NAVINET BASICS

Provider User Guide

August 2026

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OVERVIEW

The purpose of this User Guide is to demonstrate how to access and navigate through the NaviNet portal in order to help you access and navigate NaviNet and all its features.

Learning Objectives

In this guide, you will learn to do the following:

1. Log in to NaviNet
2. Password Resets
3. Access provider's specific Health Plan
4. How to use NaviNet Support
5. How to use the plan specific Workflows:
    - Benefits and Eligibility Inquiry
    - Claims Status Inquiry
    - Claims Submission
    - Report Inquiry
    - Provider Directory
    - Pre-Authorization Management
    - Forms and Dashboards

IMPORTANT NOTE

While this guide will focus on the NaviNet functions/workflows used by AmeriHealth Caritas Family of Companies, NaviNet has a very informative website to assist providers. The Support section on the NaviNet website provides additional user guides and video tutorials, as outlined in the NaviNet Support section of this guide.

AmeriHealth Caritas is not responsible for maintaining or updating the NaviNet site; and this guide may not necessarily reflect the most current updates to the NaviNet site.

Not all the functionalities represented in this user guide are supported for all health plans.

PROVIDER REGISTRATION

Through NaviNet, you can access and submit:

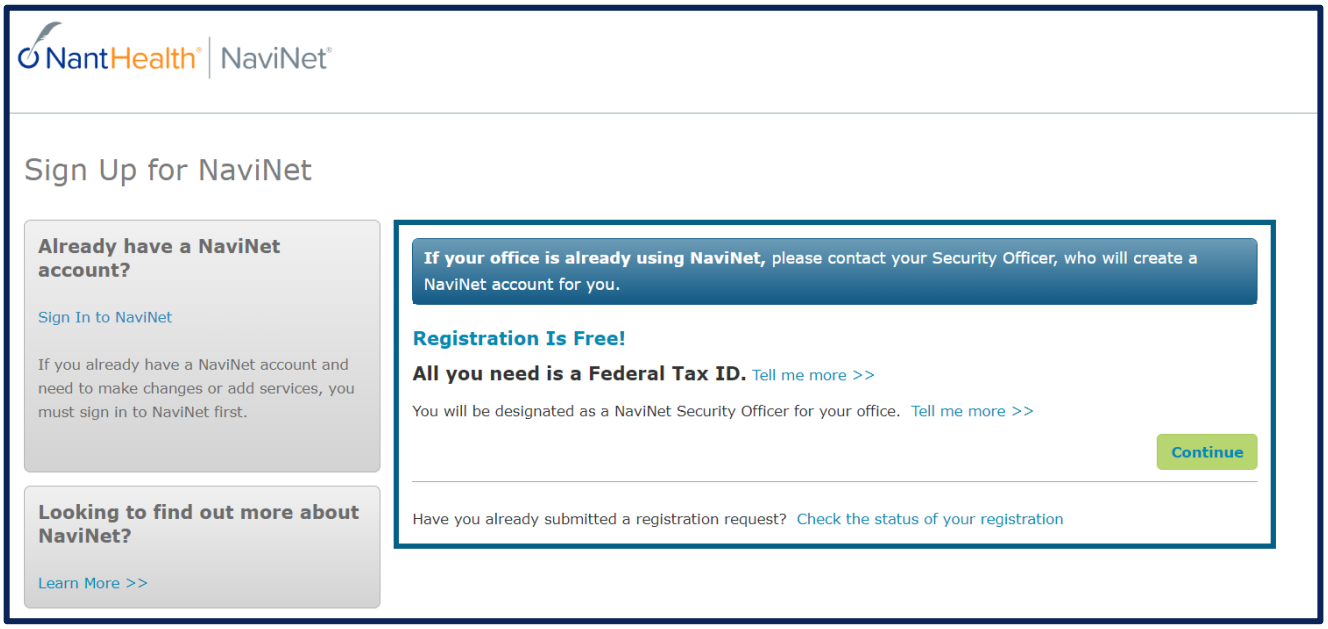
- Prior authorizations
- Real-time clinical Healthcare Effectiveness Data and Information Set (HEDIS) alerts
- Claims information and updates
- Member eligibility information
- Benefits information
- Drug authorizations

NaviNet allows you and health plans to share administrative, financial, and clinical data in one place.

If you haven't signed up for NaviNet yet, be sure to register at https://register.navinet.net.

What you need to know:

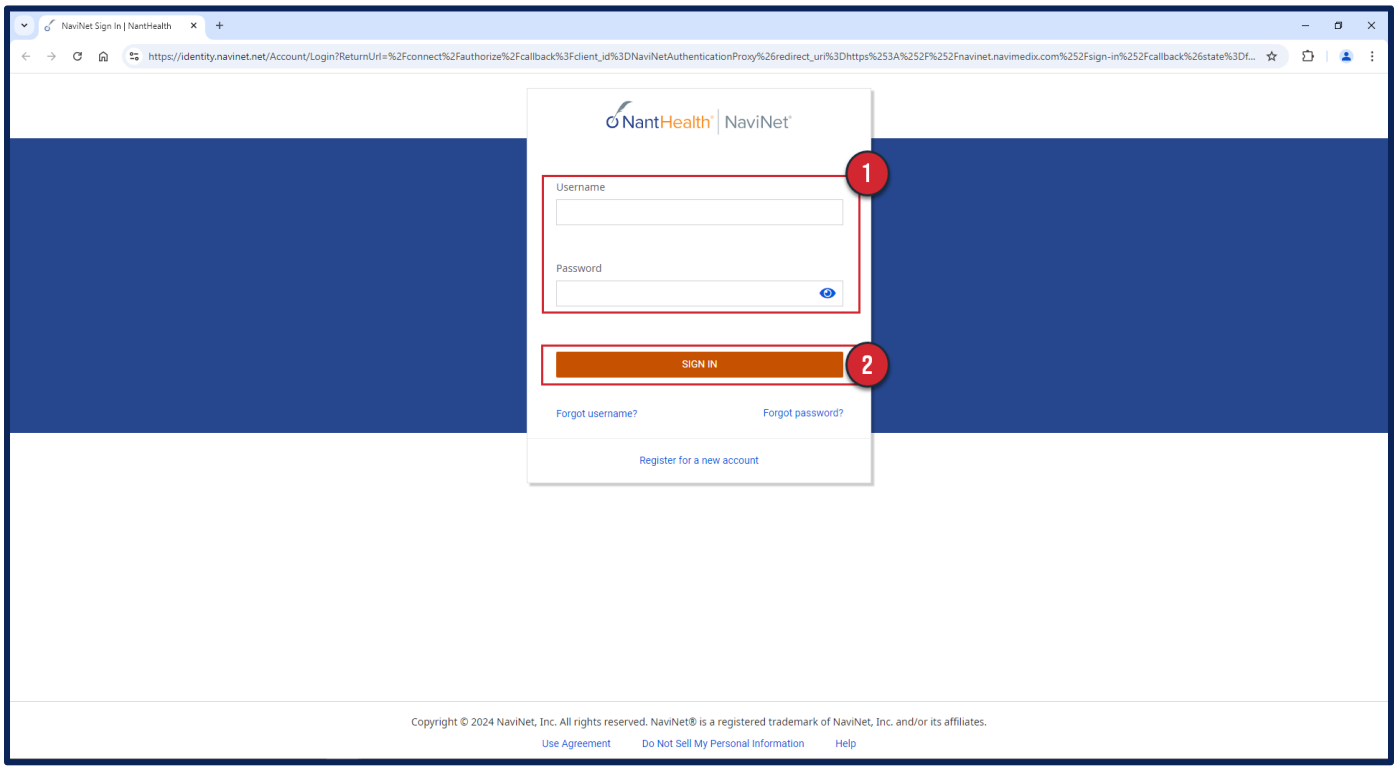
NaviNet is an easy-to-use, no-cost, secure web-based platform that links you to your health plans. NaviNet helps speed up the provider-health plan connection and can often replace paper transactions.



To login to NaviNet:

You can access NaviNet directly from your internet browser using the following link: https://navinet.navimedix.com.

1. Enter your username and password.
2. Click Sign in.

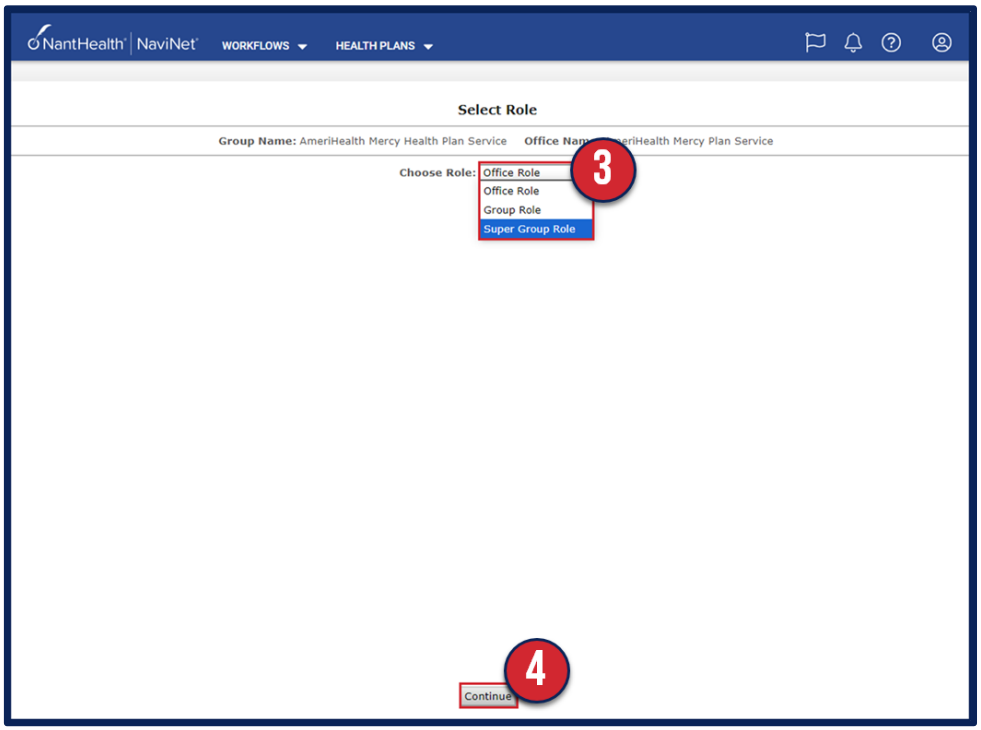


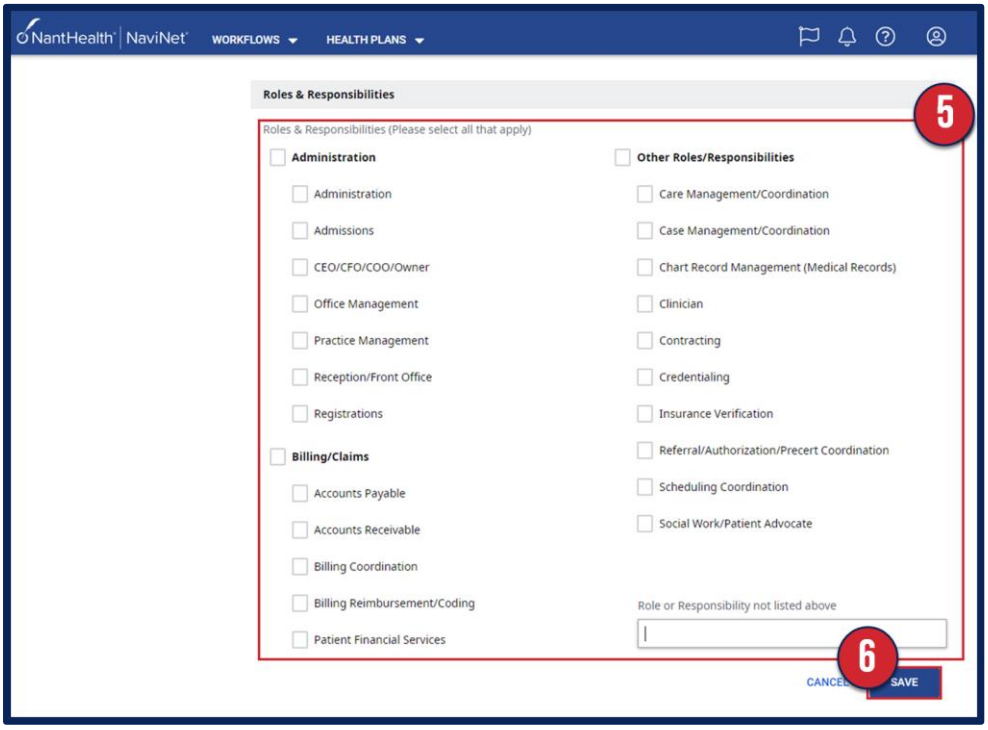
ACCESSING NAVINET CONT'D.

Role

Once you are logged in, you are placed into your 'profile' and will have access to member and claim information specific to the practice.

3. Select the appropriate role from the drop-down
4. Click Continue





Roles and Responsibilities

Once you open your profile, you will be taken to the verification page, where you can identify your roles and responsibilities.

