healthfirst®
Health Insurance for New Yorkers

Frequently Asked Questions

Healthfirst Leaf and Leaf Premier Plans

1. General Information: Affordable Care Act and NY State of Health

The Affordable Care Act (ACA) requires the establishment of competitive health insurance "Exchanges," or online marketplaces. These entities are intended to allow individuals and small businesses to more easily navigate the healthcare system and purchase affordable coverage.

The Official Health Plan Marketplace in New York State (the "Marketplace") is called NY State of Health (NYSOH). NY State of Health is a "one-stop shopping" option for consumers (both individuals and small businesses) to purchase health insurance. On NYSOH, consumers can select the health plan coverage that best suits their needs. They can calculate costs, compare health plan options, and determine if they are eligible for subsidies to offset premiums and cost-sharing, or for public programs such as Medicaid and Child Health Plus.

One of the primary goals of the ACA is to make the purchase of health insurance simpler and more transparent for consumers. For that reason, New York State has created a user-friendly web portal to help consumers select the health plan that is right for them and their families.

Consumers will input their demographic information and income to see the specific plans for which they qualify. NYSOH has also created a call center so that people without internet access can still get information and enroll.

For more information about federal healthcare reform and NY State of Health, visit **www.nystateofhealth.ny.gov**. You may also contact your Healthfirst Network Management Representative for a more in-depth presentation.

2. What types of Health Insurance Marketplaces are there in New York?

There are two types of marketplaces in New York:

- **Individual Health Marketplace** – for direct consumers (individuals and families)
- **SHOP Health Marketplace** – for small businesses (with 100 or fewer employees)

Both are under the umbrella of the organization called NY State of Health.

3. What are Healthfirst Leaf and Leaf Premier Plans?

Healthfirst Leaf and Leaf Premier Plans are Qualified Health Plans certified by NY State of Health's Marketplace.

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Healthfirst Leaf Plans provide essential health benefits, follow established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meet other requirements.

Healthfirst Leaf Premier Plans include the set of essential health benefits and also adult dental and vision care coverage. The copay or coinsurance paid for a dental or vision office visit is the same as that paid for an office visit with a primary care provider (PCP) and will apply after the deductible has been met. One vision exam and one standard pair of lenses & frames or contact lenses are covered every 12 months. Preventive and routine dental care is covered, including teeth polishing and dental exams every six months. Emergency dental care, major dental care, and orthodontia are also covered.

Both Healthfirst Leaf and Leaf Premier Plans:

- are offered at different metal levels (Platinum, Gold, Silver, and Bronze), depending on the proportion of healthcare costs that they will cover
- cover routine vision care/eyewear to children under the age of 19
- cover routine dental care to children under the age of 19

Healthfirst offers individual health plans for consumers (individuals and families).

Leaf Plans	**Leaf Premier Plans (Adult Vision & Dental)**	**Metal Coverage for Average Healthcare Consumer**
Healthfirst Platinum Leaf	Healthfirst Platinum Leaf Premier	Platinum covers 90% of healthcare costs
Healthfirst Gold Leaf	Healthfirst Gold Leaf Premier	Gold covers 80% of healthcare costs
Healthfirst Silver Leaf	Healthfirst Silver Leaf Premier	Silver covers 70% of healthcare costs
Healthfirst Bronze Leaf	Healthfirst Bronze Leaf Premier	Bronze covers 60% of healthcare costs
Healthfirst Green Leaf		Catastrophic coverage for individuals under 30 years of age

4. What are "essential health benefits" according to the Affordable Care Act (ACA)?

As defined in the ACA, essential health benefits include coverage for at least the following types of services:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness and chronic-disease management
- Pediatric services, including routine vision and dental care

5. Who is eligible for a Healthfirst Leaf Plan?

One can purchase a Healthfirst Leaf Plan as long as they:

- Live in New York State (Healthfirst offers Leaf Plans in NYC and on Long Island)
- Are between the ages of 18 and 64 (or older than 64 and not eligible for Medicare)
    - Although individuals under the age of 18 cannot purchase a Healthfirst Leaf Plan, they can be enrolled into one by an adult
- Are not eligible for government-sponsored public health insurance (i.e., Medicaid)
- Are citizens or legal residents

6. How can a patient interested in enrolling in a Healthfirst Leaf Plan get in contact with Healthfirst?

Potential Leaf Plan consumers can go to **www.joinhealthfirst.org** and fill out their contact information. Healthfirst will contact them to schedule an appointment and help them sign up for a health plan. Alternatively, consumers can call Healthfirst at 1-888-974-9901 to speak with a Healthfirst Representative or visit one of our **community locations**.

