider Program's focus on immunizations. QPP has successfully achieved their target for adolescent immunizations, reaching 39% compliance by vaccinating 3,497 members over the past year (preliminary data to be finalized after March 2025).

QPP is working to strengthen efforts in boosting childhood immunization rates, with the goal of meeting our 2025 entry goal of 74.48% and 67.8% for childhood immunizations (CIS_CB7) and childhood flu vaccinations (CIS_FLU), respectively.

VISIT THE SELECT HEALTH WELL-CHILD VISITS PAGE FOR RESOURCES



18-MONTH WELL-CHILD VISIT IS KEY!

All well-child visits are important, but data shows that the 18-month visit is the most impactful in determining if a child is complete with the recommended vaccine schedule by the 2nd birthday.

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ADDITIONAL RESOURCES FOR PROVIDERS

Advisory Committee on Immunization Practices (ACIP) Reports: Under the auspices of the Centers for Disease Control and Prevention (CDC), ACIP develops recommendations on how to use vaccines and passive immunizations to control diseases in the U.S. Select Health makes these reports available on our provider website in our "Tools" area.

CDC Resources:

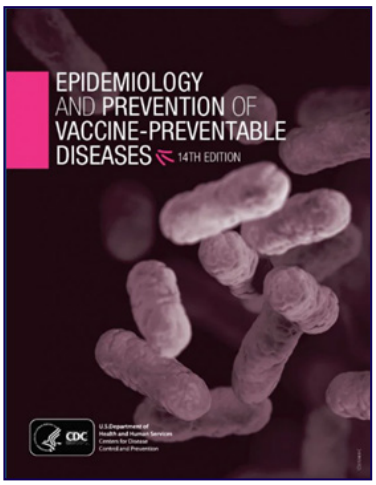
- Vaccines & Immunizations Website
- Epidemiology and Prevention of Vaccine-Preventable Diseases, 14th Edition (2021)
- "Wild-to-Mild" Social Media Toolkit

IMMUNIZATION BEST PRACTICE: CASE STUDY

One of our Utah community health clinics increased clinic Children Immunization status (CIS) vaccine rates* by **17 percentage points** from 2023–2024 by:

- Designating a Clinic Vaccine Champion
- Focusing on immunization messaging from the moment the patient walks in the door
- Providing materials in English and Spanish
- Holding monthly staff meetings with vaccine education
- Scheduling next appointments before patients leave
- Praising for success
- Using the reminder recall report from the Colorado Immunization Information System (CIIS)
- Creating an environment where all staff are on board

* Childhood Immunization Status (CIS) is a measure of the percentage of children who have received certain vaccines by a specific age. The National Committee for Quality Assurance (NCQA) uses a set of performance measures (Healthcare Effectiveness Data Information Set or HEDIS). HEDIS includes CIS.



2025 CDC Vaccine Schedules:

Child and Adolescent Immunization Schedule by Age, last updated November 21, 2024, (ages 18 years or Younger). Download the CDC Vaccine Schedules app for providers.

RESOURCE FOR PATIENTS AND THEIR FAMILIES

Institute for Vaccine Safety — Let's Talk Shots Video Library, a collection of 23 animated videos (example at right)

Pharmacy

Changes in Medicare Part D and Medicare Advantage Drug Coverage

In 2025, Medicare Part D and Medicare Advantage coverage of prescription drugs will be different from previous years due to several changes included in the Inflation Reduction Act that went into effect January 1, 2023. This law was intended to lower the cost of medications for Medicare enrollees. Below is a summary of some of the changes and how they will impact Select Health Medicare members:

1. **Vaccines**: More vaccines will be covered under Medicare Part D with no out-of-pocket cost. Vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) will be covered with no copay or deductible, including vaccines for RSV, shingles, whooping cough, and others.
2. **Insulin**: Out-of-pocket costs for insulin will be capped at $35 for a month supply and $105 for a 3-month supply on Part D. For members using an insulin pump, insulin covered under Part B will also be capped at $35 per month or $105 per 3-month supply.
3. **Prescription Drugs**: Yearly Part D out-of-pocket costs will be capped at $2000, and catastrophic coverage phase will continue to be of no cost to the member.
4. **Price Negotiations**: CMS has negotiated pricing with manufacturers for ten high-spend brand-name Part B and Part D drugs. Negotiated prices will apply in 2026. Each year going forward, CMS will negotiate pricing for additional drugs, and the savings will be passed on to plan administrators and participants.
5. **Medicare Prescription Payment Plan (M3P)**: For 2025, Medicare members can opt-in to a new program that will make their out-of-pocket prescription costs more consistent over the calendar year. Members who choose this option will pay no copay or coinsurance at the pharmacy counter, but will be invoiced monthly by the plan administrator. For members who anticipate pharmacy costs to meet the $2000 max for 2025, this program may help them plan for expenses in a more consistent manner.

