NONCONTRACTED PROVIDERS

Ohio provider manual

Effective date December 1, 2023

sidecar health®

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Introduction

Sidecar Health is an Ohio-based major medical health insurer. Our no-network plans means our members can see any provider they choose and receive the same benefits. This manual will provide billing instructions when providing care to your patients with Sidecar Health.

Working with a no-network model

Providing an itemized pre-bill/good faith estimate

Our non-network plans provide a specified Benefit Amount for each procedure. Your Sidecar Health patient was free to see any provider they wished, and they chose you. To help your Sidecar Health patient have the best experience possible, please provide them with an itemized good faith estimate of expected care. Your Sidecar Health patient will use this estimate to lookup their expected benefits and plan their care accordingly. Here's what should be included in a good-faith estimate:

- Patient's full name
- Provider's name, address, and NPI
- Expected date(s) of service
- Itemized expected procedure codes (CPT/HCPCS) with estimated charge amounts
- Diagnosis codes (ICD-10)

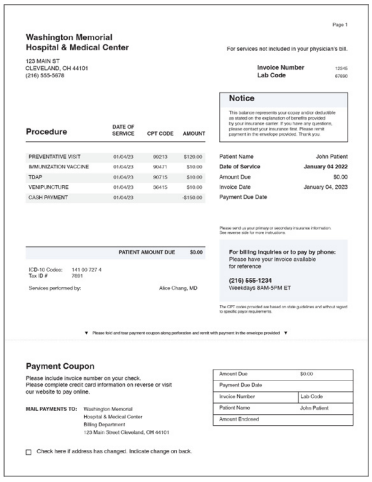
Verifying benefits

Sidecar Health does not require prior authorizations. For most non-emergency services, you will bill your Sidecar Health patient directly, in which case it is your patient's responsibility to know and verify their benefits prior to receiving care. For emergency services, or for Sidecar Health patients who need to coordinate benefits with other payers, you can bill us directly. You may verify your Sidecar Health patient's benefits by calling Member Care at (877) 653-6440.

When to bill your Sidecar Health patient directly

For most non-emergency services, you will not need to submit a claim to Sidecar Health. Instead, your Sidecar Health patient will pay at the point of service and receive reimbursement from us later. All you need to do is bill your Sidecar Health patient your cash price for the requested service. You will not need to worry about copays, coinsurance, or deductibles.

If you do not charge your Sidecar Health patient at the point of service, you must invoice them directly for services rendered. If you bill Sidecar Health directly (except where described in the “WHEN TO SUBMIT A CLAIM TO SIDECAR HEALTH” section), we will reject the claim.



Washington Memorial
Hospital & Medical Center

123 MAIN ST
CLEVELAND, OH 44101
(216) 555-5678

For services not included in your physician's bill.

Invoice Number
Lab Code

Notice

Procedure	DATE OF SERVICE	CPT CODE	AMOUNT
PREVENTATIVE VISIT	01/04/23	99213	$120.00
IMMUNIZATION VACCINE	01/04/23	90471	$10.00
TDAP	01/04/23	90715	$10.00
VENIPUNCTURE	01/04/23	36415	$10.00
CASH PAYMENT	01/04/23		-$150.00

Patient Name John Patient
Date of Service January 04 2022
Amount Due $0.00
Invoice Date January 04, 2023
Payment Due Date

PATIENT AMOUNT DUE $0.00

For billing inquiries or to pay by phone:
Please have your invoice available
for reference

(216) 555-1234
Weekdays 8AM-5PM ET

ICD-10 Codes: 141.90 727.4
Tax ID #: 7891

Services performed by: Alice Chang, MD

Payment Coupon

Please include invoice number on your check.
Please complete credit card information on reverse or visit
our website to pay online.

MAIL PAYMENTS TO: Washington Memorial
Hospital & Medical Center
Billing Department
123 Main Street Cleveland, OH 44101

Amount Due $0.00
Payment Due Date
Invoice Number Lab Code
Patient Name John Patient
Amount Enclosed

Check here if address has changed. Indicate change on back.

Itemized medical invoices

Your Sidecar Health patient must submit an itemized invoice to us to receive their health insurance benefits. Please ensure your Sidecar Health patient is provided with an itemized medical invoice (superbill) for their visit, or ensure they have the contact information for the billing office that can provide them with such superbill.

An example of an itemized bill appears on the left.

When to submit a claim to Sidecar Health

You should bill Sidecar Health directly for emergency services or when your Sidecar Health patient needs to coordinate benefits with another payer.