7. When can people enroll in Healthfirst Leaf and Leaf Premier Plans?

Open Enrollment for Healthfirst Leaf Plans on the NY State of Health website begins Nov. 1, 2017 and ends Jan. 31, 2018.

Individuals and families can enroll in or make changes to their health insurance outside of the annual Open Enrollment period if they have experienced a Qualifying Life Event (QLE), which includes special circumstances such as marriage, divorce, pregnancy, birth of a child, or loss of job.

Before each annual Open Enrollment Period, all current members will receive a notification from NY State of Health regarding their eligibility for renewal.

- If a member qualifies to stay on their current insurance plan, they may be automatically re-enrolled in their current plan without action from the member
- If a current member does not qualify for the same plan or the member wants to enroll in a different plan (e.g., switch to Healthfirst Leaf Premier Plan for dental and vision coverage), the member may enroll on the NY State of Health's website

8. Can a patient get help applying for insurance on NY State of Health's website?

Yes. Some people may not be able to navigate NY State of Health's website easily on their own; others may want in-person assistance while making this important and complex decision. In New York, organizations called 'Navigators' and individuals called 'Certified Application Counselors' (CACs) can assist people to enroll in a plan through NY State of Health. Navigators are entities funded by the State to provide in-person application assistance to individuals, families, and small businesses and their employees who wish to apply for health insurance through NY State of Health's website.

In addition, Healthfirst has extensively trained staff (called 'Facilitated Enrollers' and 'Retention Specialists') in place throughout New York City and on Long Island to assist patients in this process. For in-person assistance from a Facilitated Enroller or Retention Specialist, patients may visit a **Healthfirst Community Office**. For additional help, patients may reach out to Healthfirst directly:

- visit **www.joinhealthfirst.org**
- call Enrollment at **1-888-974-5809**, Monday to Friday, 9am–8pm
- call Member Services at **1-888-250-2220**, Monday to Friday, 8am–8pm

9. Is enrollment for Healthfirst Leaf Plans limited to NY State of Health's website?

Yes. Leaf Plans are available only on NY State of Health's website. For information on Healthfirst plans available off NY State of Health's website, please visit **www.healthfirst.org/health-insurance/healthfirst-2017-total-epo-plans** (Healthfirst Total EPO Plans for individuals and families) and **www.healthfirst.org/health-insurance/healthfirst-pro-and-pro-plus-plans** (Healthfirst Pro EPO and Pro Plus EPO Plans for small businesses with 1–100 eligible employees).

10. Under the Affordable Care Act, who is required to obtain health insurance?

Effective 2014, every United States citizen and legal resident is required to obtain health insurance (with very few exceptions). This is part of the "individual mandate." Those without insurance must pay a fee called the "individual shared responsibility payment." This fee is calculated two different

ways: (1) percentage of the household income, or (2) per person. The 2017 penalty will be the higher of the two calculations.

- Percentage of Income:
  - 2.5% of household income
  - Maximum: Total yearly premium for the national average price of a Bronze plan sold through the Marketplace
- Per Person:
  - $695 per adult
  - $347.50 per child under 18 years of age
  - Maximum: $2,085

11. Where can I find more information about NY State of Health's website?

For more information about NY State of Health and the ACA in New York, please visit NY State of Health's website at **nystateofhealth.ny.gov**. You can also reach out to a Healthfirst Network Management Representative for a more in-depth presentation.

12. Does the ACA affect my Medicaid and Child Health Plus (CHP) patients?

Yes. New Medicaid and Child Health Plus (CHP) members must enroll through NY State of Health's website. Current Medicaid and CHP members must recertify through the original format that they submitted when the initial application was created. For example, if a CHP member applied for coverage through a paper application, then the recertification must be done through paper as well.

13. Does the ACA affect my Medicare patients?

Most insurance-related reforms in the ACA will not affect Medicare patients. Medicare members are not required to enroll via NY State of Health's Marketplace.

14. If I can no longer see new patients (my panel is closed), will a Healthfirst Leaf Plan member be allowed to select me as his/her PCP?

If a PCP's panel is closed, new members will not be assigned to it. If the PCP has inquiries about their panel status, they may contact Healthfirst Provider Services at **1-888-801-1660**, Monday to Friday, 8:30am–5:30pm.