5. Check the values that best match your roles or responsibilities at your office.
6. Click Save

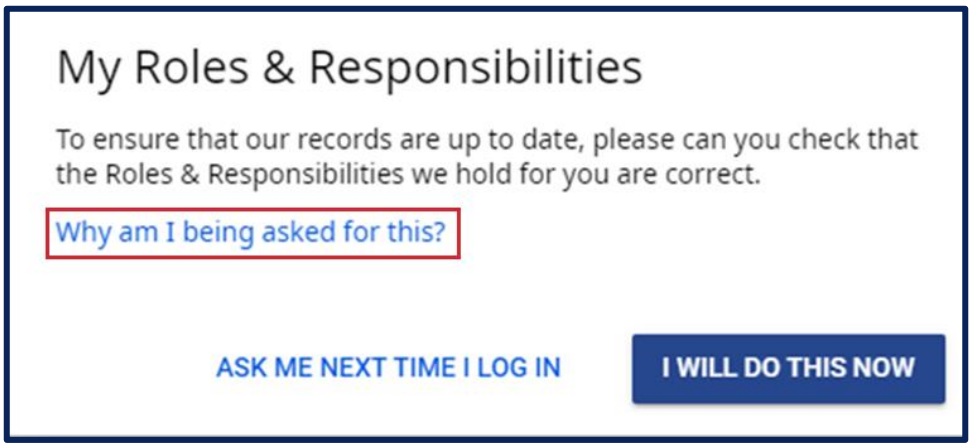
ACCESSING NAVINET CONT'D.

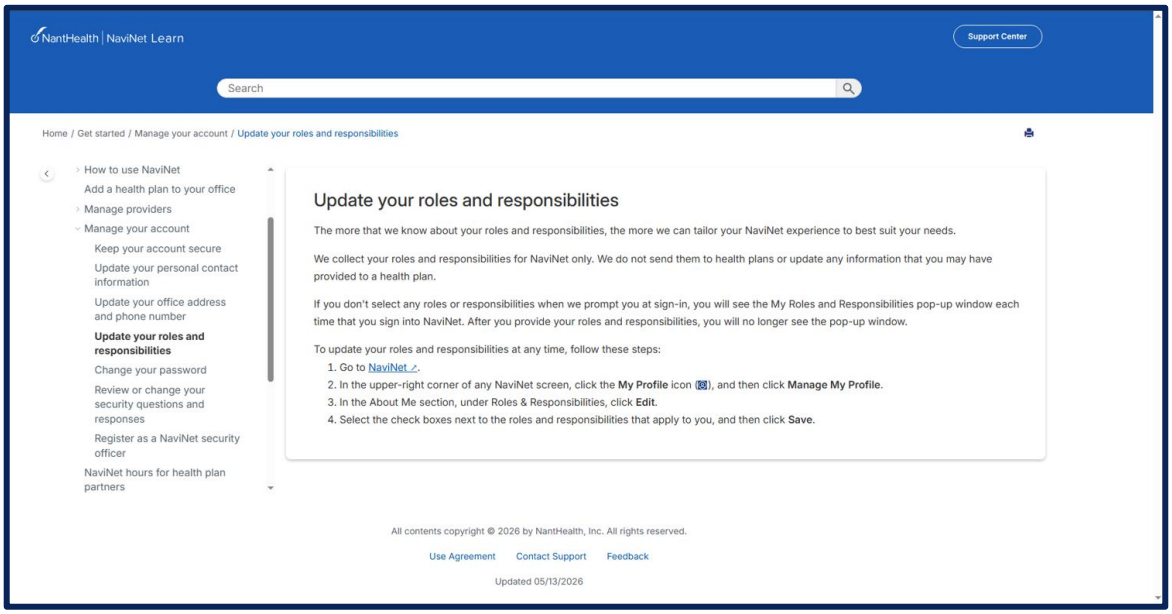
Roles and Responsibilities Cont'd.

NaviNet will ask you to confirm your roles and responsibilities once a year when you sign in. The more NaviNet knows about the user's roles and responsibilities, the more they can tailor your NaviNet experience to best suit your needs.

The My Roles & Responsibilities pop-up will appear every time you log in until you complete that section.

- To complete the Roles & Responsibilities pop-up request, click on I WILL DO THIS NOW.
- The "Why are you asking for this?" link will take you to the NaviNet Support page for FAQs relating to roles and responsibilities and other NaviNet Questions.





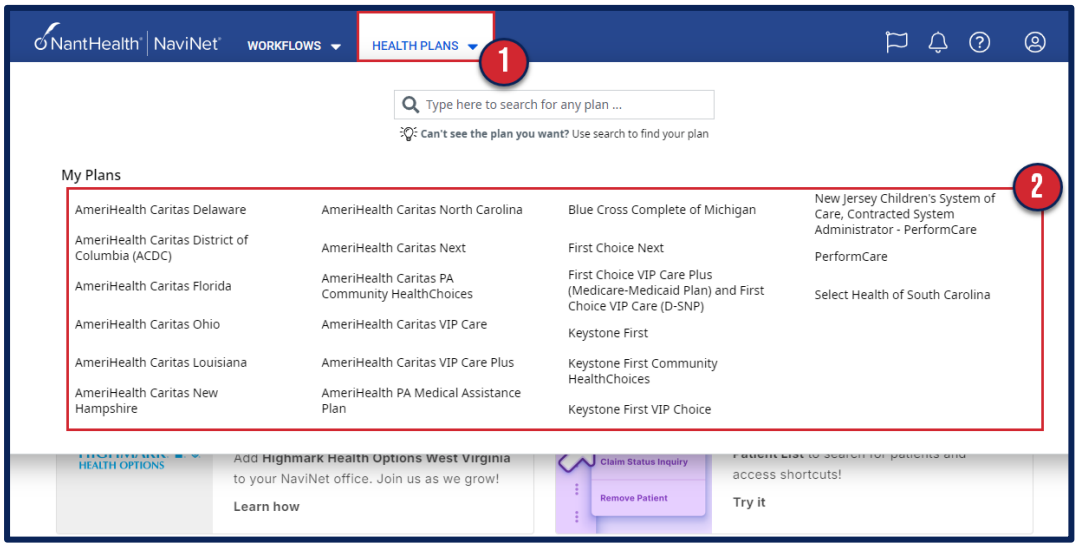
ACCESSING NAVINET CONT'D.

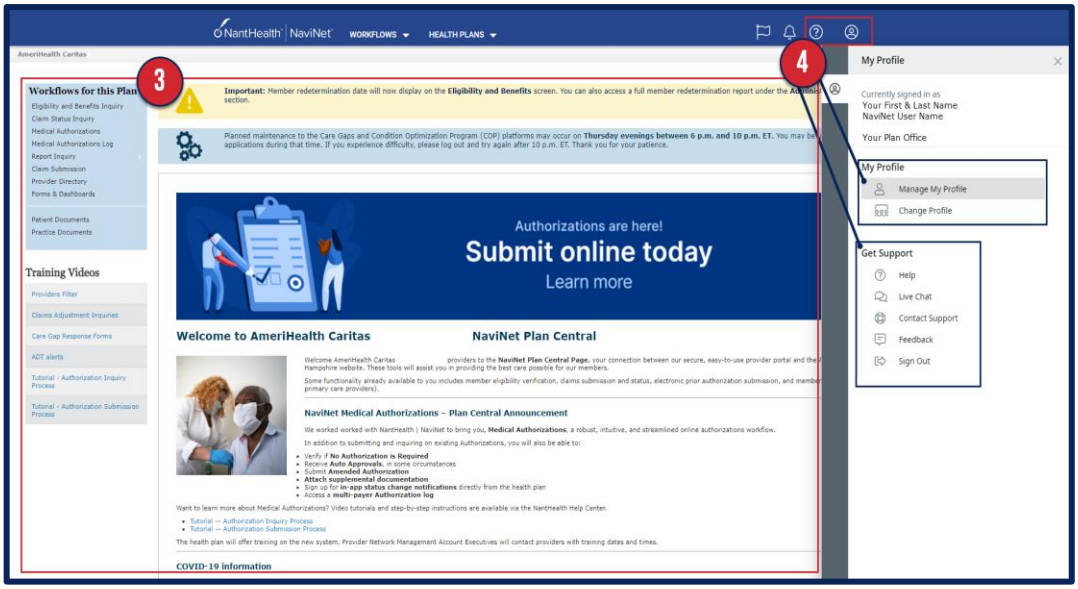
My Health Plan

Once logged into NaviNet, the NaviNet Homepage will display.

To view a specific health plan central page, you can choose a specific health plan by completing the following:

1. Click on Health Plans from the top menu bar.
2. Select the health plan from the My Plans options.
3. The health plan's NaviNet central page will display.
4. The Help and My Profile icons give you access to:
    - Your account
    - Change profile
    - Get support/help or to Contact Support



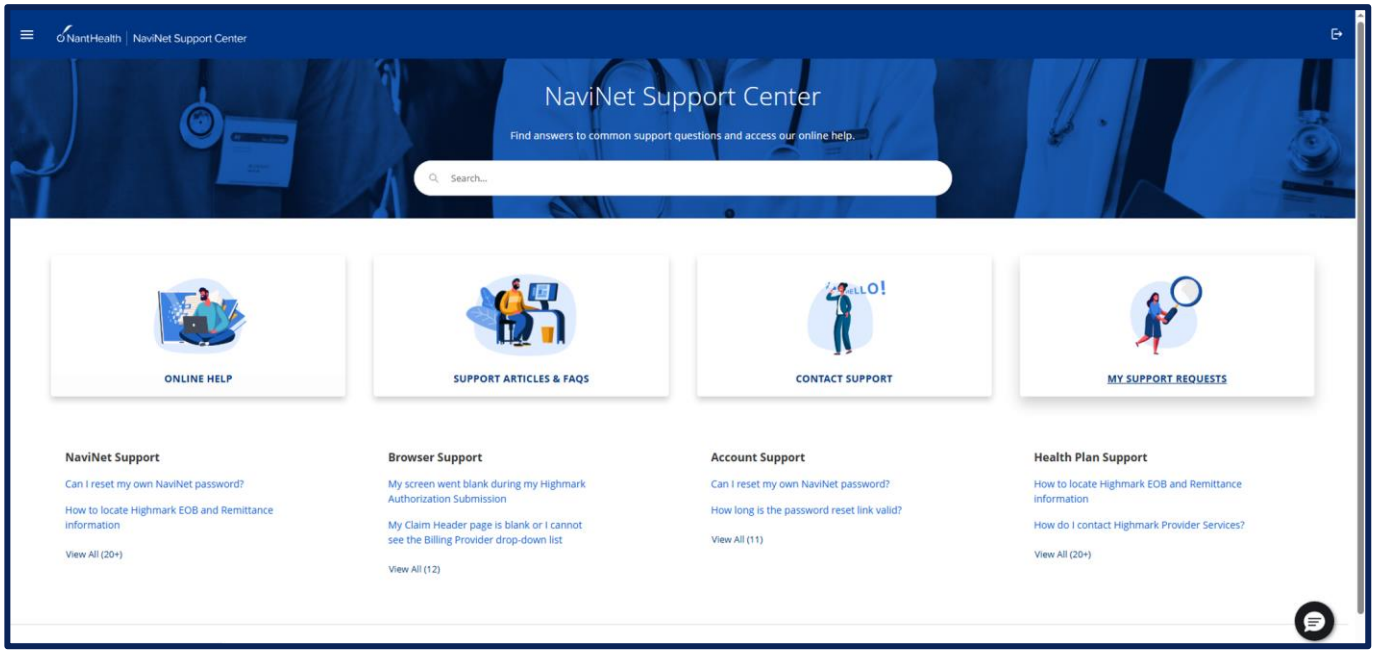


Note: Do not use your Web browser's back button. Use the navigation bar at the top of your screen to navigate between health plans, and the links under Workflows for this Plan to navigate between desired functions. Using your browser's back button can impact functionality and may cause errors.

