Provider Resource Guide

Revised: July 2026

The information in this guide should align with the terms of the agreement(s) between you and Promise Health Plan. However, in the event of any inconsistency between information contained in this guide and those agreement(s), the terms of such agreement(s) shall govern.

Promise Health Plan Network Provider:

Welcome to the **Promise Health Plan Provider Resource Guide**.

This guide serves as a comprehensive resource for providers participating in the Promise Health Plan network. Inside, you'll find information on provider support, claims and billing, member benefits, pre-certification requirements, provider accessibility, and other operational resources designed to support your practice.

Our goal is to provide you with the information and tools you need to deliver high-quality, efficient care to Promise Health Plan members while making it easy to do business with us.

Promise Health Plan, a Prisma Health company, was created to bring employers and health systems together to address today's healthcare challenges. Born in South Carolina, built for our communities, and supported by the inVio Health Network Clinically Integrated Network, Promise Health Plan offers employee health benefit solutions designed to improve health outcomes, reduce healthcare costs, and deliver an exceptional experience for members and providers alike.

The following pages provide quick access to key contacts, processes, policies, and resources to help you navigate working with Promise Health Plan. We encourage you to keep this guide readily available and refer to it whenever questions arise.

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Provider Portal

Accessing Your Provider Portal
Login to your provider portal with Promise Health Plan by either visiting the Providers section of our website at www.promisehealthplan.com/providers/ or by accessing it directly at www.myPromiseHealthPlan.com

Portal User Guide
For assistance in navigating the provider portal, our User Guide can be reviewed at www.promisehealthplan.com/providers/ by selecting it from the Provider Resources section or accessing it within your links section in the portal.

Portal Provider Services
Access the following provider services within your portal:
- View claims
- Check patient eligibility and benefits
- Submit pre-certification requests
- Contact Support
- And more

Claims & Eligibility

Accessing Plan Benefits
Information about member benefits is available through the following channels:

- Promise Health Plan Provider Portal at www.myPromiseHealthPlan.com
- Payer ID for Benefits and Eligibility: RP128

Verification of Benefits:
Online verification of benefits can be accessed through Electronic Data Interchange (EDI):

EDI can be used to:
- Verify member eligibility
- Obtain member ID number
- Obtain copay, and YTD deductible amounts
- Obtain Coordination of Benefits (COB) information

Payer ID for Benefits and Eligibility: RP128

Claims Submission and Timely Payment:

Please refer to the member's ID card and specific plan benefits information for appropriate submission details for confirmation.

For all claims associated with Promise Health Plan with the **Cigna Healthcare Shared Administration PPO Network** as the Tier 2 network, send all medical claims to the following address or use the following Payer ID for electronic submission:

Cigna
PO Box 188061
Chattanooga, TN 37422-8061

Payer ID for Claims Submission: 62308

For all claims associated with Promise Health Plan with the **First Health Complementary Network** as the Tier 2 network, send all medical claims to the following address or use the following Payer ID for electronic submission:

Promise Health Plan
P. O. Box 4278
Clinton, IA 52733-4278

Payer ID for Claims Submission: RP128

Claims must be submitted within twelve (12) months of the date of service. Non-electronic claims may be submitted on any approved claim form, available from the provider. The claim must be completed in full, with all the requested information. A complete claim must include the following:

- Name of patient
- Patient's date of birth
- Name of employee
- Address of employee
- Name of employer and group number
- Name, address and tax identification number of provider
- Employee Member Identification Number
- Date of service
- Diagnosis and diagnosis code
- Description of service and procedure number
- Charge for service
- The nature of the accident, injury or illness being treated.
- Sufficient documentation, in the sole determination of the Plan Administrator, to support the Medical Necessity of the treatment or service being provided to enable the Plan Supervisor to adjudicate the claim pursuant to the terms and conditions of the Plan.

CLAIMS WILL NOT BE DEEMED SUBMITTED UNTIL ALL REQUIRED INFORMATION IS RECEIVED.

Claims will be paid within 30 days from when all necessary information is received.

Provider Support

Promise Health Plan Provider Support is available from 8am-8pm EST, Monday through Friday. You can access support by either giving us a call at one of the numbers below or by accessing support via your portal at the link below. Please also refer to the member's ID card for appropriate support contact information as well.