15. Is the provider network for Healthfirst Leaf Plans the same as for other Healthfirst Plans?

Healthfirst Leaf Premier and Leaf Plans offer an extensive provider network. Most of the providers and facilities within the Healthfirst Medicaid network are participating in the Healthfirst Leaf Premier and Leaf Plan network. Members must utilize in-network providers and hospitals, which can be sought through our online provider look-up tool at **www.HFdocfinder.org**.

16. If a member seeks out-of-network coverage, will he/she be covered under Healthfirst Leaf products?

Aside from emergency services, there is no out-of-network coverage for Healthfirst Leaf products.

17. What types of referrals do Healthfirst Leaf Plan members need?

Effective October 1, 2017, providers are no longer required to use the Change Healthcare (formerly known as Emdeon) portal to submit referrals for Healthfirst Leaf Plan or Healthfirst Small Group Plan members. This change includes in-network referrals from PCPs or OB/GYNs to other network specialists.

However, Leaf Plan members do not have out-of-network benefits except when emergency medical care is received.

Please visit our online provider directory at **www.HFDocFinder.org** to confirm provider participation status for Healthfirst Leaf Plans.

18. What types of preauthorizations do Healthfirst Leaf Plan members need?

Preauthorization requirements have been expanded for Healthfirst Leaf Premier and Leaf Plan members—more services require preauthorization under the Healthfirst Leaf Premier and Leaf Plans than under the Healthfirst Medicaid and Medicare plans. If you have any questions, please contact your Network Management Representative or Provider Services at **1-888-801-1660**.

19. How are pharmacy benefits under the Healthfirst Leaf Plans different than under other Healthfirst Plans?

Healthfirst is urging our members to take advantage of the cost savings provided by generic medications whenever possible. To that end, we also encourage physicians to prescribe generic equivalents when medically appropriate.

You may view the Healthfirst Leaf Plan Comprehensive Formulary at **www.healthfirst.org/formulary**.

Some medications require a prior authorization. Healthfirst may also require that some patients undergo step therapy when starting new medications. They will be asked to use generic equivalents or less-expensive medications first. If these prove to be ineffective, then the more expensive medications will be approved. A complete list of medications that are on the formulary, along with tier information, prior authorization, and step-therapy requirements, is available at **www.healthfirst.org/formulary**.

20. Do members have additional (non-preventive) free PCP visits for 2017?

In addition to free preventive care, members enrolled in Gold and Silver Leaf Premier plans have three free PCP "sick visits" before the deductible applies. In these cases, the members will have no cost sharing (copayments, coinsurance, or applicable deductible). Healthfirst will track number of visits used based on the claims received. Once a member exhausts the free visits, the system will automatically work to reapply the deductible/cost-sharing responsibility to the member's PCP office visits. The free visits apply only to the "PCP office visit" and not to other services such as laboratory and phlebotomy. Members will still be charged for those services. To confirm if a member has used their free PCP visits, a provider should check through eligibility or call Provider Services at **1-888-801-1660** if the member's ID card states "3 Free PCP Visits."

Members enrolled in the following plans have three free PCP visits before the deductible:

- Gold Leaf Premier
- Silver Leaf Premier
- Silver Leaf Premier CSR 200–250
- HMO B-VAD
- HMO C-VAD
- Green Leaf
- HMO E

21. What is a deductible?

A deductible is the out-of-pocket amount that members have to pay toward healthcare costs before insurance coverage begins.

22. What is a copayment?

A copayment is a set amount that is the member's responsibility for certain services. For example, copayments for a PCP visit range from $15 to $30, depending on the Healthfirst Leaf Plan.

- The Silver Leaf Plan has the highest copayment
- The Platinum Leaf Plan has the lowest copayment
- The Bronze Leaf Plan has no copayment. However, members are responsible for coinsurance when they visit a provider
- The Green Leaf Plan has no copayment because its deductible equals its "maximum out of pocket (MOOP)"

Please note: copayments cannot be collected until the member's deductible limit is met.

23. What is coinsurance?

Coinsurance is a percentage of agreed-upon costs that the member is responsible for:

- The Green Leaf Plan has no coinsurance because its deductible equals its MOOP
- The Bronze Leaf Plan is identified as a coinsurance plan. There are little to no copays for this plan. Once the member meets the plan's deductible, the member will pay a percentage already set per medical service performed, until MOOP is met. As of now, that percentage is set at 50
- The Green Leaf Plan has no coinsurance because its deductible equals its MOOP

Additional information on Healthfirst Leaf Plan deductibles, copayments, and coinsurance is available at **www.healthfirst.org/members/plan-materials/2017-leaf-plan-materials**.