Support Center

NaviNet has a robust Support Center to assist you with the following:

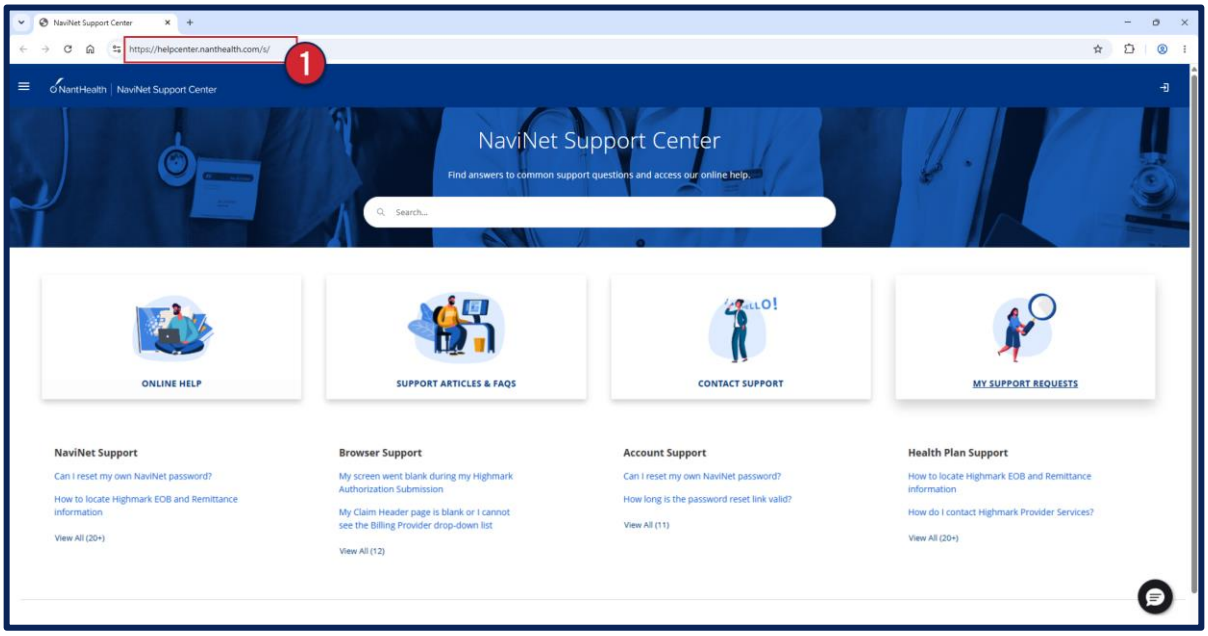
- Find answers by reading support articles and Frequently Asked Questions (FAQs)
- Access user guides and training videos
- Review the latest NaviNet updates
- Contact NaviNet Support via chat or by opening a support request
- Get involved with the NaviNet User Panel
- Send feedback and suggestions
- Links to other helpful information to assist with NaviNet and its functionality

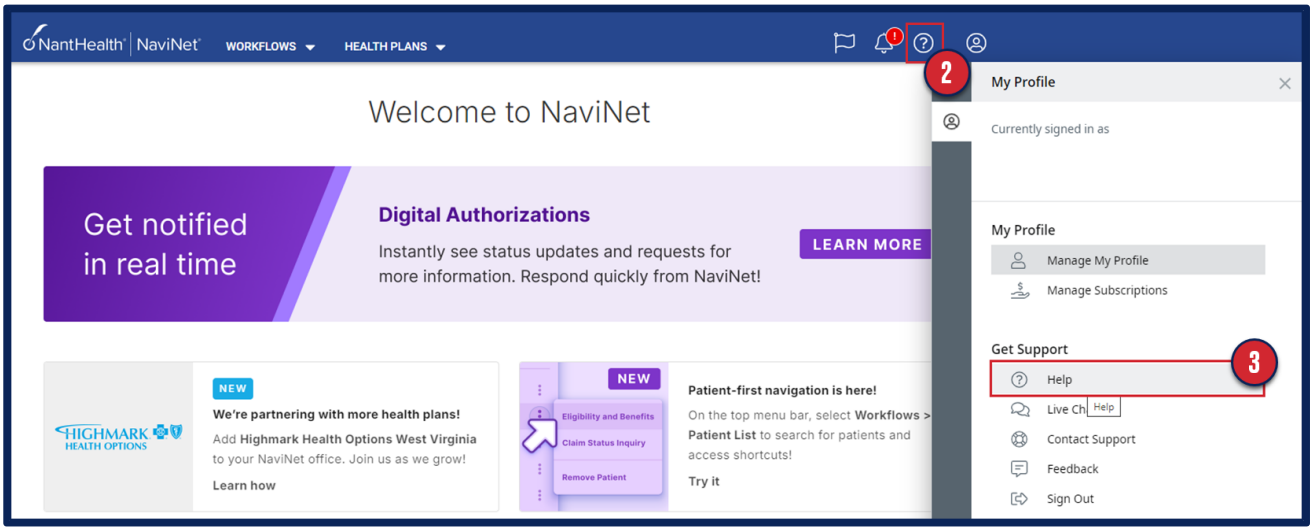


NAVINET SUPPORT CONT'D.

You can access the NaviNet Support Center by:

1. Entering the following link on your browser: https://helpcenter.nanthealth.com/s/
2. Or by clicking on the question mark at the upper right on the Plan Central Page
3. Then clicking 'Help' under Get Support





Note: You may need to login to access full content in the Support Center.

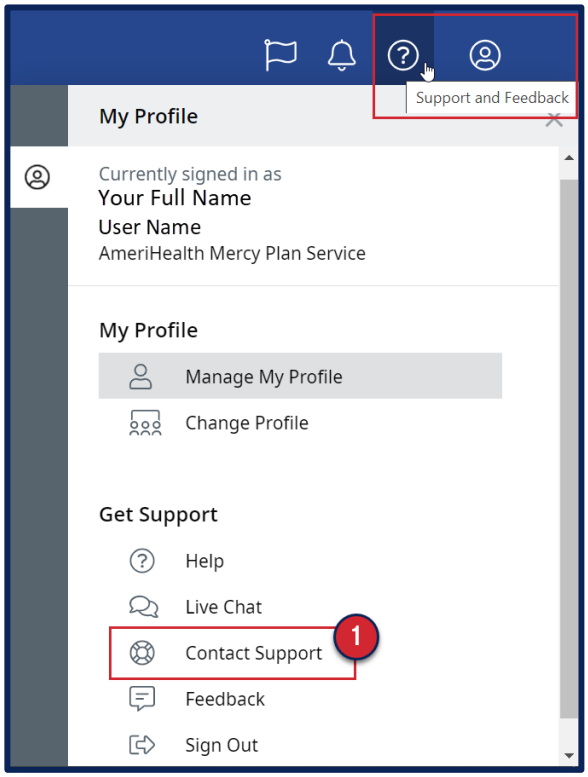
NAVINET SUPPORT CONT'D.

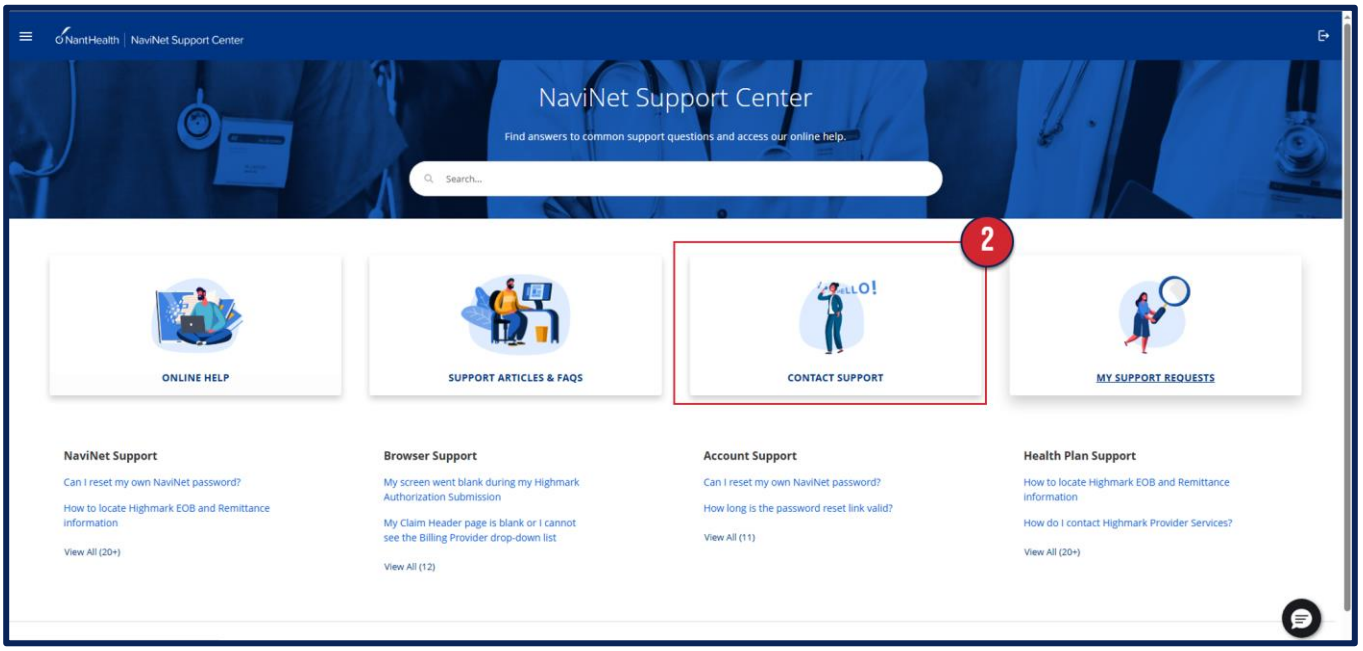
Contact Support

In addition to the Support Center, a support team is available via an online support case or chat.

You can view the support team contact information by:

1. Clicking 'Contact Support' in the Support and Feedback menu.
2. Clicking Contact Support on the Support Center landing page

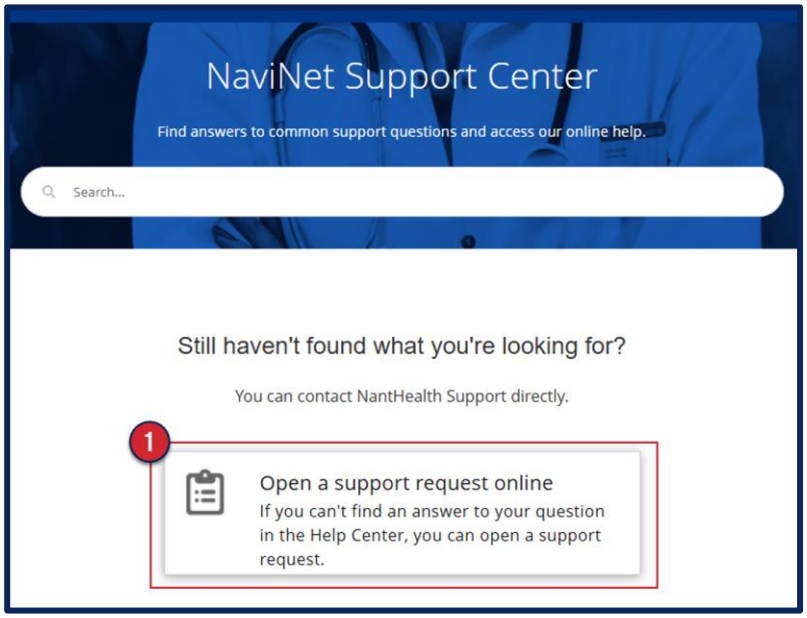


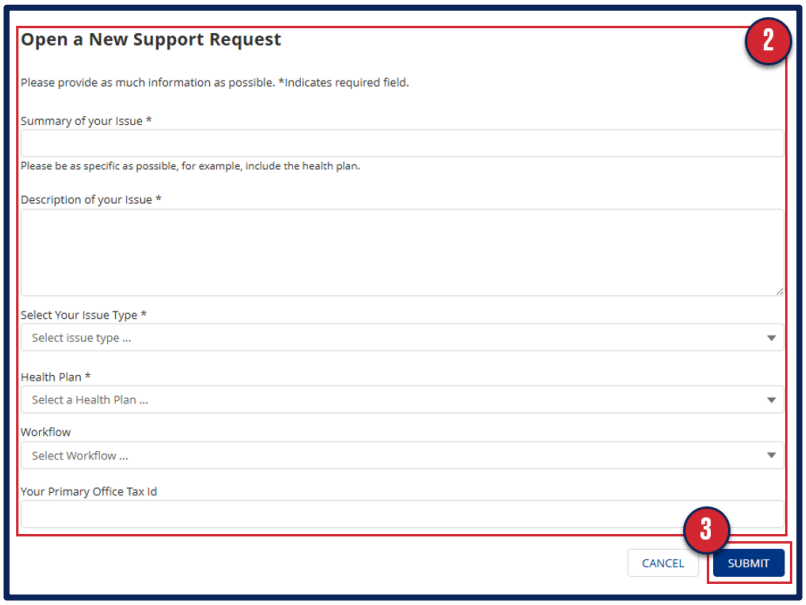


Open a Support Case Online

If you are encountering a technical/registration issue or need assistance with the portal, you can also open a support case online.