Promise Health Plan's Provider Support: (855) 366-6660
(For Prisma Health Team Members)

Promise Health Plan's Provider Support: (855) 504-6363
(For Non-Prisma Health Team Members)

Promise Health Plan Portal: www.myPromiseHealthPlan.com

Promise Health Plan's Provider Support can help you:

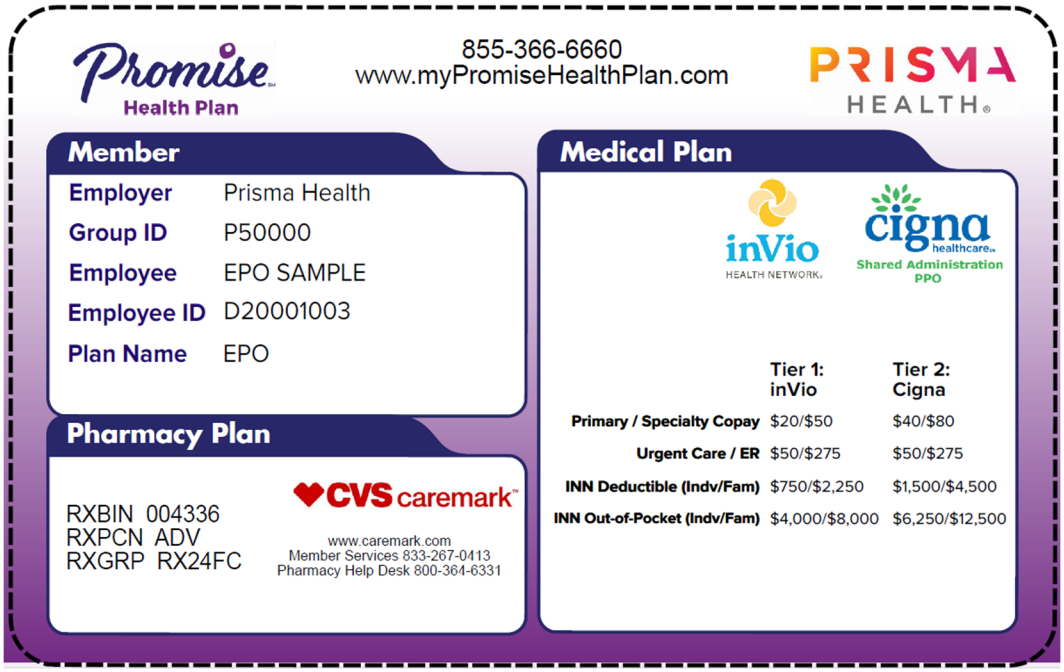
- Check claim status
- Submit an administrative appeal
- Get copies of EPPs
- Check a member's Deductible/Out-of-Pocket Maximum Accumulation Status

Promise Health Plan utilizes Luminare Health Benefits, Inc. for Third-Party Administration (TPA) services.

Sample Member ID Cards

Sample Member ID Cards for Prisma Health EPO Plan
Employer: Prisma Health

Front:



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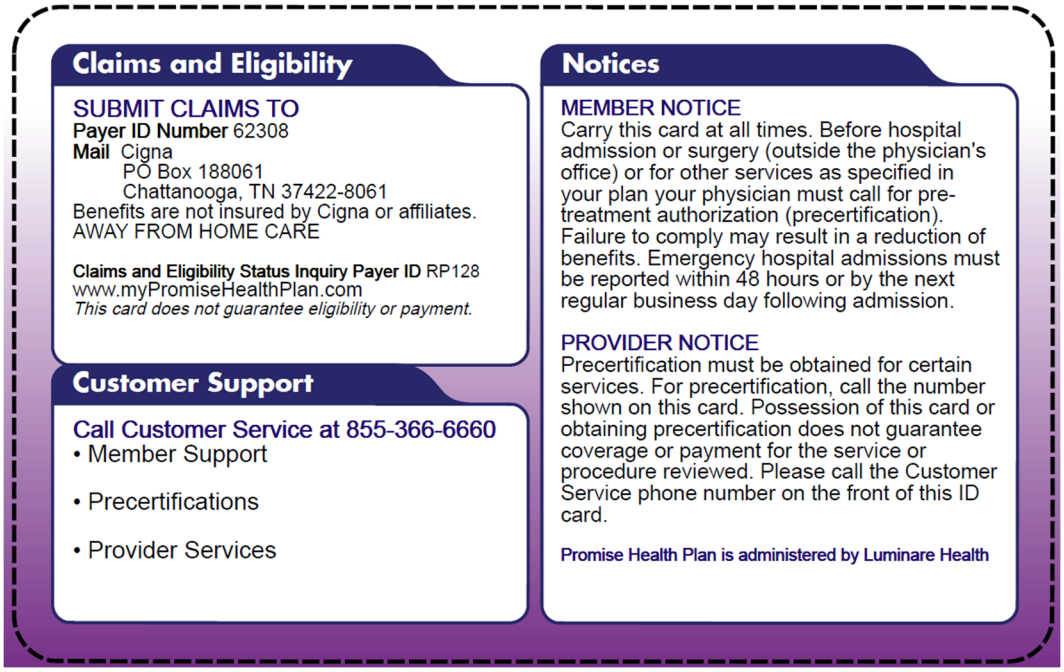
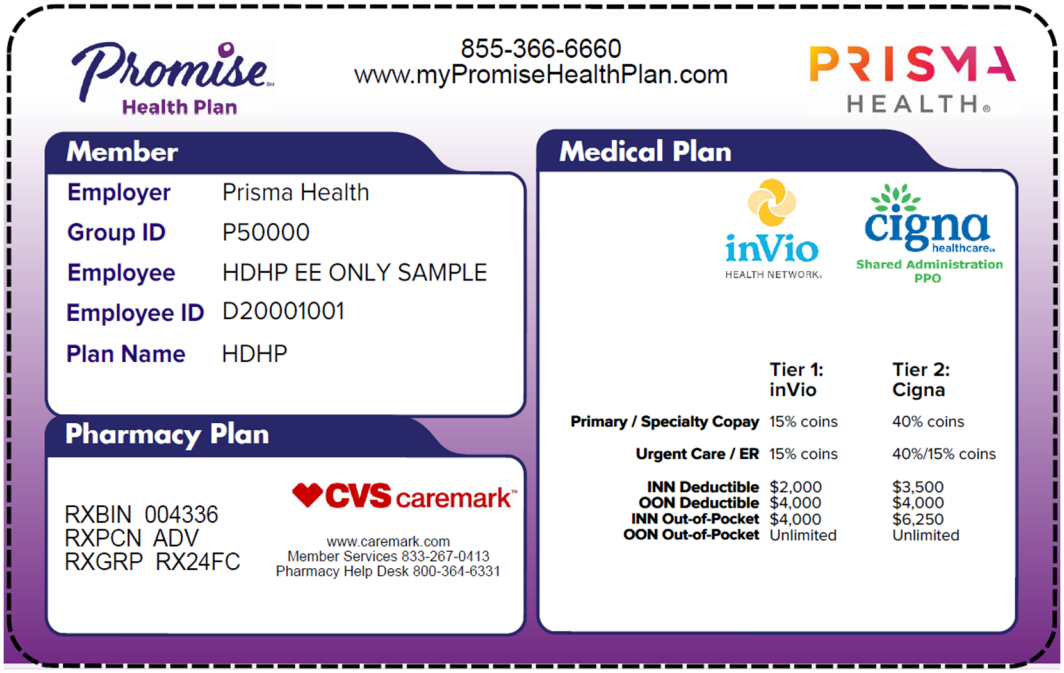


Sample Member ID Cards for Prisma Health HDHP Plan
Employer: Prisma Health

Front:



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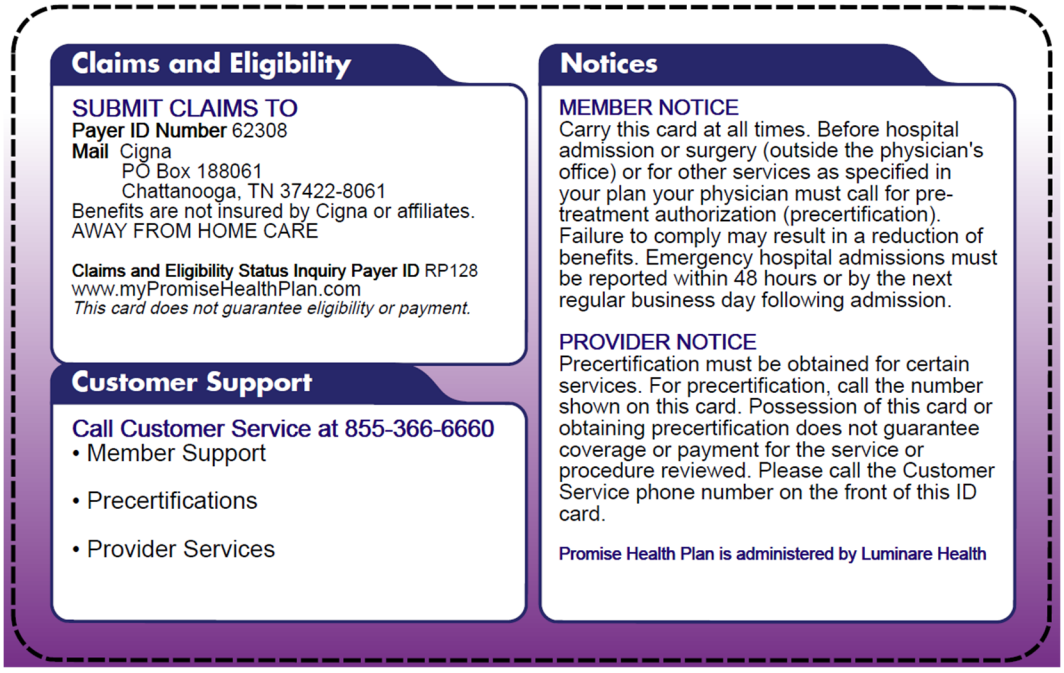
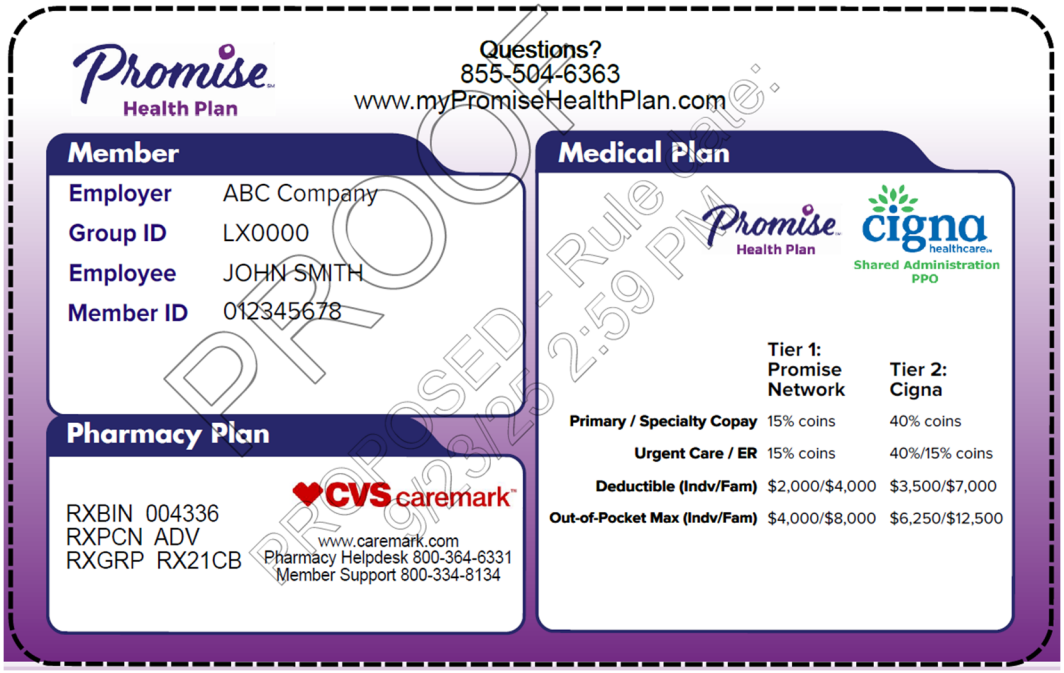


Sample Member ID Cards for Promise Health Plan with Cigna Healthcare Shared Administration PPO Network

Front:



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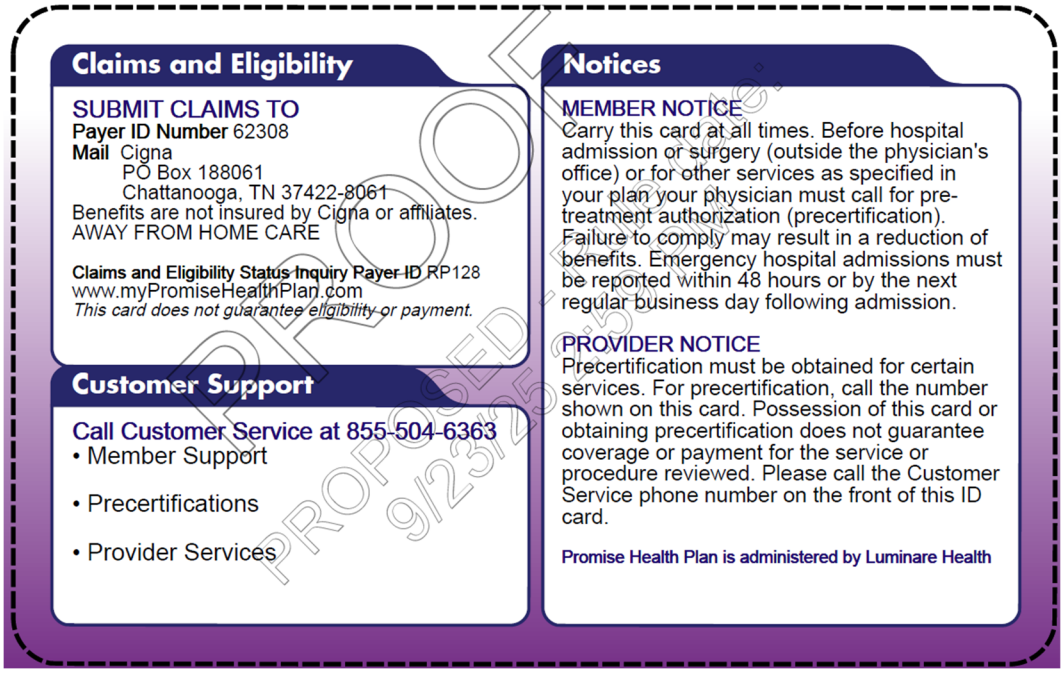

Pharmacy Support

Pharmacy Benefits Manager Details and Contact Information

Our members may have different pharmacy benefits managers based on their employer's selection. Please confirm the appropriate PBM on the member's ID card and review their ID card for group specific items as well.

CVS Caremark for Prisma Health Team Members

Rx BIN: 004336
Rx PCN: ADV
Rx GRP: RX24FC

Support Information

Method	Contact
Phone – Pharmacy Support	(800) 364-6331
Phone - Member Support	(833) 267-0413
Fax	(888) 836-0730
Website	www.caremark.com

CVS Caremark through RxBenefits for Non-Prisma Health Members

Rx BIN: 004336
Rx PCN: ADV
Rx GRP: RX2169

Support Information

Availability: M-F, 7am-7pm EST (Managed by RxBenefits)

Overflow & Weekends (Managed by CVS Caremark)

Method	Contact
Phone – Pharmacy Helpdesk	(800) 364-6331
Phone - Member Support	(800) 334-8134

Fax	(888) 836-0730
Website **Email:**	www.caremark.com CustomerCare@RxBenefits.com

Provider Directory

Accessing Provider Directory

Prisma Health Team Members:

The Promise Health Plan Prisma Team Member directory can be accessed by visiting www.promisehealthplan.com/prisma-health-team-members/ and selecting "Find a Provider". Tier 1 providers are identified within the provider listing.

Non-Prisma Health Members:

The Promise Health Plan Provider Directory can be accessed by visiting https://www.promisehealthplan.com/member-login/, navigate to the "Members" tab and select "Find a Provider". The directory identifies whether a provider is Tier 1 or Tier 2 using the Tier box on the right side of the provider card.

Pre-certification Process

Some inpatient admissions, outpatient services, and surgical procedures require pre-certification by Promise Health Plan before services are rendered.

Pre-certification, sometimes referred to as prior authorization or prior approval, helps ensure that services meet medical necessity and benefit requirements. Please refer to the Pre-certification List below to determine whether a service requires pre-certification.

Pre-certification requests may be submitted through the following channels:

Method	**Contact Information**
Phone Non-Prisma Health Team Members	(855) 504-6363
Phone Prisma Health Team Members	(855) 366-6660
Fax	(717) 295-1208

Services Requiring Pre-certification:

Promise Health Plan - Prisma Health Team Members

Note: Examples included in category descriptions are illustrative and not exhaustive. This list is subject to change without notice.