24. What is the process for collecting deductibles and copayments?

FFS Providers: A member who has a deductible is required to pay out of pocket for medical expenses until their deductible is met.

While members are in their deductible phase, the provider's office is to collect the Qualified Health Plan (Healthfirst Leaf Plan) "contracted rate" from the member. When a member visits the provider and has not met their deductible, one of two things can happen: 1) the provider charges the member their contracted rate for the visit (this will occur if the provider knows what their specific contracted rate is for the services rendered to the member); or 2) the provider sees the member, bills Healthfirst for services, Healthfirst sends the Explanation of Payment (EOP) to the provider, and the provider then bills the member for their contracted rate. This continues until the member's deductible is met.

Once the deductible is met, the provider can start collecting copayments at each visit from members enrolled in the Platinum, Gold, or Silver Plans. For Bronze Leaf Plan members, providers will collect coinsurance, not a copay. Green Leaf Plan providers won't collect any fee because the plan's deductible equals its MOOP.

Capitated Providers: A member who has a deductible is required to pay out of pocket for medical expenses until their deductible is met.

When a provider is capitated, a similar process is followed. The provider will receive their monthly capitation payment for each member at the beginning of each month for the PCP services he/she renders. Considering a member has a deductible, Healthfirst needs to acknowledge that the member had services so that their deductible doesn't stay zero. While members are in their deductible phase, the capitated provider's office is to collect the Healthfirst (HF) Qualified Health Plan Standard Rate from the member. When a member visits the provider and has not met their deductible, the provider sees the member, bills Healthfirst for services, Healthfirst sends the EOP to the provider, and the provider then bills the member for their HF Standard Rate. This continues until the member's deductible is met.

Healthfirst will take the encounter data submitted by the provider during the member's deductible phase and add it to the member's maximum out of pocket, which will help the member meet their MOOP. Once the deductible is satisfied, the member will start paying copayments. Providers can collect copayments at the time services are rendered. In theory, it is like a double payment: Capitation + Negotiated Rates.

Once the deductible is met, the provider can start collecting copayments at each visit from members enrolled in Platinum, Gold, or Silver Leaf Plans. For Bronze Leaf Plan members, providers will collect coinsurance, not a copay. Though the doctor still gets capitation, Green Leaf Plan providers won't collect any fee, because the plan's deductible equals its MOOP.

Certain recommended preventive visits are not subject to a deductible or copay for any Healthfirst Leaf Plan.

Example: A member's deductible is $500 in a benefit year, with a coverage effective date of January:

1. On January 15, the member visits a PCP and gets an annual physical and a mammogram. In this case, the member's visit will be free of charge. The provider will be reimbursed at their contracted rate but CANNOT BILL THE MEMBER.
2. On February 1, the member gets the results and notification of any further testing that is needed. Because this new visit is not part of preventive care, the member will have to pay for any medical services performed until the $500 deductible is met. If this new visit costs $150, the member will be billed for this and will have a deductible balance of $350 for the rest of the year.

25. What is the Maximum Out of Pocket (or MOOP) cost?

This is the maximum amount that a member pays for healthcare during one year of coverage. MOOP consists of the following: Deductible + Copayment + Coinsurance = MOOP, which is the amount the member pays out of pocket. The MOOP ranges from $2,000 to $7,150, depending on the Healthfirst Leaf Plan. The Green Leaf Plan (catastrophic coverage up to age 30) has the highest MOOP; the Platinum Leaf Plan has the lowest.

Certain individuals who make between $16,349 and $29,700 (138%–249% of the FPL) and who purchase a Silver Leaf Plan will receive financial assistance to help reduce their MOOP:

- $16,349–$17,819 (138%–149% of the FPL): MOOP = $1,000
- $17,820–$23,760 (150%–199% of the FPL): MOOP = $2,350
- $23,760–$29,700 (200%–249% of the FPL): MOOP = $5,700
- Silver Leaf Plan MOOP with no assistance: $6,750

A family of four making between $33,534 and $60,750 (138%–249% of the FPL) and who purchase a Silver Leaf Plan will receive financial assistance to help reduce their MOOP:

- $33,534–$36,449 (138%–149% of the FPL): MOOP = $2,000
- $36,450–$48,600 (150%–199% of the FPL): MOOP = $4,700
- $48,600–$60,750 (200%–249% of the FPL): MOOP = $11,400
- Silver Leaf Plan MOOP with no assistance: $13,500

26. Will a member's deductible, MOOP status, and eligibility status be identified on the Healthfirst secure Provider Portal?