1. Click on the Open a support request online box.
2. Complete the New Support Request form.
3. Click Submit.

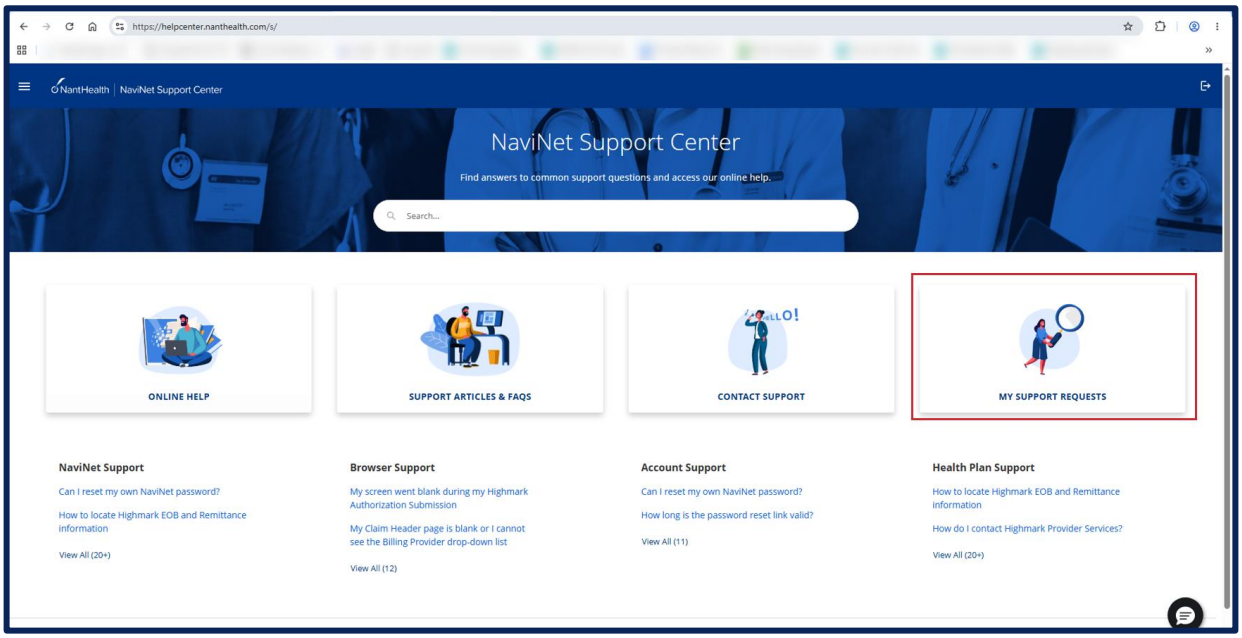




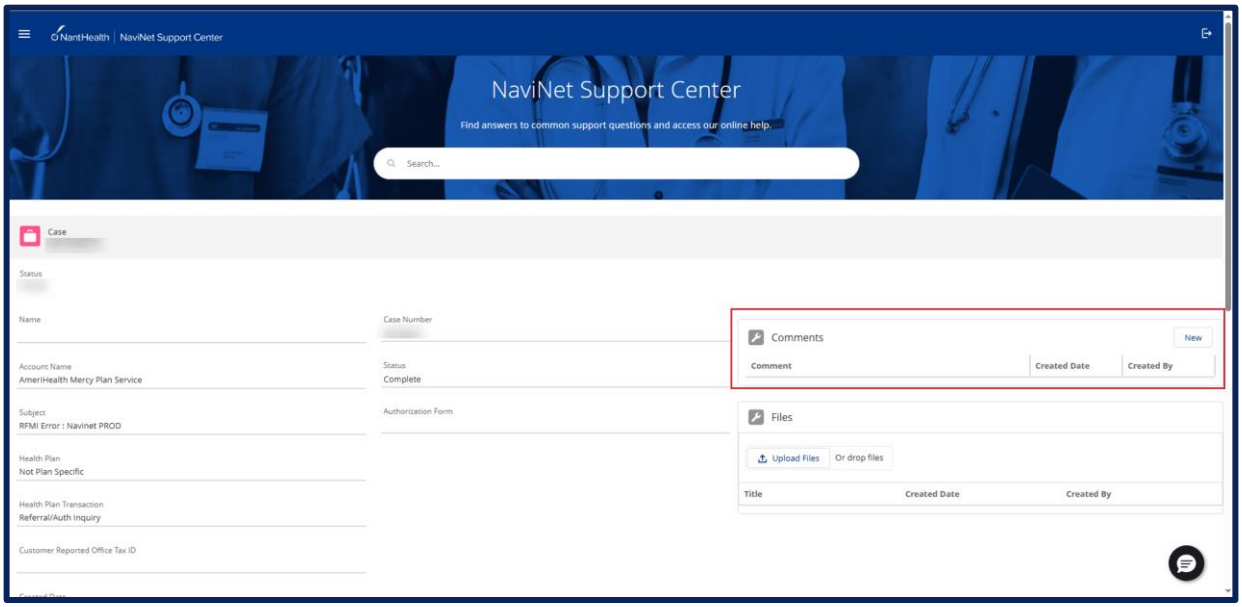
Open a Support Case Online Cont'd.

You can view/track the status of the request by clicking on My Support Requests in the NaviNet Support Center or by visiting:

https://helpcenter.nanthealth.com/s/case/Case/Default



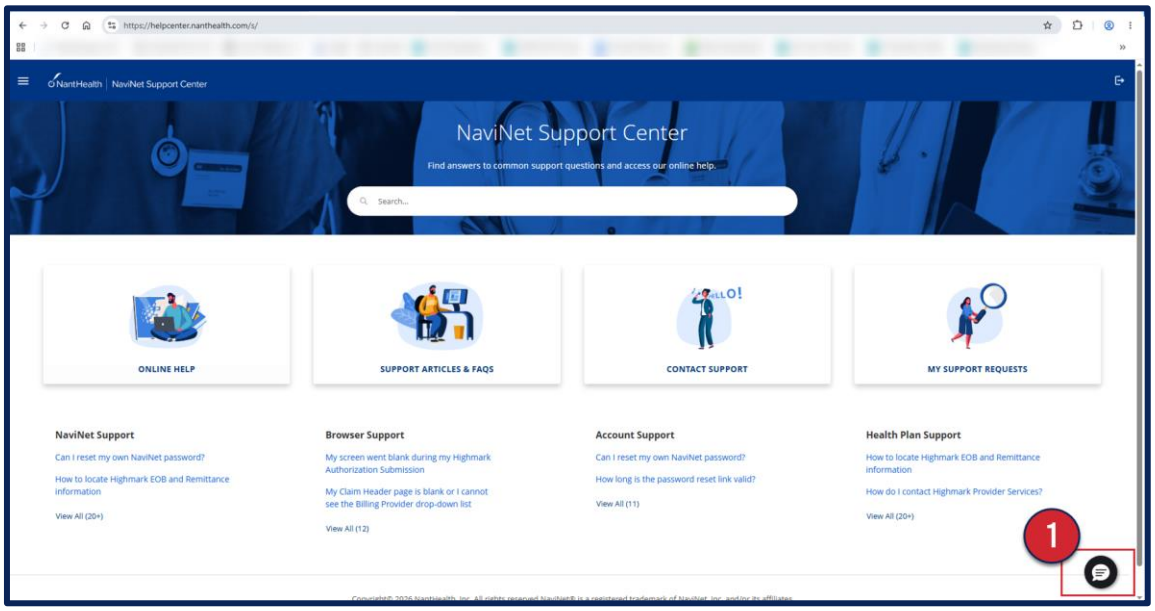
Additionally, you can open your support case to add comments. If the case has been assigned to an agent, you will automatically receive a notification to alert you of any new responses.



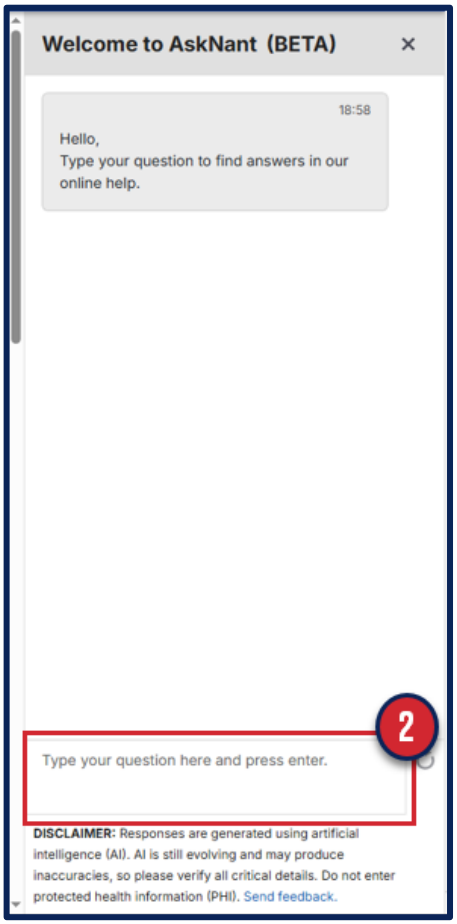
NAVINET SUPPORT CONT'D.

AskNant AI assistant

AskNant chatbot is also available on all NaviNet screens for all NaviNet offices. If you don't want to search for an answer to your question in the Support Center, you may choose this option to find answers more quickly.



1. Click on the AskNant AI Assistant icon on the lower right side of the page.
2. A new screen will display. Type your question and press enter.

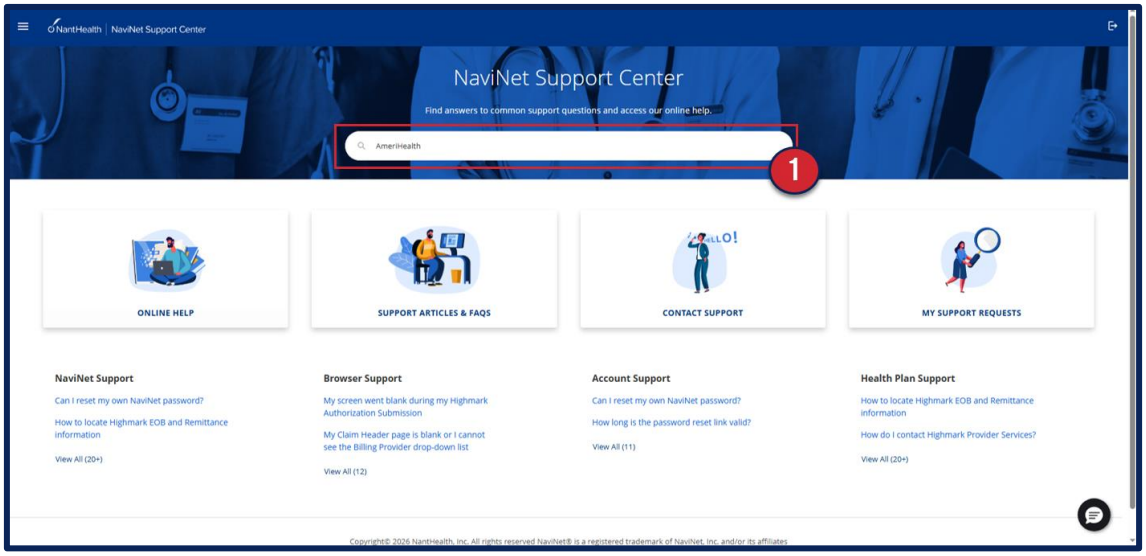


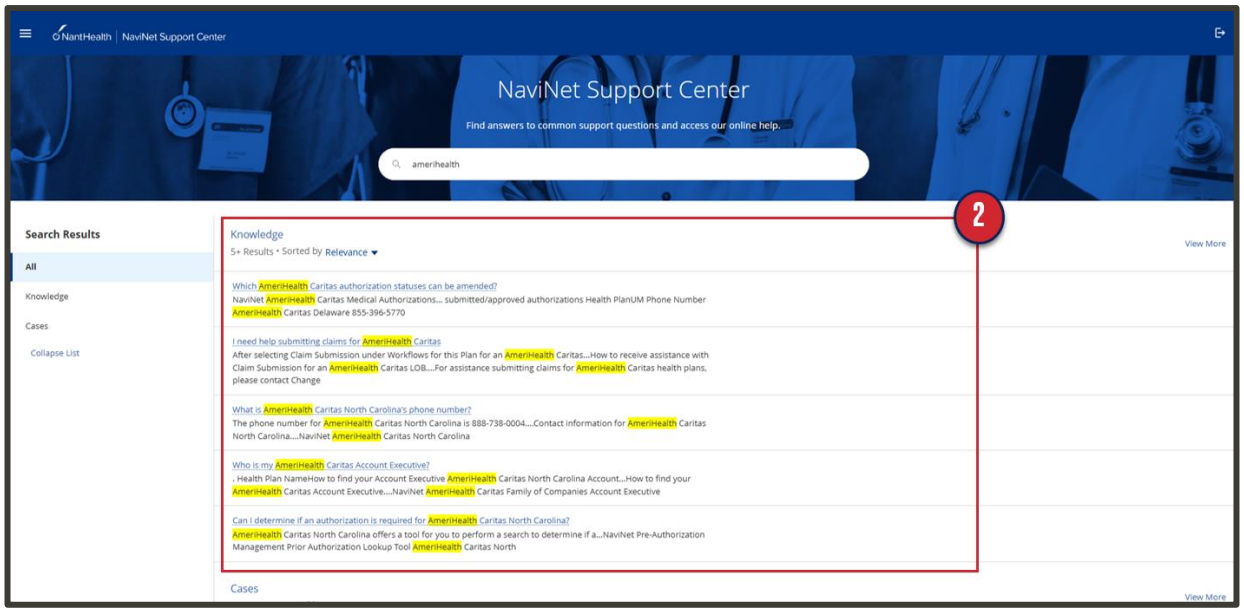
Health Plan Resources

Within the NaviNet Support Center, you can pull applicable resources and guides for your specific plan.

To access plan-specific resources:

1. Type in the plan name in the search field and press the Enter key on your keyboard.
2. Select a title from the results.
3. The resource will display.

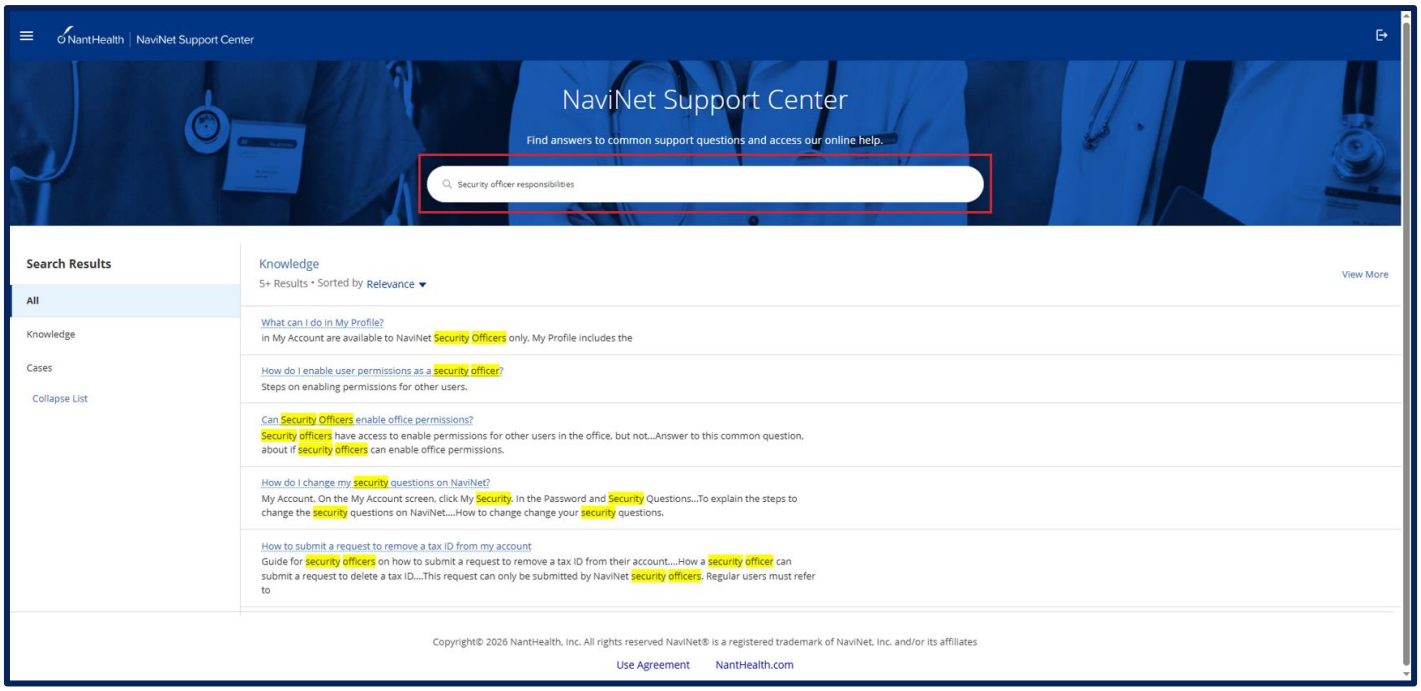




NaviNet Security Officer

A NaviNet security officer manages user access to NaviNet. To ensure HIPAA compliance, each provider office should designate a Security Officer to be aware of the electronic storage and transmission of member information within and from their office.