Inpatient Services Requiring Pre-certification

Pre-certification Category	Tier 1: Promise	Tier 2: Cigna
Inpatient Hospital / Acute Care (excluding observation)		X
Skilled Nursing Facilities		X
Rehabilitation Facilities		X
Long-Term Acute Care Facilities		X
Psychiatric Treatment Facilities / IP Mental Health and Substance Abuse		X
Chemical Dependency Treatment Facilities / Detox		X
Organ and Tissue Transplants (all settings)		X
Routine and High-Risk Maternity (routine only if inpatient stay exceeds federal requirements)		X

Outpatient Services Requiring Pre-certification

Pre-certification Category	Tier 1: Promise	Tier 2: Cigna
Spinal Procedures • Lumbar Laminectomy • Cervical Laminectomy		X

• Lumbar **Diskectomy/Foraminotomy/Laminotomy** • Cervical Diskectomy or Microdiscectomy • Cervical Fusion (Anterior) • Cervical Disk Arthroplasty • Vertebroplasty and Kyphoplasty • Lumbar Disk Arthroplasty • APLD – Low Back Pain		
Home Health Care / Home Infusion Therapy		X
Musculoskeletal and Pain Management (MSK)		X
Cosmetic Procedures • Reduction mammoplasty • Breast reconstruction following mastectomy • Blepharoplasty • Rhinoplasty • Septoplasty • Abdominoplasty • Panniculectomy	X	X
Cochlear Implants		X
DME with potential convenience/non-medical necessity concerns		X
Radiation Therapy • Brachytherapy • IMRT • Radiofrequency Ablation of Tumor • Radionuclide Therapy of Bone Metastases • Stereotactic Body Radiotherapy • Proton Beam		X
Bariatric Surgery		X
Genetic Testing / Molecular Lab • Breast Cancer genetic panels and BRCA testing • Prostate Cancer genetic and expression testing • Non-small Cell Lung Cancer genetic testing (ALK, EGFR, KRAS) • Melanoma genetic and expression profiling • Hereditary Colon Cancer gene panels		X
Interventional Vascular Surgery / Radiology • Percutaneous lower extremity revascularization	X	X

• Carotid artery angioplasty with stent • Iliac and femoral-popliteal interventions • Thoracic aortic EVR • Vertebral artery angioplasty ± stent • Sclerotherapy and ligation procedures • Saphenous vein stripping/ablation • Radiofrequency and laser procedures		
Diagnostic Radiology (MRI/MRA/PET Scans)		X
Injectable Medications (select IV/injectable drugs)		X
Oral Pharynx Procedures for Snoring/OSA	X	X
Potential Experimental / Investigational / Unproven Procedures		X
Unlisted Procedures (often codes ending in 99)		X

Promise Health Plan Direct to Employer with Cigna Network

Note: Examples included are illustrative and not exhaustive. This list is subject to change without notice.

Inpatient Services Requiring Pre-certification

Category / Examples	Tier 1: Promise	Tier 2: Cigna
Inpatient Hospital / Acute Care (excluding observation)	X	X
Skilled Nursing Facilities	X	X
Rehabilitation Facilities	X	X
Long-Term Acute Care Facilities	X	X
Psychiatric Treatment Facilities / IP Mental Health & Substance Abuse	X	X
Chemical Dependency Treatment Facilities / Detox	X	X
Organ and Tissue Transplants (including Gene/Cellular Therapy)	X	X
Routine and High-Risk Maternity		X

Outpatient Services Requiring Pre-certification

Category / Examples	Tier 1: Promise	Tier 2: Cigna
Partial Hospitalizations	X	
Home Health Care / Home Infusion Therapy	X	X
Outpatient Surgeries	X	X
Spinal Procedures • Lumbar & Cervical Laminectomy • Diskectomy / Foraminotomy / Laminotomy • Cervical Fusion • Cervical & Lumbar Disk Arthroplasty • Vertebroplasty & Kyphoplasty • APLD	X	X
Cosmetic Procedures • Reduction Mammoplasty • Breast Reconstruction • Blepharoplasty • Rhinoplasty • Septoplasty • Abdominoplasty • Panniculectomy	X	X
Joint Replacements (Knee, Hip)	X	X
Orthognathic Procedures • LeFort I, II, III	X	
Varicose Vein Procedures • Sclerotherapy, Ligation, Vein Stripping, Ablation, RF & Laser	X	
Cochlear Implants	X	X

Category / Examples	Tier 1: Promise	Tier 2: Cigna
DME over $2,500	X	
DME potentially not medically necessary / convenience items		X
Radiation Therapy • Brachytherapy • IMRT • Tumor Ablation • Radionuclide Therapy • SBRT • Proton Beam	X	X
Bariatric Surgery	X	X
Genetic Testing • Breast Cancer Panels / BRCA • Prostate Cancer Genetic Testing • Non-Small Cell Lung Cancer Testing	X	X