Yes, the member's deductible, MOOP status, and eligibility status will be available on the Healthfirst secure Provider Portal.

27. What is a 'grace period'?

Healthfirst Premier Leaf and Leaf Plan members who do not receive subsidies have a 30-day grace period to pay their premium, and members who receive subsidies have a 90-day grace period to pay their premium.

- Claims incurred by members in the first 30 days of a 90-day grace period will be paid
- Claims incurred by members in days 31–90 (for those members who have 90-day grace periods) will not be paid unless the member pays their premium by the end of the grace period

28. If a member has exceeded the grace period and has not paid their premium, can the member be billed?

Leaf Plan coverage remains active while the member is in a grace period. If a Leaf Plan member has exceeded their grace period and has not paid their premium, Healthfirst Leaf Plan coverage will be terminated effective 30 days after the beginning of his/her grace period. The member will no longer be covered by their respective Leaf Plan if they exceed their grace period without paying their plan premium.

29. What specific steps can my practice take to ensure proper billing of services?

We recommend your staff perform the following functions to ensure that patients are properly billed for services that they have received:

- Check member coverage effective dates
- Verify deductible status
- Verify MOOP status (Maximum Out-of-Pocket costs)
- Verify copayment amounts
- Collect copayment and coinsurance after the deductible is met

Coverage effective date, deductible, MOOP, and copayment amounts can all be verified by calling Provider Services at **1-888-801-1660**, by going to the provider portal at **www.healthfirst.org/providers**, or by looking at the member's ID card.

Additionally, it is important that all physicians in your practice be aware of which providers and hospitals are in the Healthfirst Leaf Plan network, and of which services and procedures require preauthorization. If you have any questions, please contact your Network Management Representative or Provider Services at **1-888-801-1660**.

30. How can preauthorizations be generated for Healthfirst Leaf Premier and Leaf Plan members?

Providers can call Utilization Management at **1-888-394-4327** to request authorizations as necessary per the new requirements for Leaf Plans. Alternatively, providers can submit requests for preauthorization using the secure Provider Portal, or by sending a fax.

31. What must I include in a preauthorization submission?

- Diagnosis code (if there is more than one diagnosis code, the primary diagnosis should be added:
  - Referrals are specific to the diagnoses listed in the request
  - **REMINDER**: ICD-10-CM coding was implemented industrywide as of October 1, 2015, to replace ICD-9-CM coding. All claims submitted with DOS on or after October 1, 2015, must include only ICD-10-CM codes. Claims submitted with combined ICD-9-CM and ICD-10-CM coding, and claims submitted without the appropriate code versions, will result in denials. More information on ICD-10 can be found at **www.healthfirst.org/ICD10**.
- Date of service range
- Unit amount(s)
- Procedure or service code
- Healthfirst Provider ID number
- Member ID number

32. How long are preauthorizations valid for from the date of approval?

Generally, you have three months to complete the preauthorized procedure. Please verify the specific amount of time to submit a claim based upon the date of service, network status on the date services were rendered, and member's health plan.

33. Where can I review past preauthorization determinations by the Healthfirst Medical Management team?

Please log into the secure Provider Portal to view past preauthorization determinations.

34. If I am not registered as a user of the Change Healthcare tools, how do I sign up for the Change Healthcare Provider Webconnect?

At the Login Screen:

- Enter your User ID and Password
- Click Login
- You will be directed to the Home Page
- If you do not yet have a User ID, click on **Enroll New Customer** and complete the preregistration process

35. What is the cost of using Change Healthcare Provider Webconnect?

There is no cost to the provider for registering or using the Change Healthcare Provider Webconnect. This tool is FREE for our Healthfirst providers. Healthfirst also pays the costs of any transaction done on behalf of a Healthfirst member using Provider Webconnect.

36. If I am registered as a current user of Change Healthcare Office, how do I use it for Healthfirst Leaf Plan referrals?

Effective October 1, 2017, providers are no longer required to use the Change Healthcare Office (formerly known as Emdeon) portal to submit referrals for Healthfirst Leaf Plan or Leaf Premier Plan members. This change includes in-network referrals from PCPs or OB/GYNs to other network specialists.

However, Leaf or Leaf Premier Plan members do not have out-of-network benefits except when emergency medical care is received.

Please visit our online provider directory at **www.HFDocFinder.org** to confirm provider participation status for Healthfirst Leaf Plans.