Visit us online for more information about changes to prescription coverage on Select Health's Medicare for 2025.

Select Health Medicare + Kroger Plan

In **January 2024**, Select Health launched co-branded Medicare Advantage and Kroger Health plans in Colorado, Idaho, Nevada, and Utah. Member benefits apply as follows:

- All members on the new **Select Health Medicare + Kroger** plans receive monthly funds on a flexible spending card to use for over-the-counter (OTC) health-related purchases.
- **Members with one or more qualifying chronic conditions, verified by a physician,** (see **Figure 1** at right) will have access to a monthly balance to spend on groceries at Kroger-owned stores. (e.g., Smiths, King Soopers, City Market, Fred Meyer, etc.).

  Access a **full list of eligible grocery brands** across the nation.

Help us verify the diagnoses for members with these listed chronic conditions to ensure they have access to available grocery funds. Verification can be confirmed by an outreach to your office, a mailed questionnaire, and/or the member's medical history.

Questions? Contact Provider Development at **provider.development@selecthealth.org**.

Figure 1. Qualifying Conditions for Grocery Dollars

Qualifying Condition	Examples/Other Qualifying Information
Autoimmune disorders	Rheumatoid arthritis, lupus, vitiligo, hypothyroidism
Cancer	Any type of cancer or precancer diagnosis, includes cancer diagnoses currently treated or treated within the past year
Cardiovascular disorders	Heart attack, heart valve disease, peripheral vascular disease
Chronic alcohol and other drug dependence	
Chronic and disabling mental health conditions	Depression, anxiety, bipolar disorder, ADHD
Chronic heart failure	
Chronic kidney disease	Kidney stones, elevated kidney test results
End-stage renal disease (ESRD)	Dialysis or transplant
Chronic liver disease	Fatty liver, chronic hepatitis
End-stage liver disease	
Chronic lung disorders	Chronic obstructive pulmonary disease, asthma
Dementia	Significant memory loss, Alzheimer's disease
Diabetes	Type 1 or Type 2 diabetes, prediabetes
HIV/AIDS	
Hypertension	Currently treated for high blood pressure
Malnutrition	Vitamin or mineral deficiencies, eating disorders
Musculoskeletal disorders	Arthritis, muscle wasting/weakness, back pain, foot pain, other chronic joint pain
Neurologic disorders	Migraines, peripheral neuropathy, ALS
Obesity	BMI higher than recommended for patient's age/gender/ethnicity
Severe hematologic disorders	Anemia, hemophilia, polycythemia, leukemia)
Stroke	

Kidney Health Evaluation for Patients with Diabetes

For the Kidney Health Evaluation (KED) measure, it is very important that providers know the changes necessary to be compliant. **Figure 2** indicates tests recommended to detect and manage kidney disease in patients with diabetes.

QUANTITATIVE URINE ALBUMIN ORDERS

Providers must order a **quantitative urine albumin** if ordering the urine albumin and urine creatinine separately.

NOTE: A semi-quantitative urine albumin is **NOT** considered compliant for the KED measure.

Providers should continue ordering any tests necessary for their patient's care, but the codes listed in **Figure 2** below are those that will fulfill an open care gap for your patients:

CODING CHANGES

For a quantitative urine albumin test, CPT code **82044** was removed from the acceptable codes, and now only **82043** is acceptable.

For measure compliance, both tests must be completed:

- **Urine test — urine albumin-creatinine ratio (uACR).** This can be ordered as a separate quantitative urine albumin test and a urine creatinine test as long as they have service dates four days or less apart.
- **Blood test — estimated glomerular filtration rate (eGFR).**

Learn more about the KED measure and coding changes, visit the National Committee for Quality Assurance (**NCQA) website**.

Questions? Contact Azure Gaskill, Quality Consultant RNs at **azure.gaskill@selecthealth.org**.