• Melanoma Testing • Hereditary Colon Cancer Panels		
Interventional Radiology • Lower Extremity Revascularization • Carotid Angioplasty with Stent • Iliac/Femoral-Popliteal Intervention • Thoracic Aortic EVR • Vertebral Artery Angioplasty	X	X
MRI / MRA / PET Scans (Not in ER)	X	X
Intensive Outpatient Treatment	X	
Outpatient Therapies (review after first 12 visits) • Physical Therapy • Occupational Therapy • Speech Therapy	X	
Injectable Medications (select IV/injectable drugs)		X
Oral Pharynx Procedures for Snoring / OSA		X
Potential Experimental / Investigational / Unproven Procedures		X
Unlisted Procedures (often codes ending in 99)		X

Initial Certification Requirements

When requesting pre-certification, please be prepared to provide the following information:

- Member name, address, phone number, and ID number as shown on the member ID card
- Patient name, address, and phone number (if different from the member)
- Admitting physician's name and phone number
- Name of the facility or home health agency
- Admission date or proposed admission date
- Diagnosis, condition, or reason for admission

Initial Certification Time Frames

Non-Urgent Requests

For non-urgent services, providers or authorized representatives should submit a pre-certification request at least **15 calendar days before services begin** or before continuation of services after Medicare benefits have been exhausted.

Urgent Requests

For urgent services, providers or authorized representatives must notify Promise Health Plan **within 48 hours of service initiation**, or by the **next business day**, whichever is later.

If no additional information is needed, Promise Health Plan will make a coverage determination within a reasonable period, but no later than **15 calendar days** after receiving the request.

Incomplete Requests

If Promise Health Plan receives a request that does not follow the required pre-certification process but includes at least:

- The member's name
- A specific medical condition or symptom
- A specific treatment, service, or product requiring pre-certification

Promise Health Plan will notify the provider or authorized representative of the procedural deficiency within **five calendar days**, either verbally or in writing upon request.

Requests for Additional Information

If additional time is needed because of circumstances beyond Promise Health Plan's control, notice will be provided within the initial **15-calendar-day review period**. The notice will explain:

- The reason for the delay
- The expected decision date
- Any additional information required to complete the review

If the delay is due to missing information, the notice will specifically identify the information needed. The provider or authorized representative will have **45 calendar days** to submit the requested information.

Once all requested information is received, Promise Health Plan will issue a determination within **15 calendar days**.

Failure to Provide Information

Failure to provide requested information completely and within the required time frame may result in denial of the certification request.

Certification Extension Time Frames

Requests to extend a previously approved hospitalization, skilled nursing facility stay, or ongoing course of treatment will be processed according to the following time frames.

Non-Urgent Extension Requests

Non-urgent extension requests will be processed within **15 calendar days** of receipt.

Urgent Extension Requests

If the request is received **at least 24 hours before** the approved hospitalization or course of treatment is scheduled to end, Promise Health Plan will:

- Make a determination as soon as possible, and
- Notify the provider no later than **24 hours** after receipt of the request.

If the request is received **less than 24 hours before** the approved hospitalization or course of treatment is scheduled to end, Promise Health Plan will:

- Make a determination, and
- Notify the provider no later than **72 hours** after receipt of the request.

Changes to an Approved Certification

If Promise Health Plan determines that an approved hospitalization, skilled nursing facility stay, or course of treatment should be shortened or terminated before the previously approved duration or number of treatments has been completed, we will:

- Notify the member and/or authorized representative of the proposed change
- Provide the opportunity to appeal the decision
- Issue an appeal decision before the end of the previously approved certification period

Certification Denials

If a certification or certification extension request is denied in whole or in part, Promise Health Plan will provide a written **Notice of Certification Denial** within the applicable time frames described above.

The notice will include:

- The specific reason(s) for the denial
- The plan provisions on which the denial is based
- If applicable, a description of any additional information needed to support certification and an explanation of why the information is necessary
- A description of the appeal process and applicable time limits
- If the denial is based on an internal rule, guideline, protocol, or similar criterion, either:
    - A copy of the criterion, or
    - A statement that the criterion was relied upon and will be provided free of charge upon request
- If the denial is based on custodial care, lack of medical necessity, experimental or investigational treatment, or a similar exclusion or limitation, either:
    - An explanation of the clinical or scientific basis for the decision as it applies to the member's circumstances, or
    - A statement that the explanation will be provided free of charge upon request
- A statement explaining the member's right to appeal the decision

Appeals and Disputes

- If you have questions about how a claim was processed or about a pre-certification denial, contact **Promise Health Plan Provider Support** using the information provided in the **Provider Support** section. Our team can explain the determination, answer questions, and help resolve issues when possible.
- In some cases, a claim or pre-certification decision may be reconsidered if additional information is submitted as requested by Promise Health Plan.