- The person who registers the practice for NaviNet will be automatically assigned as the Security Officer.
- To learn more about the security officer's roles and responsibilities, type "security officer responsibilities" in the search field.



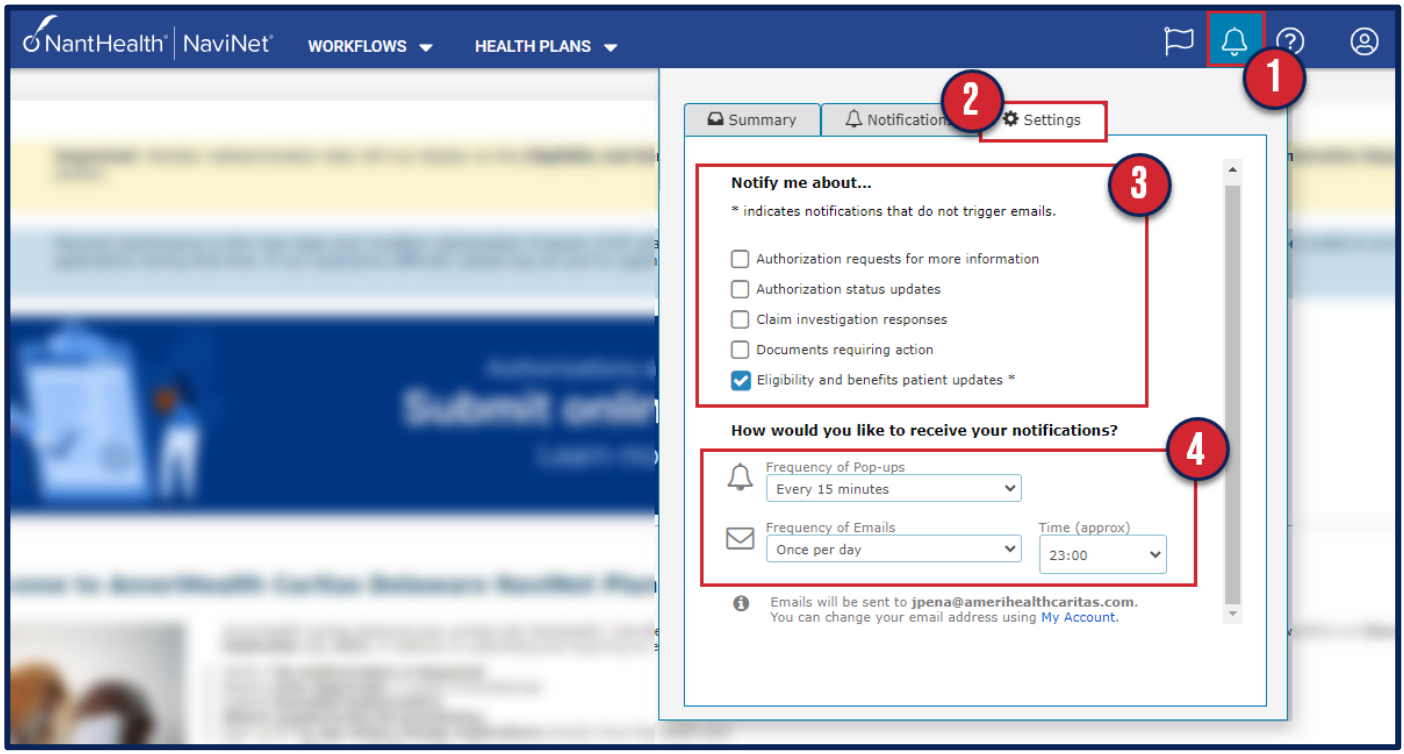
Note: Since the person who enrolls the office is automatically assigned as the Security Officer, it is important that the office determine who is best suited for this role prior to beginning the enrollment process.

Activity Icon

NaviNet notifications inform you about updates that may require your attention. Notifications can be a badge, pop-up window, or email. You choose the type and frequency of your notifications.

To update your notification preferences at any time:

1. Click the Activity icon (bell) in the upper-right corner of any screen
2. Click the Settings tab
3. Under "**Notify me about"**, select the types of notifications that you want to receive, such as Eligibility and benefits patient updates
4. Select the frequency in which you would like to receive your notifications from the Frequency of pop-ups and Emails drop-down menus

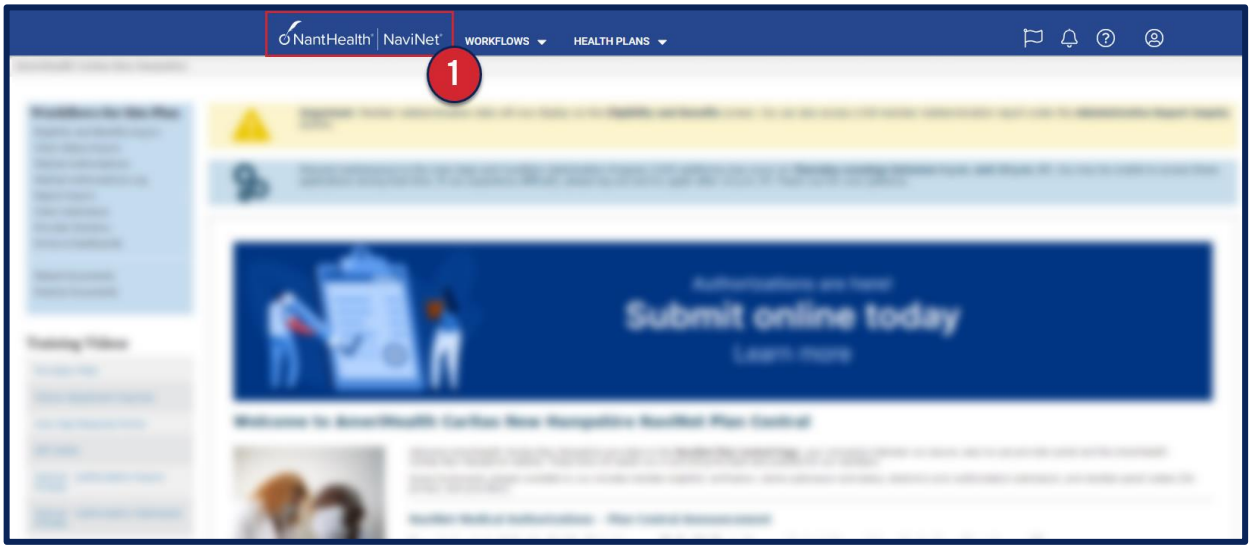


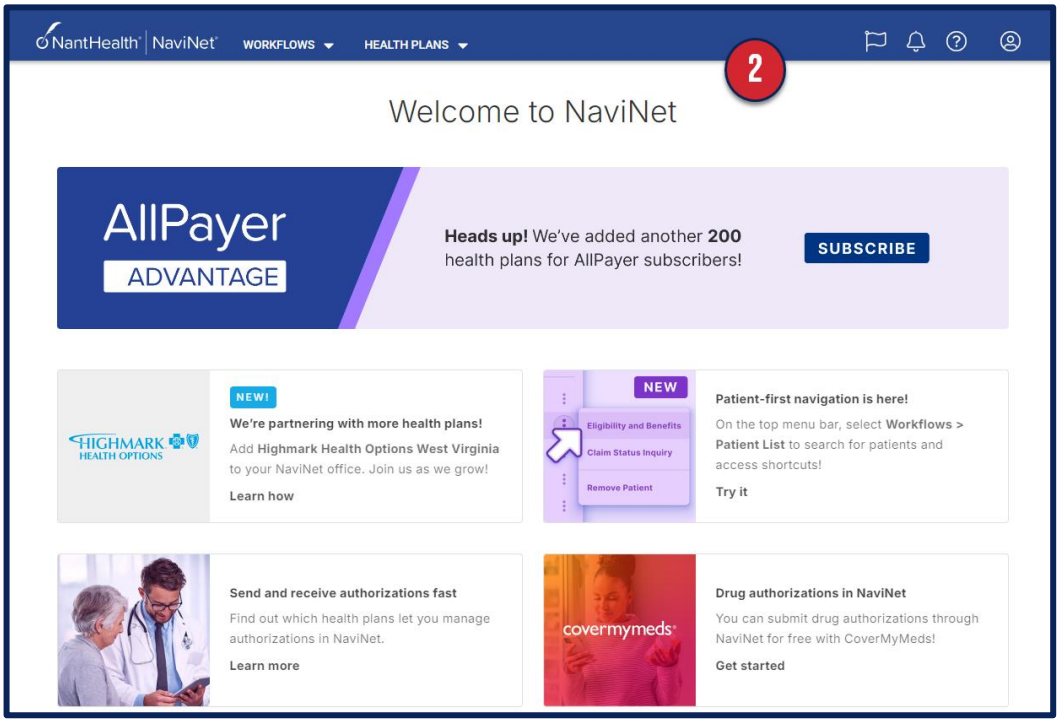
NantHealth | NaviNet Logo

The NaviNet logo allows you to return to the NaviNet homepage from any screen.

To return to the NaviNet homepage at any time:

1. Click the NantHealth | NaviNet logo on the toolbar
2. The NaviNet homepage displays.





Password Security

Every 90 days, your NaviNet password will expire and will need to be changed. You will receive an email from noreply@NaviNet.net alerting you this will occur. Please follow the instructions in the email to change your password.

NantHealth | NaviNet

This message relates to username [redacted] affiliated with [redacted]

Hi [redacted],

Your NaviNet password will expire in two weeks.

To change your password now, sign into Navinet [navinet.navimedix.com] and click change your password now in the pop-up window.

The NantHealth Support Team

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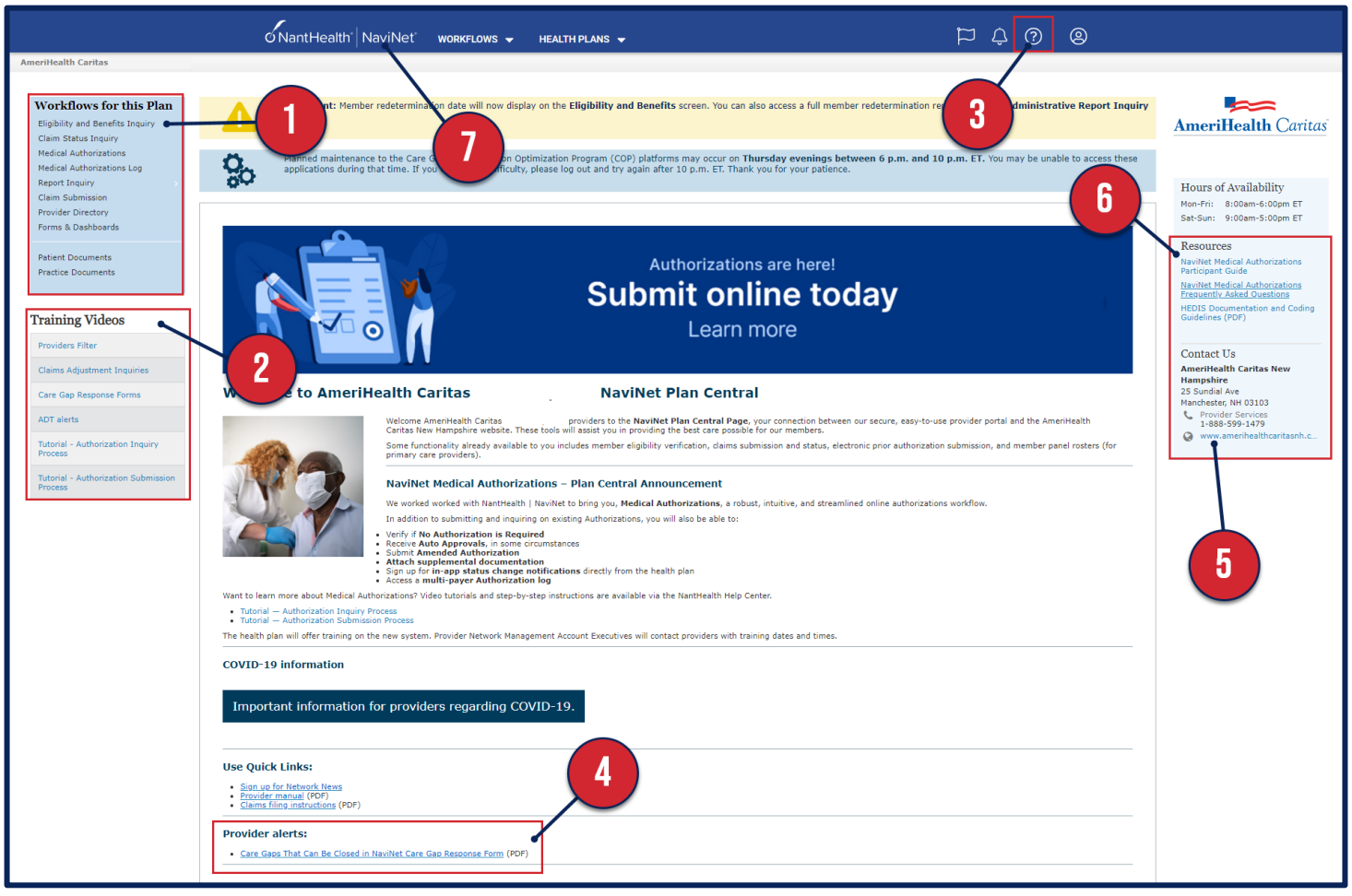
NAVINET PLAN CENTRAL PAGE

NaviNet Plan Central Page

The NaviNet Plan Central page provides access to the following specific to the health plan:

1. Claims and Billing Information
2. Educational Tools
3. FAQs
4. Plan Updates
5. Contact information
6. Resource Information
7. NaviNet Homepage



WORKFLOWS FOR THIS PLAN

You can access workflows from the Plan Central Home Page (workflows may vary according to the health plan).