Figure 2. Coding for KED in Patients with Diabetes

TEST	CPT CODES	LOINC CODES
Urine albumin creatinine ratio lab test	N/A	9318-7, 13705-9, 14958-3, 14959-1, 30000-4, 44292-1, 59159-4, 76401-9, 77253-3, 77254-1, 89998-9
Quantitative urine albumin lab test (**cannot** be semi-quantitative)	82043	1754-1, 14957-5, 21059-1, 30003-8, 43605-5, 53530-2, 53531-0, 57369-1, 89999-7, 100158-5
Urine creatinine lab test	82570	2161-8, 20624-3, 35674-1, 39982-4, 57344-4, 57346-9, 58951-5
Estimated glomerular filtration rate lab test	80047, 80048, 80050, 80053, 80069, 82565	50044-7, 50210-4, 50384-7, 62238-1, 69405-9, 70969-1, 77147-7, 94677-2, 98979-8, 98980-6, 102097-3

Avoid Denials for Pain Procedures

Submitting complete medical necessity documentation helps pain procedure providers avoid denied claims and preauthorization requests.

Remember: **A referral alone is insufficient for a procedure justification.** The proceduralist must determine and communicate medical necessity and procedure appropriateness, **either** by:

- Documenting discussions with patients and agreement with the referring provider notes; **OR**
- Evaluating the patient and adding notes to the original referral information.

HOW DO PAIN PROCEDURE PROVIDERS BEST DOCUMENT MEDICAL NECESSITY?

For Select Health members, ensure medical necessity criteria is met via the procedure notes by **either**:

1. Acknowledging having read the referring provider's notes, if complete, and documenting agreement; **OR**
2. Evaluating the patient and documenting medical necessity for the procedure when referring provider notes are incomplete based on relevant medical policies (see below).

WHERE CAN PROVIDERS FIND MORE INFORMATION?

Access relevant medical policies for medical necessity and appropriateness criteria as follows:

- **Medicare:** Centers for Medicare and Medicaid Services policies, **LCD 38803 (Facet Joint Interventions for Pain Management)** and **LCD 39242 (Epidural Steroid Injections for Pain Management**).
- **Commercial Select Health Plans:** Select Health Medical Policy #626, Diagnostic and Therapeutic Interventions for Spinal Pain (which begins on page 27 of the online **Physical Medicine Policy Booklet**).

Questions? Contact Dr. Mary Suchyta, Select Health Medical Director, at **mary.suchyta@selecthealth.org**.

Colorectal Cancer Screening: What Providers Need to Know

WHO SHOULD GET COLORECTAL CANCER SCREENING?

All adults, **ages 45 to 75, should be screened for colorectal cancer**. For those **ages 76 to 85**, screening should be discussed with their provider based on preferences, overall health, and past screening history.

Those **younger than 45** who have risk factors (e.g., family history, hereditary diseases) should discuss the need for screening with their providers.

WHAT SCREENING DOES SELECT HEALTH COVER?

Select Health covers colonoscopy and stool-based testing as follows:

- **Colonoscopy**: Members should have a colonoscopy every 10 years or every 3 to 5 years if there are risk factors (e.g., a history of polyps, family history, or other factors; see information at right).
- **Stool-based Testing:** These at-home tests of stool samples can be mailed into the lab for analysis (see instructions on page 13). Select Health promotes fecal immunochemical testing (FIT) because of its accuracy, cost, and frequency. FIT testing should be done every calendar year for eligible Select Health Advantage (Medicare) members and every 365 days for commercial members. See page 13 for exclusions.

WHAT RISK FACTORS ARE ASSOCIATED WITH COLON CANCER?

Colon cancer risk factors include:

- **Age.** About 90% of the time, colorectal cancer occurs in adults older than 45.
- **Family History.** A close relative who has had colon cancer or a colon polyp may increase risk.
- **Ethnicity.** Rates of colorectal cancer are higher in African Americans compared with other races.

Latest Screening Guidelines

The U.S. Preventive Services Task Force (USPSTF) recently expanded recommended adult colorectal cancer screening to those aged 45 to 49 years.[1] These guideline changes reflect that:

- **There has been a dramatic increase in colorectal cancer among those aged 40 to 49 years.** By expanding the recommendations and offering more screening options, we can help members live the healthiest lives possible.
- **Screening detects colon cancer at an early stage (localized) when it is curable.** The five-year survival rate for localized colorectal cancer (cancer that is confined to the colon or rectum) is **90.6%** as compared to **14.7%** for those whose cancer is detected in later stages.[2]

Thanks to the new guidelines, many insurance plans cover colorectal cancer screenings with no copays (according to the United States Preventive Services Taskforce) as mandated by the Affordable Care Act.