- If an issue cannot be resolved informally, providers have the right to appeal a claim or service denial by submitting an appeal to Promise Health Plan.
- Instructions for filing an appeal are available on the **Explanation of Provider Payment (EPP)**. You may also contact **Provider Support** for assistance with the appeals process.
- Appeal filing deadlines vary based on applicable state and federal requirements. Please refer to the EPP or contact Provider Support for information regarding the timeframe that applies to your appeal.

Care Management Programs

Promise Health Plan's Care Management team provides care coordination and case management services for eligible members, including those identified through:

- Utilization management reviews
- Discharge from a Promise Health Plan Network-affiliated inpatient facility
- Provider referrals, client, or self-referrals
- Existing care management programs and ongoing case management services

Promise members have access to **Integrated Care Management (ICM) Programs** through our Clinically Integrated Network.

Referring a Member to Care Management

Providers are encouraged to refer members who may benefit from care management services, including care coordination, care transitions support, and assistance managing complex health needs.

Referral instructions and forms are available on the Provider Resources page at:

https://www.promisehealthplan.com/providers/

For assistance with a referral, please contact Provider Support.

Care Management Program Details:

Integrated Care Model (ICM)

The Integrated Care Model (ICM) uses a multidisciplinary approach to coordinate care for members with complex healthcare needs. The ICM team may include:

- Nurse Care Managers
- Health Coaches
- Social Workers
- Pharmacists
- Behavioral Health Professionals
- Other clinical and support staff, as appropriate

Advanced data analytics support patient identification and risk stratification, helping to identify members with rising healthcare risks in real time. The risk assessment process incorporates multiple data sources, including electronic medical record data, to evaluate factors such as:

- Medical complexity
- Patient engagement and activation
- Social determinants of health
- Utilization patterns
- Other factors affecting overall health risk

Once a member is identified, the appropriate ICM team member is assigned to coordinate care and engage the multidisciplinary team as needed. The member's primary care provider is notified and remains central to the coordination of care.

The goal of the ICM program is to ensure members receive the right care at the right time while improving health outcomes and reducing unnecessary healthcare utilization and costs.

Complex Care Management

The Complex Care Management Program supports members with multiple chronic conditions, complex medical needs, or significant healthcare challenges.

Care Managers help members access needed services, coordinate care across providers and settings, and navigate the healthcare system to achieve their health goals and improve outcomes.

Complex Care Management is a collaborative process that includes:

- Assessment
- Care planning
- Care coordination

- Facilitation of services
- Monitoring and evaluation of outcomes

The program advocates for services and resources that address a member's comprehensive needs, including medical, behavioral, psychological, social, and, when appropriate, spiritual considerations. Support may also be extended to family members and caregivers.

Participation is voluntary. Members who are eligible for the program may choose to participate or opt out at any time.

The Care Transitions Program is a component of Complex Care Management and focuses on assessing and coordinating post-hospitalization needs for members who may be at risk for readmission.

Condition Management

Condition Management programs are available to eligible members diagnosed with one or more of the following conditions:

- Diabetes
- Congestive Heart Failure (CHF)
- Chronic Obstructive Pulmonary Disease (COPD)
- Asthma
- Hypertension
- Hyperlipidemia

The Condition Management Program uses a proactive, multidisciplinary, evidence-based approach to help members manage chronic conditions and improve overall health. Working in partnership with healthcare providers, the program supports self-management, helps prevent complications and exacerbations, and promotes improved quality of life.

Based on each member's individual health needs, the program identifies opportunities for intervention and develops personalized care strategies using targeted, evidence-based resources and communications.

Program objectives include:

- Promoting consistent, evidence-based management of targeted conditions
- Optimizing treatment and improving health outcomes
- Improving members' understanding of their conditions and treatment plans

- Increasing provider awareness and engagement with recommended treatment approaches
- Monitoring members' health status, including coexisting conditions and lifestyle factors
- Supporting early intervention when clinical indicators suggest increased risk
- Improving adherence to prescribed treatment regimens
- Reducing emergency department utilization
- Reducing avoidable inpatient admissions
- Delaying or reducing disease progression and complications

Case Management

Promise Health provides Case Management services that include assessment, planning, implementation, coordination, monitoring, and evaluation of healthcare services and resources.

These services are designed to support members in meeting their healthcare needs through effective communication, care coordination, and access to appropriate resources while promoting high-quality, cost-effective outcomes.