Emergency services claims

When rendering emergency services to your Sidecar Health patient, ask to see their digital member ID card for instructions on how to bill Sidecar Health directly.

Emergency services are **(a)** an appropriate medical screening examination that is within the capability of the emergency department of a hospital or an independent freestanding emergency department, including ancillary services routinely available to the emergency department, to evaluate whether an emergency medical condition exists; and **(b)** such further medical examination and treatment as may be required to stabilize your Sidecar Health patient (regardless of the department of the hospital in which the further medical examination and treatment is furnished) within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department.

Do not balance bill/charge the Sidecar Health patient for emergency services. Ohio's House Bill 388 and the Federal No Surprises Act establish patient protections which prohibit out-of-network providers from surprise billing ("balance billing") patients for emergency care and other specified items or services.

Coordination of benefits

Sidecar Health coordinates payment for covered services with other payers. If your Sidecar Health patient indicates they have two or more insurance coverages, ask to see their digital member ID card for instructions on how to bill Sidecar Health directly. Where Sidecar Health is secondary, you must bill the primary payer before you submit any claim to Sidecar Health. Any balance due after receipt of payment from the primary payer should be submitted to Sidecar Health for consideration and the claim must include information verifying the payment amount received from the primary plan.

Claims submission instructions

Sidecar Health requires providers to use the CMS-1500 Form for all professional services and the UB-04 Form for facility services. Claims can be submitted to us by mail at:

Sidecar Health Insurance Solutions, LLC
440 N Barranca Avenue, Suite 7028
Covina, CA 91723
Attention: Claims Department

Claims for emergency services can also be sent to the NSA fax number of (866) 376-2053 or by email at nsa@sidecarhealth.com.

Timely filing of claims

We must receive notice of a claim within thirty (30) days from the date of service or as soon as reasonably possible. Claims are not fully adjudicated by Sidecar Health until care has been received and a claim has been submitted to us. All benefit determinations, including Adverse Benefit Determinations, are therefore made retrospectively.

Incomplete claims

Sidecar Health will pay claims within 30 days of receipt. If a claim is missing critical information such as invalid CPT Codes, NPI, date(s) of services, etc. it will be rejected and returned for correction before the end of the first 30-day period, together with a notice explaining the additional information needed. You will have 45 days to supply the missing information. If we receive the requested information we will notify you of our decision 45 days after we have received your claim, not counting the days between when we notified you of the information needed to make our decision and the date we received the information.

Correction of claims

When you submit an incorrect or incomplete claim, you must re-submit an updated claim to correct the initial submission. Claims that are corrected must follow the same procedures as timely filing for the initial submission listed above, which is thirty (30) days from the date(s) of service.

Overpayments

If a claim has been overpaid or paid in error, we have the right to recover the amount overpaid or paid in error by any of the following methods:

1. A request for lump sum payment of the amount overpaid or paid in error; or

2. Reduction of any proceeds payable under this Plan by the amount overpaid or paid in error.

When we notice an overpaid claim, Sidecar Health will begin the process to collect the overpayment. A refund request will be sent to the provider in the form of an invoice. The provider must pay the invoice within thirty (30) days of the invoice date. During the thirty (30) day period, the provider can pay the invoice by check, appeal the overpayment adjustment, or allow the invoice due date expire. If the invoice due date expires without an appeal or payment, Sidecar Health will offset the balance amount against future payments.

Denial of claims

Any denials for non-coverage of service(s) will be based on the terms of your Sidecar Health patient's health plan. If a claim is denied, Sidecar Health will provide an Explanation of Benefits (EOB), which will outline the reason for denials and an explanation of appeal rights.

Balance billing

The benefits we pay are fixed and may be less than a provider's charge. For non-emergency services, you may balance bill your Sidecar Health patient for uncovered amounts. We cannot prohibit a provider from billing the difference between the provider's charge for a covered service and the applicable Benefit Amount.

Additional information requests

When a claim is undergoing the determination process, Sidecar Health may request additional information from the provider, such as medical records, acquisition invoices, and itemized medical invoices to determine whether the services from the submitted claim should be reimbursed.

Appeals & claim payment disputes

You may appeal a denied claim in writing, either by mail or by fax, to:

Fax Number:	(866) 376-2053
Email Address:	grievances@sidecarhealth.com
Mailing Address:	Attn: Grievances, 440 N Barranca Avenue #7028, Covina, CA 91723

Please include in your written appeal or be prepared to tell us the following information:

- Name, address, and telephone number of the insured person
- The insured's health plan identification number
- Name of health care provider, address, and telephone number
- Date the health care benefit was provided
- Name, address, and telephone number of an authorized representative (if appeal is filed by a person other than the insured)
- A copy of the notice of Adverse Benefit Determination

When you request an appeal, we will review our decision and provide you with a written determination. If we continue to deny the payment, coverage or service requested or you do not receive a decision within 30 days, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision.