37. What is the cost of using Change Healthcare Office?

Change Healthcare Office is a software tool that can be installed on a provider's computer for a fee. The provider is responsible for the software installation cost and maintenance. Meanwhile, Healthfirst pays for any transaction done on behalf of a Healthfirst member using Office. To find out more information on the cost of Change Healthcare Office, you may call Change Healthcare at **1-877-667-1512**.

38. If I need assistance with Change Healthcare Provider Webconnect, who can I call for technical help?

You may call the Change Healthcare help desk at **1-877-667-1512**.

39. If I am locked out of my Change Healthcare system (Office or Webconnect), how can I get my password reset?

You may call the Change Healthcare help desk at **1-877-667-1512**.

40. Can I use Change Healthcare Office or Provider Webconnect to check a member's eligibility?

You can use the eligibility function to check a member's eligibility. It will confirm whether the member is eligible as of a certain date. Both the Provider Webconnect and Change Healthcare Office can be used for the eligibility check. We recommend use of the Healthfirst Provider Portal for all eligibility verifications.

41. Where else can I get member eligibility and benefit information?

A member's eligibility and benefit information can be reviewed and printed from the Provider Inquiries tab of the Healthfirst secure Provider Portal at **www.healthfirst.org/providers**.

You can also call Healthfirst Provider Services at **1-888-801-1660**, Monday through Friday, 8:30am–5:30pm.

42. How do I find a participating Healthfirst Leaf or Leaf Premier Plan specialist?

In the Change Healthcare Provider Webconnect page, click on the link to the Healthfirst online Provider Directory in the upper right hand of the screen. You may look up their ID number in the Healthfirst online Provider Directory at **www.HFdocfinder.org**.

43. Is it the PCP's responsibility to create referrals for members to delegated vendors such as chiropractors, dentists, and opticians?

Delegated vendor preauthorization rules apply for the following services:

- *Chiropractors (ASH)
- *Pharmacy/Specialty Pharmacy (CVS Caremark)
- *Opticians (Davis Vision)
- *Prior authorization for surgical procedures of the eye (Superior Vision)
- *Prior authorization for Radiology (eviCore)
- *Dentists (DentaQuest)
- *PT/OT/ST (OrthoNet)
- *Pain Management/Spinal Surgery/Foot Surgery (OrthoNet)

Authorizations for services or procedures by delegated vendors must be made through the delegated vendors following their referral policies and procedures.

44. Is a preauthorization a guarantee of payment?

Authorizations are not a guarantee of payment, and any claim is subject to the deductible, copays, and coinsurance under the terms of the member's Healthfirst Leaf Plan. The member must be eligible as of the date of service for a claim to be considered payable by Healthfirst. Please call Provider Services at **1-888-801-1660** for any questions about the status of a member's enrollment or about grace periods.

45. Who can providers contact with general questions about preauthorizations?

Providers can contact their Healthfirst Network Management Representative or call Provider Services at **1-888-801-1660**, Monday to Friday, 8:30am–5:30pm, with any questions.

46. Is there a limit to how many people can "enroll as a new user" on Change Healthcare for a specific TIN?

No.

47. Is the Change Healthcare username/login for Healthfirst the same as the one a provider uses for other plans using the Change Healthcare systems?

Yes.

48. What resources are available?

Healthfirst Provider Website	Provider Alerts	www.healthfirst.org/alerts
	Claims & Billing	www.healthfirst.org/providers/claims-billing
	ICD-10 Tools & Information	www.healthfirst.org/icd10
	Provider Forms	www.healthfirst.org/providerforms
	Provider Newsletter, The Source	www.HFNYSource.org
Healthfirst Provider Portal	• Verify Member Eligibility • View Member Cost Sharing • Look Up Authorization • View Claims Status and Detail	www.healthfirst.org/providers
Provider Services	• All Provider Inquiries • Eligibility Inquiries • Claims Inquiries	**1-888-801-1660**
Utilization Management	Authorizations	**1-888-394-4327**

Ancillary Authorizations

CVS Caremark	Formulary Medications	**1-855-582-2022**
	Specialty Pharmacy	**1-866-814-5506**
Davis Vision	Routine Vision Care/Eyewear	**1-800-773-2847**
Superior Vision	Surgical Procedures of the Eye	**1-888-273-2121**
DentaQuest	Routine Dental Care	**1-855-343-4267**
eviCore	Radiology	**1-877-773-6964**
Orthonet	PT, OT, ST	**1-844-641-5629**
	Pain Management, Spinal Surgery, Podiatry	**1-844-504-8091**