Some workflows available and covered in this guide:

- Eligibility and Benefits Inquiry
- Claims Status Inquiry
- Medical Authorization Log
- Report Inquiry
- Claim Submission
- Provider Directory
- Forms and Dashboards

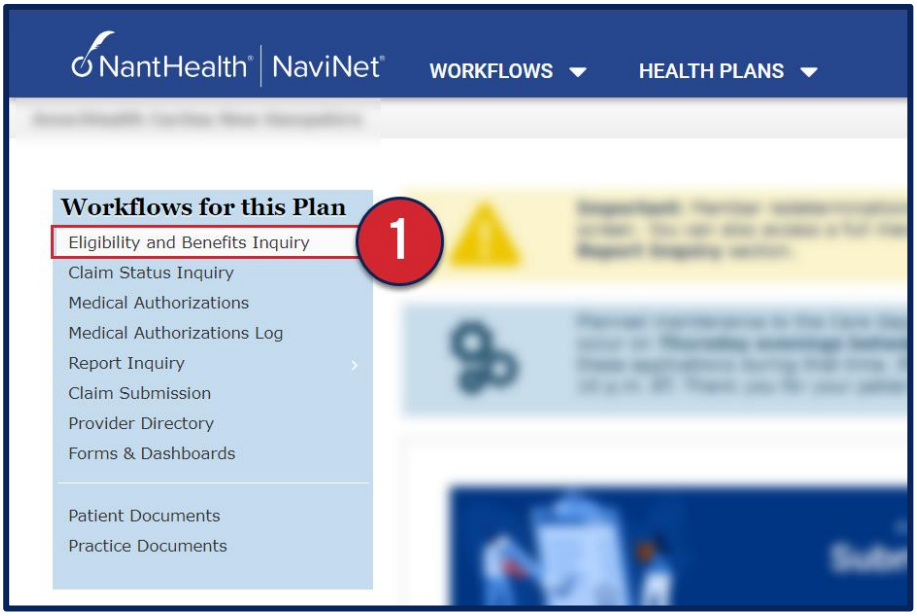
Visit the NaviNet Support Center to find more information about other workflows not mentioned in this guide.

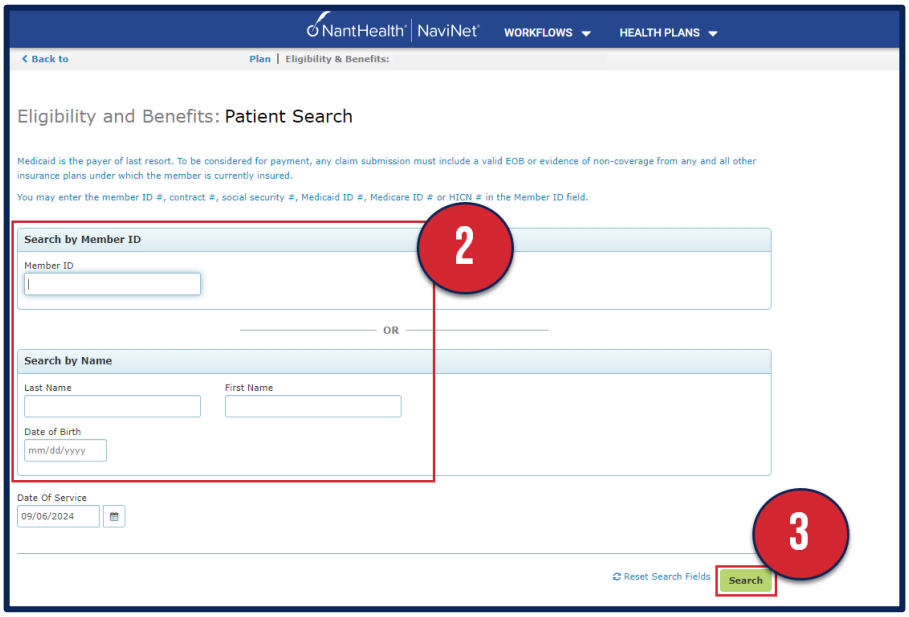
ELIGIBILITY AND BENEFITS INQUIRY

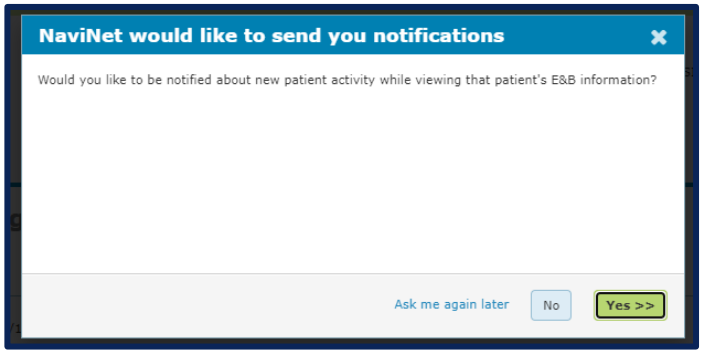
Eligibility and Benefits Inquiry

To access member eligibility and benefits information:

1. Click Eligibility and Benefits Inquiry from the Workflows for this Plan.
2. On the Patient Search screen, enter any of the following Patient (member) information:
    - Member ID #
    - Contract #
    - Social Security #
    - Medicaid #
    - Medicare ID #
    - HICN (Health Insurance Claim Number)
    - Last Name, First Name and Date of Birth
3. Click Search.





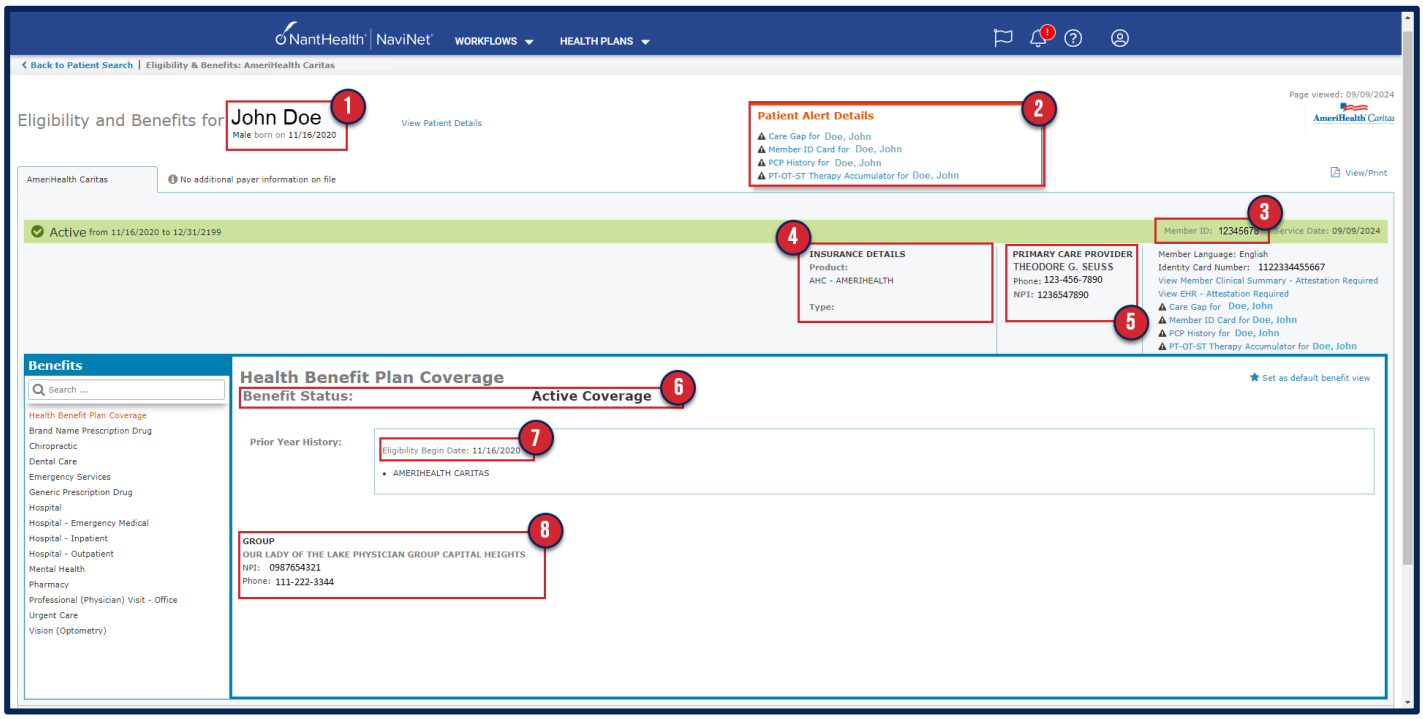


When performing a member search, a notification box will appear. This box allows you to set up notifications about the status of the patient's activity.

Eligibility and Benefits Inquiry Cont'd.

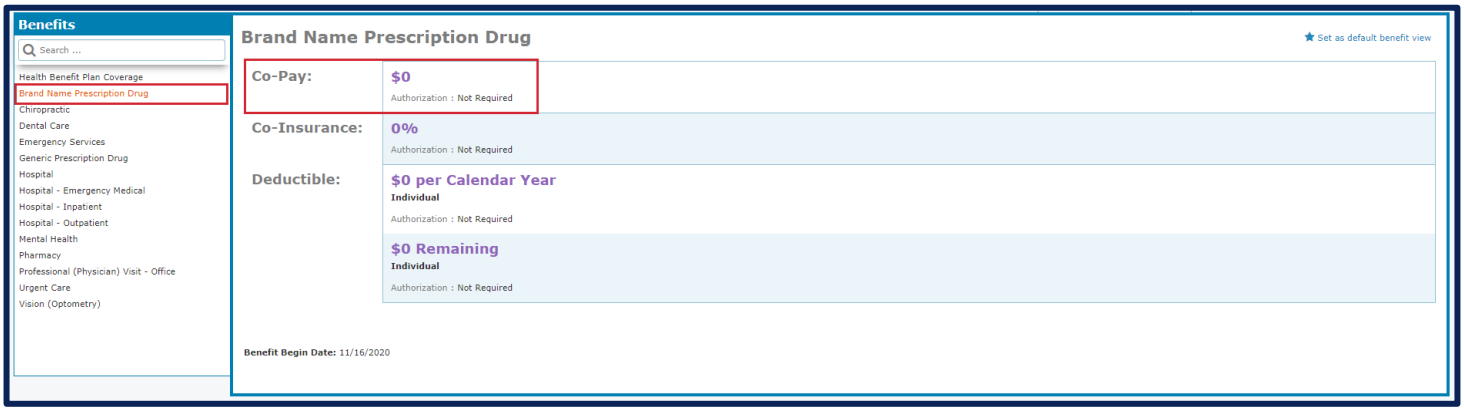
Once you click Search, the Eligibility and Benefits screen will be displayed. This screen highlights the following member eligibility and benefit details:

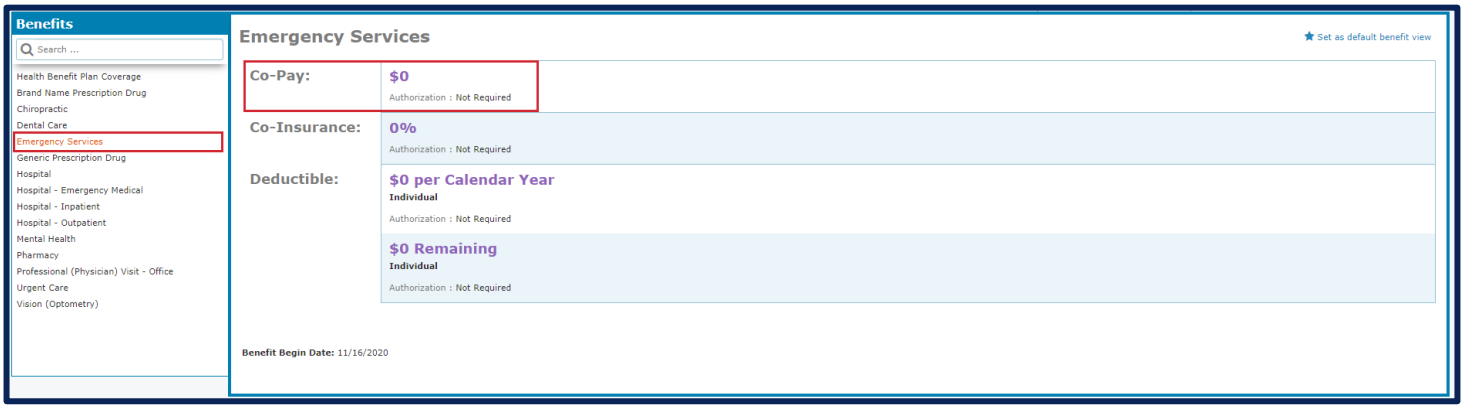
1. Name, Gender, and DOB
2. Patient Alert Details
3. Member ID
4. Insurance Plan and Product details
5. Member's Primary Care Provider
6. Current eligibility status
7. Original eligibility date
8. Provider Group details

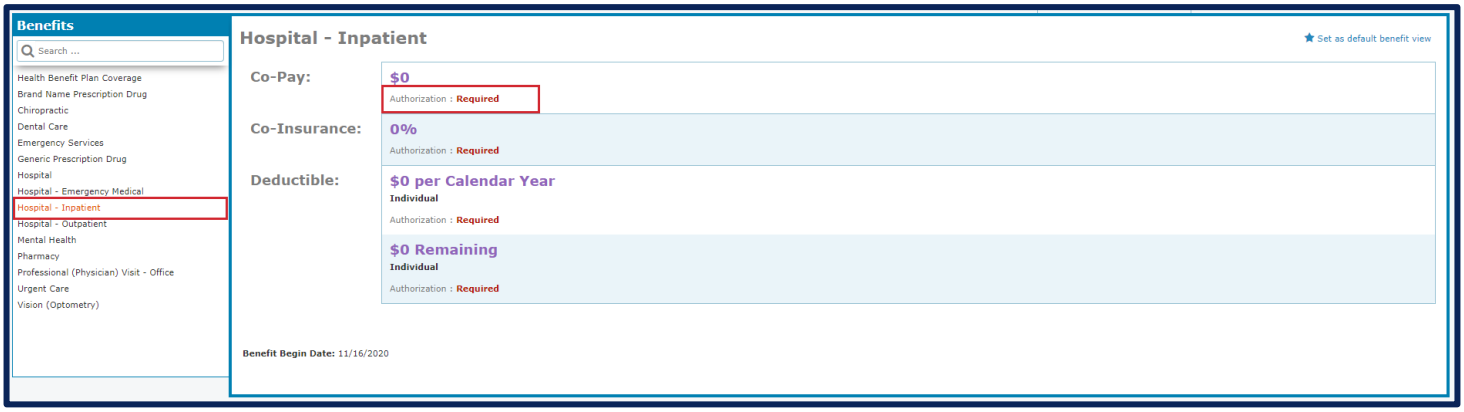


Eligibility and Benefits Inquiry Cont'd.

The Benefits section details the member's benefits and displays co-pay and authorization requirements (if applicable).





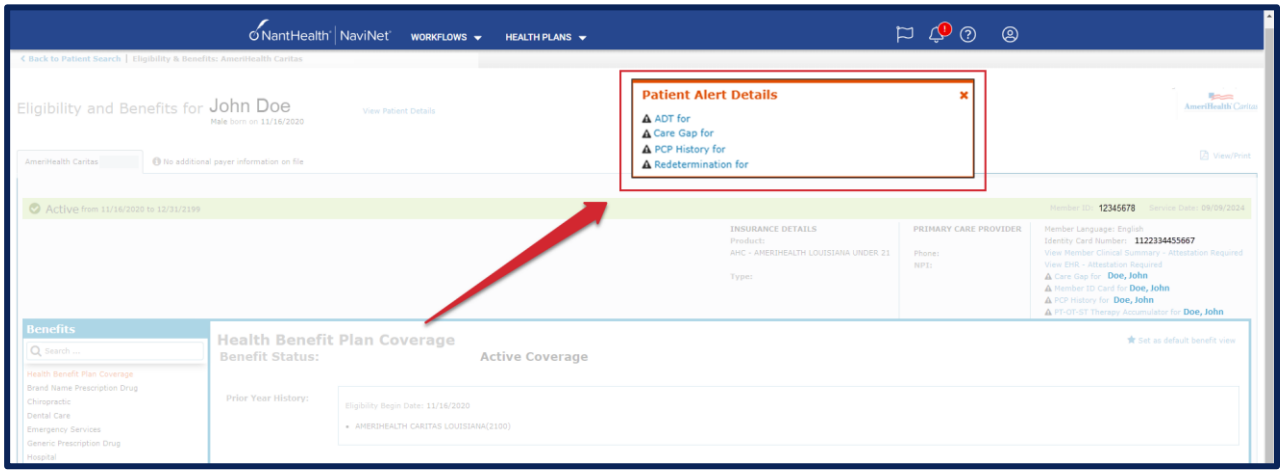


ELIGIBILITY AND BENEFITS INQUIRY CONT'D.

Patient Alert Details

The Patient Alert Details notification window appears on the patient's Eligibility and Benefits screen. This notification displays the following hyperlinked alerts that you can see for your members (if applicable):

- Admit and Discharge (ADT) alerts
- Care Gaps that need to be addressed
- Member ID Card
- Patient's PCP history
- Member Redetermination
- Vision Accumulator

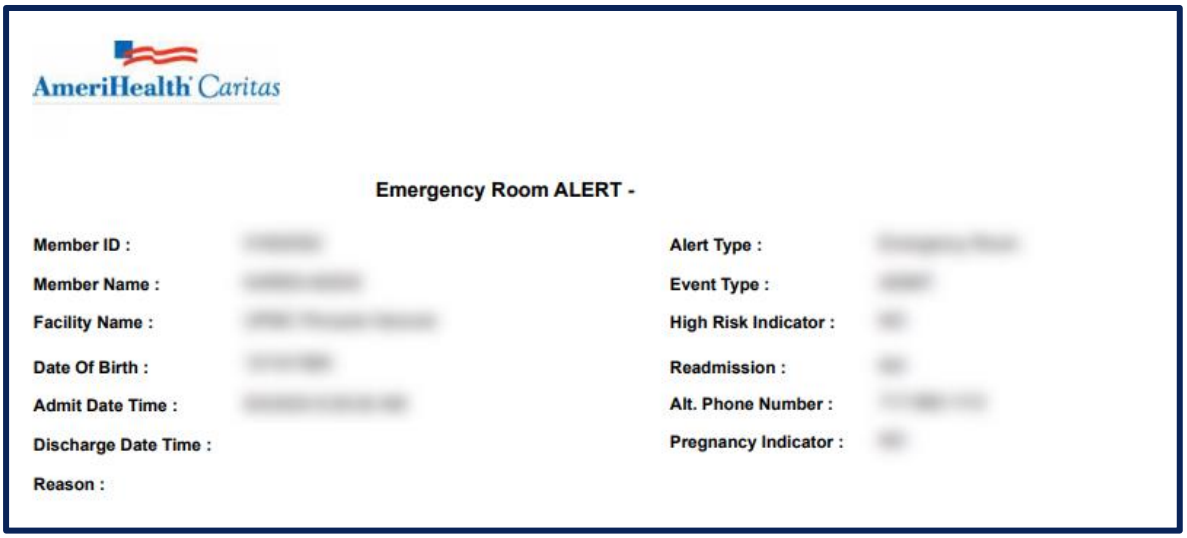


ELIGIBILITY AND BENEFITS INQUIRY CONT'D.

Admission and Discharge (ADT) Alerts

These alerts identify any time a member has been admitted, discharged, or transferred to/from a facility.

- The ADT alert is available for seven days.



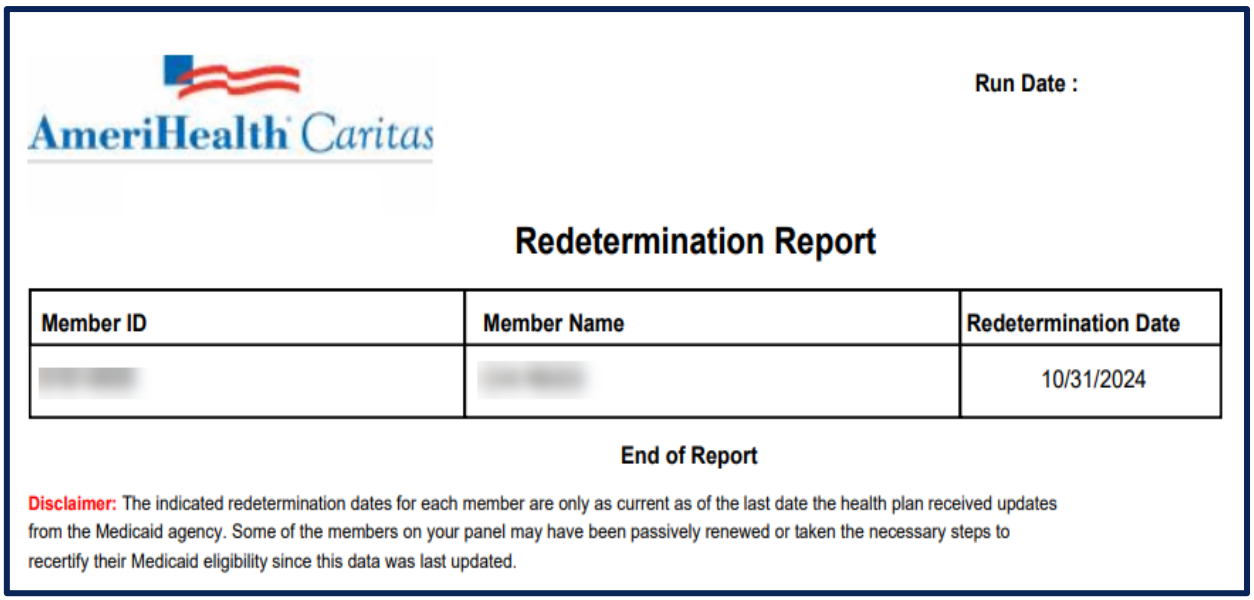
AmeriHealth Caritas

Emergency Room ALERT -

Member ID :		**Alert Type :**	
Member Name :		**Event Type :**	
Facility Name :		**High Risk Indicator :**	
Date Of Birth :		**Readmission :**	
Admit Date Time :		**Alt. Phone Number :**	
Discharge Date Time :		**Pregnancy Indicator :**	
Reason :			

Redetermination Alert

This alert indicates this member has an upcoming eligibility redetermination date. This is the scheduled date when the member needs to renew their eligibility.



AmeriHealth Caritas

Run Date :

Redetermination Report

Member ID	Member Name	Redetermination Date
		10/31/2024

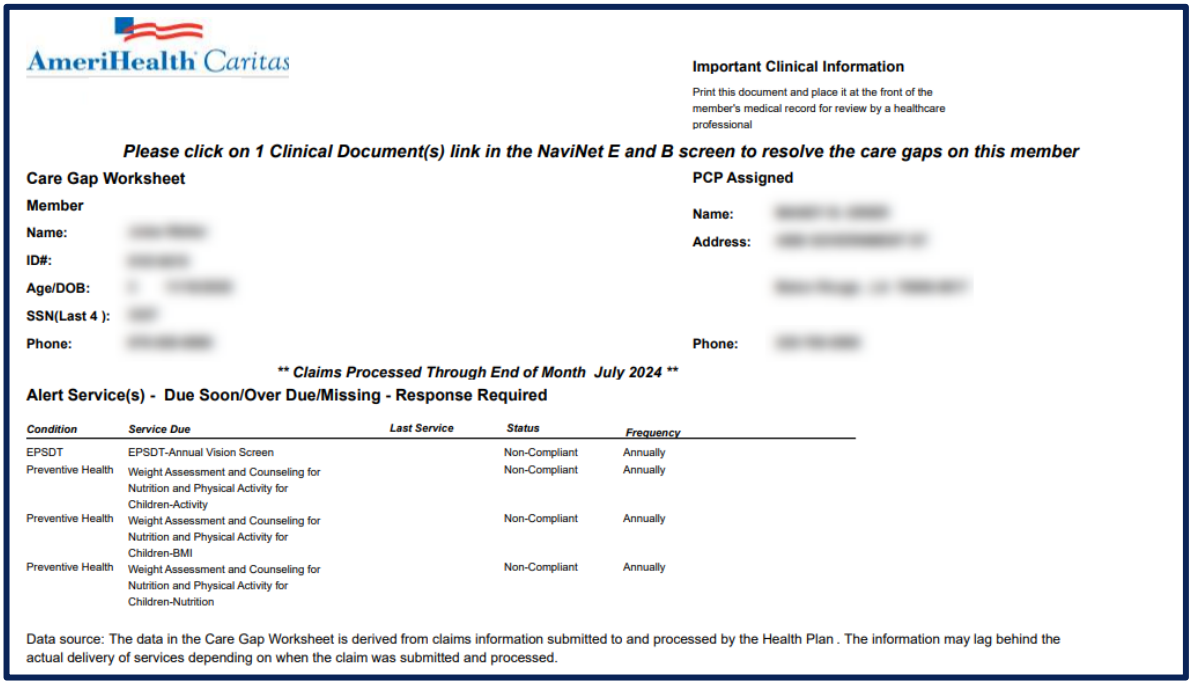
End of Report

Disclaimer: The indicated redetermination dates for each member are only as current as of the last date the health plan received updates from the Medicaid agency. Some of the members on your panel may have been passively renewed or taken the necessary steps to recertify their Medicaid eligibility since this data was last updated.