External review

Under certain circumstances, you have a right to request an external review of our adverse benefit decision by an independent review organization or by the superintendent of insurance, or both. If you have filed internal claims and appeals according with the procedures of this manual, and we have denied or refused to change our decision, or if we have failed to provide you with a final determination of your appeal within the time permitted, or if we waive, in writing, the requirement to exhaust the internal claims and appeals procedures, you may make a request for an external review of an Adverse Benefit Determination.

All requests for an external review must be made within 180 days of the date of the notice of our final Adverse Benefit Determination. Requests for an external review must be provided in writing. As all Adverse Benefit Determinations are made after receipt of the healthcare service or services in question, no expedited external review is available.

Request for an external review

We will initiate an external review within 5 days after it receives your written request if your request is complete. We will provide you with notice that it has initiated the external review that includes:

1. The name and contact information for the assigned independent review organization or the superintendent of insurance, as applicable, for the purpose of submitting additional information; and

2. A statement that you may, with 10 business days after the date of receipt of the notice, submit, in writing, additional information for either the independent review organization or the superintendent of insurance to consider when conducting the external review.

If your request is not complete, we will notify you in writing and include information about what is needed to make the request complete.

If we deny your request for an external review on the basis that the Adverse Benefit Determination is not eligible for an external review, we will notify you, in writing, the reasons for the denial and that you have a right to appeal the decision to the superintendent of insurance.

If we deny your request for an external review because you have failed to exhaust the Internal Claims and Appeals Procedure, you may request a written explanation, which we will provide to you within 10 days of receipt of your request, explaining the specific reasons for its assertion that you were not eligible for an external review because you did not comply with the required procedures.

Request for External Review to Superintendent of Insurance. If we deny your request for an external review, you may file a request for the superintendent of insurance to review our decision by contacting Consumer Services Division at (800) 686-1526 between 8:00 a.m. and 5:00 p.m., Eastern Standard Time or by sending a written request addressed to: Consumer Services, The Ohio Department of Insurance, 50 West Town Street, Suite 300, Columbus, Ohio 43215. Information about external reviews is also available on the Department's website: insurance.ohio.gov.

If superintendent upholds our decision. If you file a request for an external review with the superintendent, and if the superintendent upholds our decision to deny the external review because you did not follow our internal claims and appeals procedures, you must resubmit your appeal according to our internal claims and appeals procedures within 10 days of the date of your receipt of the superintendent's decision. The clock will begin running on all the required time periods described in the internal claims and appeals procedures when you receive this notice from the superintendent.

If our failure to comply with its obligations under the internal claims and appeals procedures was considered (i) de minimis, (ii) not likely to cause prejudice or harm to you (claimant), (iii) because we had a good reason or our failure was caused by matters beyond our control (iv) in the context of an ongoing good faith exchange of information between we and you (claimant) or your Authorized Representative and (v) not part of a pattern or practice of our not following the internal claims and appeals procedures, then you will not be deemed to have exhausted the internal claims and appeals requirements. You may request an explanation of the basis for our asserting that its actions meet this standard.

Independent Review Organization. An external review is conducted by an independent review organization (IRO) selected on a random basis as determined in accordance with Ohio law. The IRO will provide you with a written notice of its decision to either uphold or reverse our Adverse Benefit Determination within 30 days of receipt of a standard external review (not urgent). The IRO's decision is binding on the company. If the IRO reverses the health benefit plan's decision, we will immediately provide coverage for the healthcare service or services in question.

If the superintendent or IRO requires additional information from you or your healthcare provider, we will tell you what is needed to make the request complete.

If we reverse our decision. If we decide to reverse its adverse determination before or during the external review, we will notify you, the IRO, and the superintendent of insurance within one business day of the decision.

Review by the superintendent of insurance. If we have made an Adverse Benefit Determination based on a plan issue (e.g., whether a service or services are covered under your Certificate), you may request an external review by the superintendent of insurance.

If the IRO and Superintendent upholds our decision, you may have a right to file a lawsuit in any court having jurisdiction.

Have questions?

Provider services phone:	(866) 441-9993
Provider services email:	provider@sidecarhealth.com
Provider website:	sidecarhealth.com/providers