- **Medical Conditions.** Inflammatory bowel disease may increase risk of developing colon cancer.
- **Lifestyle**. Members can mitigate some risk factors (e.g., by stopping smoking, improving diet, being active, and keeping a healthy weight).

WHAT IS THE PROCESS FLOW FOR SCREENING?

The algorithm and associated notes in **Figure 3** on page 13 provide a quick view of the care process associated with colorectal cancer screening.

Be sure to contact Select Health Member Services (**800-538-5038**) to verify plan-specific coverage for preventive screening tests.

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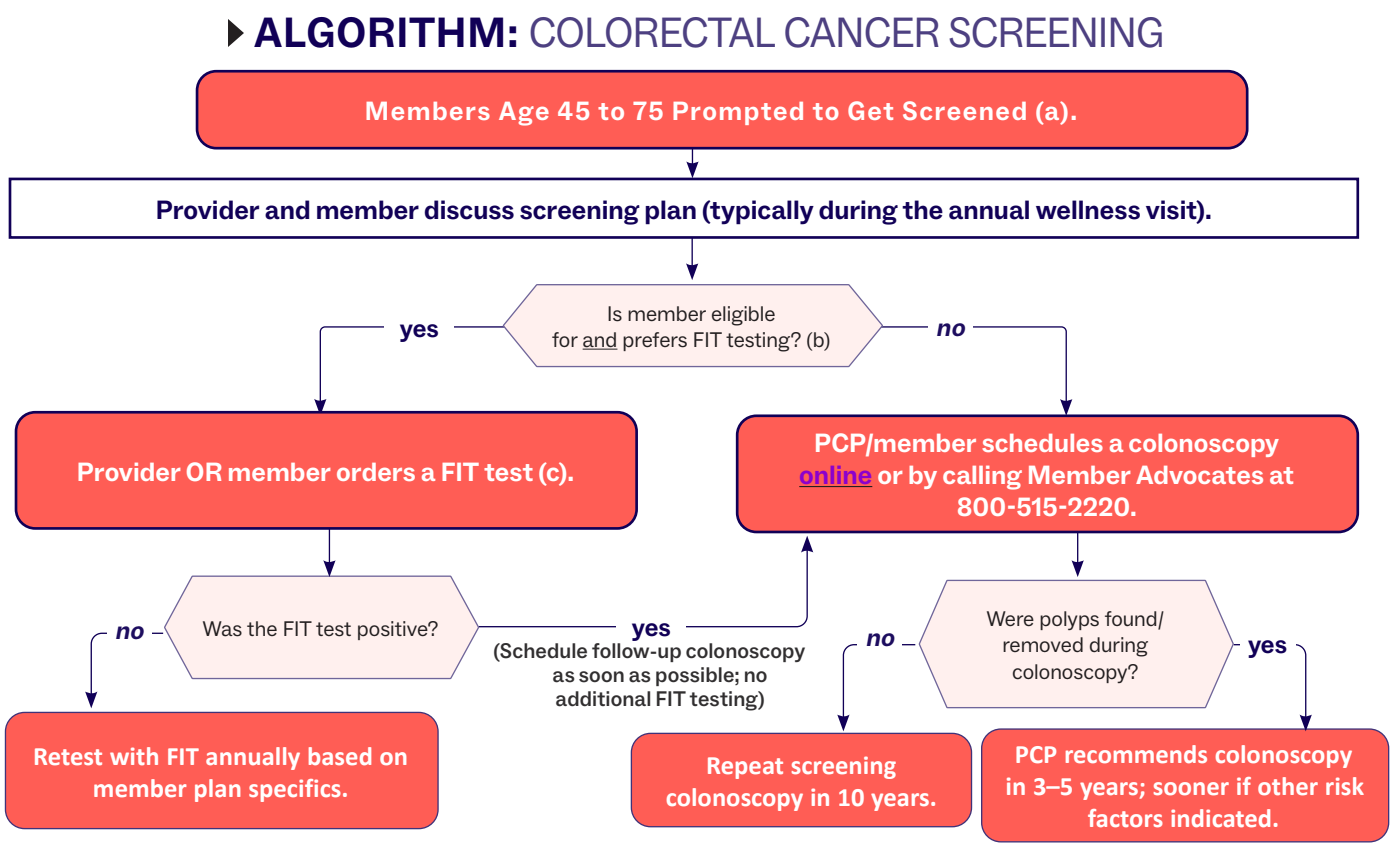
Figure 3. Colorectal Cancer Screening Algorithm



ALGORITHM NOTES

(a) Member Screening Prompt

Members are prompted to get screened when:

- Primary care providers review prevention screening status with members at annual wellness visits and develop a member-specific screening plan based on criteria.
- Select Health sends reminder letters to members when records indicate that they are due for colorectal cancer screening.

(b) FIT Test Exclusions

- History of polyps or colon cancer
- Hemorrhoids
- Ulcerative colitis or Crohn's disease
- Visible blood in the stool or on toilet paper
- A previously positive FIT test
- Normal colonoscopy within 10 years

(c) How to Order FIT Tests

1. Make sure that your clinic is set up to use Intermountain lab services. Sign up via the **Lab outreach services team**.
2. Order FIT test kits at the **Central Lab website** (online or download an order form to complete and send to client services).
3. FIT Samples must be labeled with patient information or the lab will not be able to process the sample.

1. U.S. Preventive Services Task Force. *Final Recommendation Statement - Colorectal Cancer: Screening*. May 18, 2021. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/colorectal-cancer-screening#fullrecommendationstart. Accessed September 13, 2021.
2. Moffitt Cancer Center. *Colon Cancer*. moffitt.org website. https://www.moffitt.org/cancers/colon-cancer/survival-rate/#:~:text=According%20to%20the%20National%20Cancer,can%20cause%20jaundice%20and%20nausea.Accessed February 11, 2025.

Navigate! How can we help you today?

Start with Select Health online self-service solutions. Access our provider website (**selecthealth.org/providers**) for the quickest way to get your questions answered. Direct links are in purple type.

Do you need to:	Go to:
Find member ID card information?	https://selecthealth.org/providers/claims/id-guides
Access non-covered codes/ preauthorization requirements?	https://selecthealth.org/providers/publication-resources/tools
Request preauthorization?	https://selecthealth.org/providers/preauthorization
Appeal a claim?	https://files.selecthealth.cloud/api/public/content/provider_appeal_form.pdf
Find pharmacy resources?	https://selecthealth.org/providers/pharmacy
Access dental provider resources?	https://selecthealth.org/providers/dental
Access Select Health policies (medical, dental, coding/reimbursement)?	https://selecthealth.org/providers/policies
Learn about our secure provider tools (Provider Benefit Tool, CareAffiliate®)?	For the Provider Benefit Tool (check eligibility and claims status): https://selecthealth.org/providers/claims/provider-benefit-tool For CareAffiliate (submit and track online preauthorization requests): https://selecthealth.org/providers/preauthorization/careaffiliate/ca-training

Contact us when you can't find answers online. We're here to help, Monday through Friday, 8:00 a.m to 5:00 p.m. unless otherwise indicated below. Phone and email requests are answered in the order they are received.

When you need to:	Access:
Verify member benefits or get help with claims payment issues and information	The Provider Benefit Tool (see above) or Member Services: **800-538-5038** (available 7:00 a.m. to 8:00 p.m. on weekdays, 9:00 a.m. to 2:00 p.m. on Saturdays.)
Resolve issues with provider setup or directory listing	Provider Development: **800-538-5054**; **provider.development@selecthealth.org**
Get help with access to tools on our secure Provider Portal and online tools (Provider Benefit Tool, CareAffiliate)	Provider Web Services: **providerwebservices@selecthealth.org**
Resolve claims appeals/preauth issues	Compliance and Appeals: **844-208-9012**
Manage Electronic Funds Transfer (EFT)	EDI Department: **800-538-5099** (fax: **801-442-0372**); **edi@selecthealth.org**
Change passwords, reactivate accounts, resolve issues with 2-Step Authentication (PingID)	Account Help Desk: **801-442-7979, Option 2**
Request fee schedules (contracted providers only)	Provider Development: **SHFeeScheduleRequests@selecthealth.org**

Select Health