ELIGIBILITY AND BENEFITS INQUIRY CONT'D.

Care Gap Alert

This alert identifies outstanding Care Gaps for the member. Care Gaps identify missing recommended preventive care services.



AmeriHealth Caritas

Important Clinical Information

Print this document and place it at the front of the member's medical record for review by a healthcare professional

Please click on 1 Clinical Document(s) link in the NaviNet E and B screen to resolve the care gaps on this member

Care Gap Worksheet

Member

Name:
ID#:
Age/DOB:
SSN(Last 4):
Phone:

PCP Assigned

Name:
Address:
Phone:

***** Claims Processed Through End of Month July 2024 *****

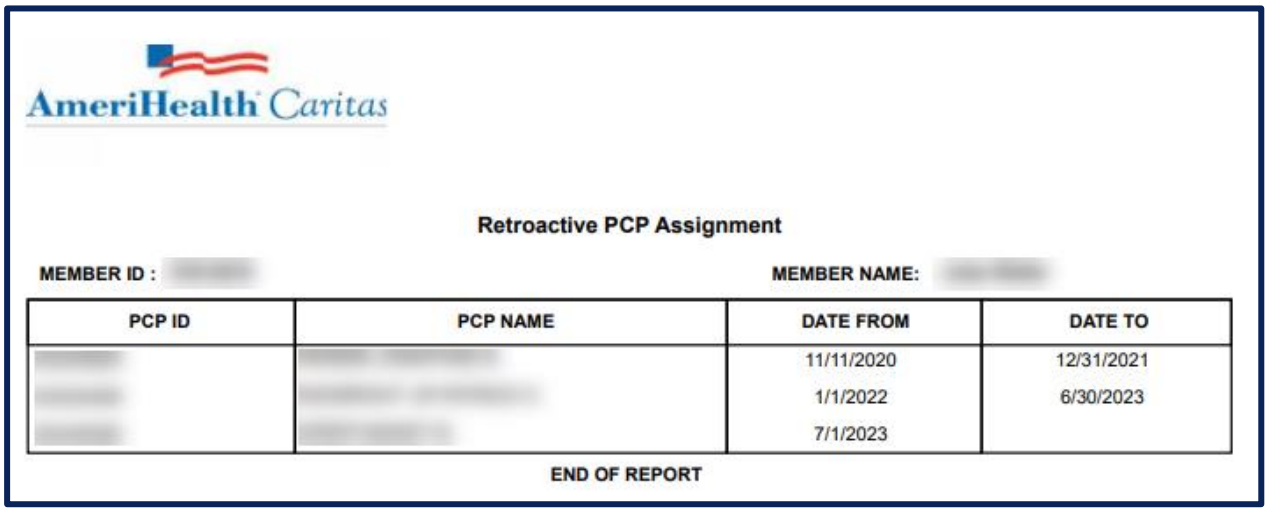
Alert Service(s) - Due Soon/Over Due/Missing - Response Required

Condition	*Service Due*	*Last Service*	*Status*	*Frequency*
EPSDT	EPSDT-Annual Vision Screen		Non-Compliant	Annually
Preventive Health	Weight Assessment and Counseling for Nutrition and Physical Activity for Children-Activity		Non-Compliant	Annually
Preventive Health	Weight Assessment and Counseling for Nutrition and Physical Activity for Children-BMI		Non-Compliant	Annually
Preventive Health	Weight Assessment and Counseling for Nutrition and Physical Activity for Children-Nutrition		Non-Compliant	Annually

Data source: The data in the Care Gap Worksheet is derived from claims information submitted to and processed by the Health Plan . The information may lag behind the actual delivery of services depending on when the claim was submitted and processed.

PCP History Alert

This alert displays the different PCPs the member has had.



AmeriHealth Caritas

Retroactive PCP Assignment

MEMBER ID : **MEMBER NAME:**

PCP ID	PCP NAME	DATE FROM	DATE TO
		11/11/2020	12/31/2021
		1/1/2022	6/30/2023
		7/1/2023	

END OF REPORT

ELIGIBILITY AND BENEFITS INQUIRY CONT'D.

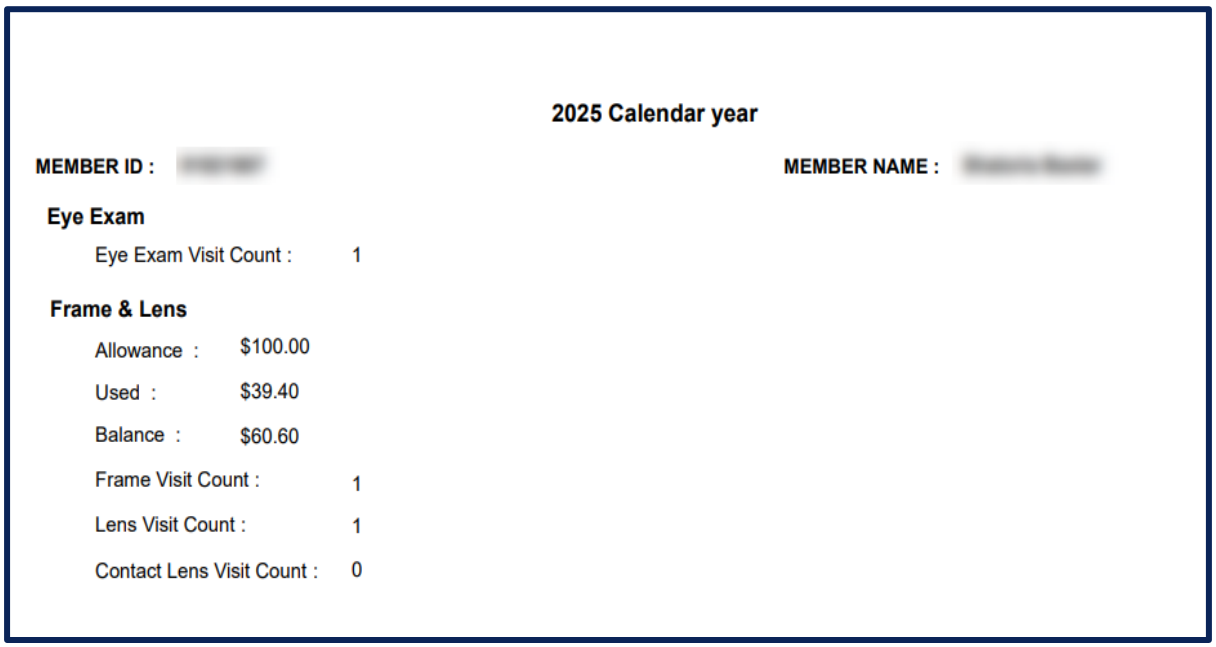
Vision Accumulator

Vision providers can view whether a member has used their vision benefits for the current benefit year.

If your patient has used their vision benefits the **Patient Alert** pop-up will include an option for ***Vision Accumulator***.

Selecting the Vision Accumulator link opens another screen, which displays:

- Eye Exam Visit Count
- Frame and Lens, including
  - Allowance, Used and Balance (if applicable)
  - Frame Visit count
  - Lens Visit Count
  - Contact Lens Visit Count



2025 Calendar year

MEMBER ID : [redacted] **MEMBER NAME :** [redacted]

Eye Exam

Eye Exam Visit Count :	1

Frame & Lens

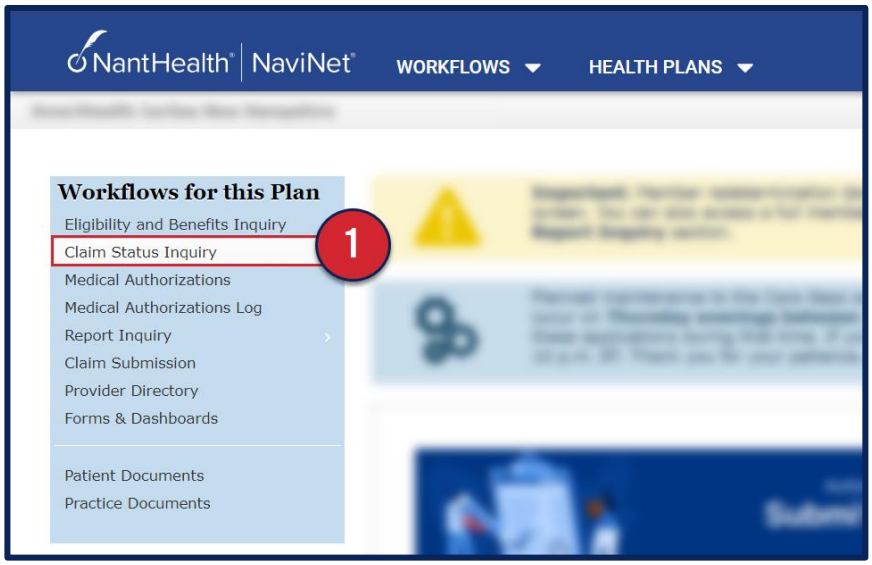
Allowance :	$100.00
Used :	$39.40
Balance :	$60.60
Frame Visit Count :	1
Lens Visit Count :	1
Contact Lens Visit Count :	0

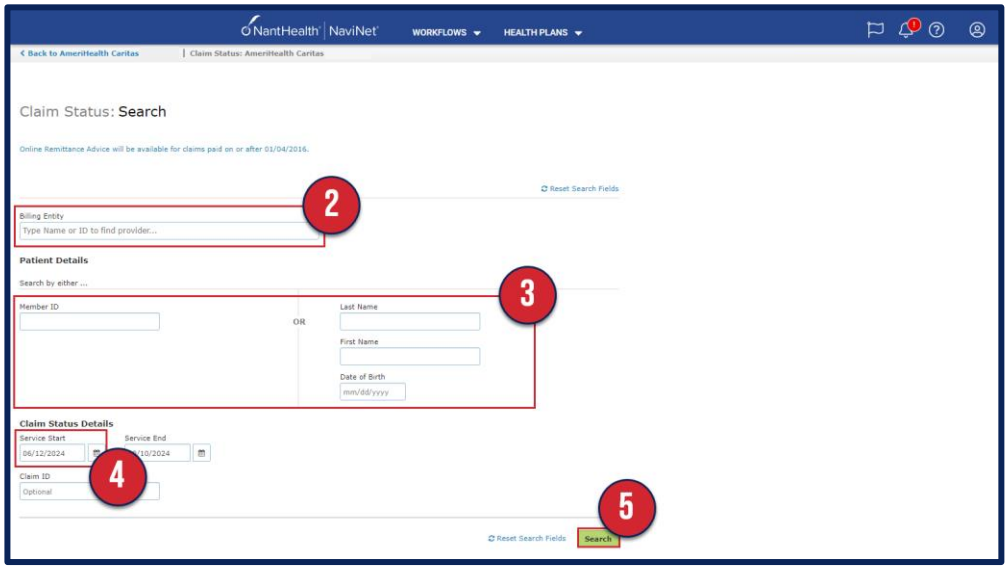
CLAIM STATUS INQUIRY

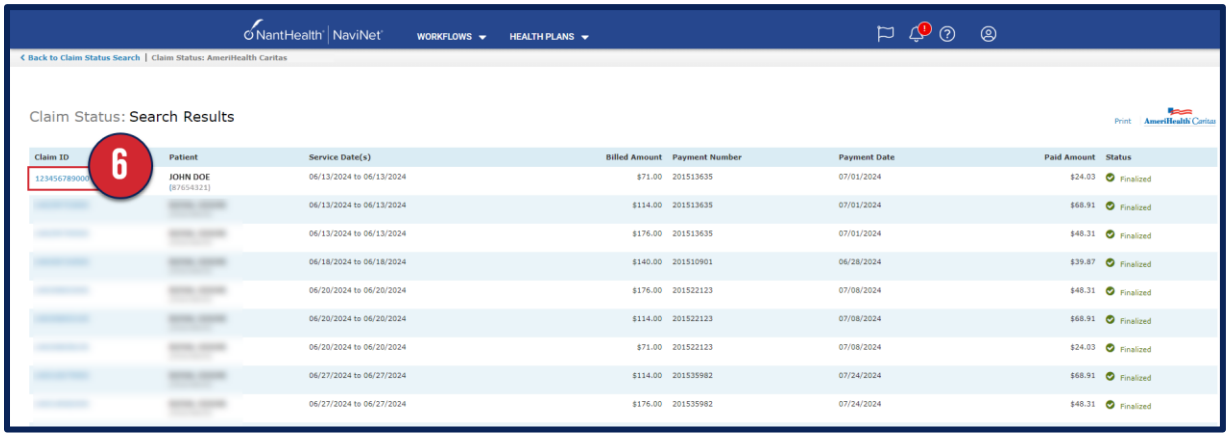
The Claims Status Inquiry workflow gives you access to real-time claim details for members.

To access this workflow:

1. Click on Claims Status Inquiry from the Workflows for this Plan.
2. From the Claim Status Search screen, select the Billing Entity (all providers or a specific practitioner).
3. Enter the Member ID or the member's Name and Date of Birth.
4. Enter the date of service.
5. Click Search.
6. Select the Claim ID from the Claim Status Search Results screen.



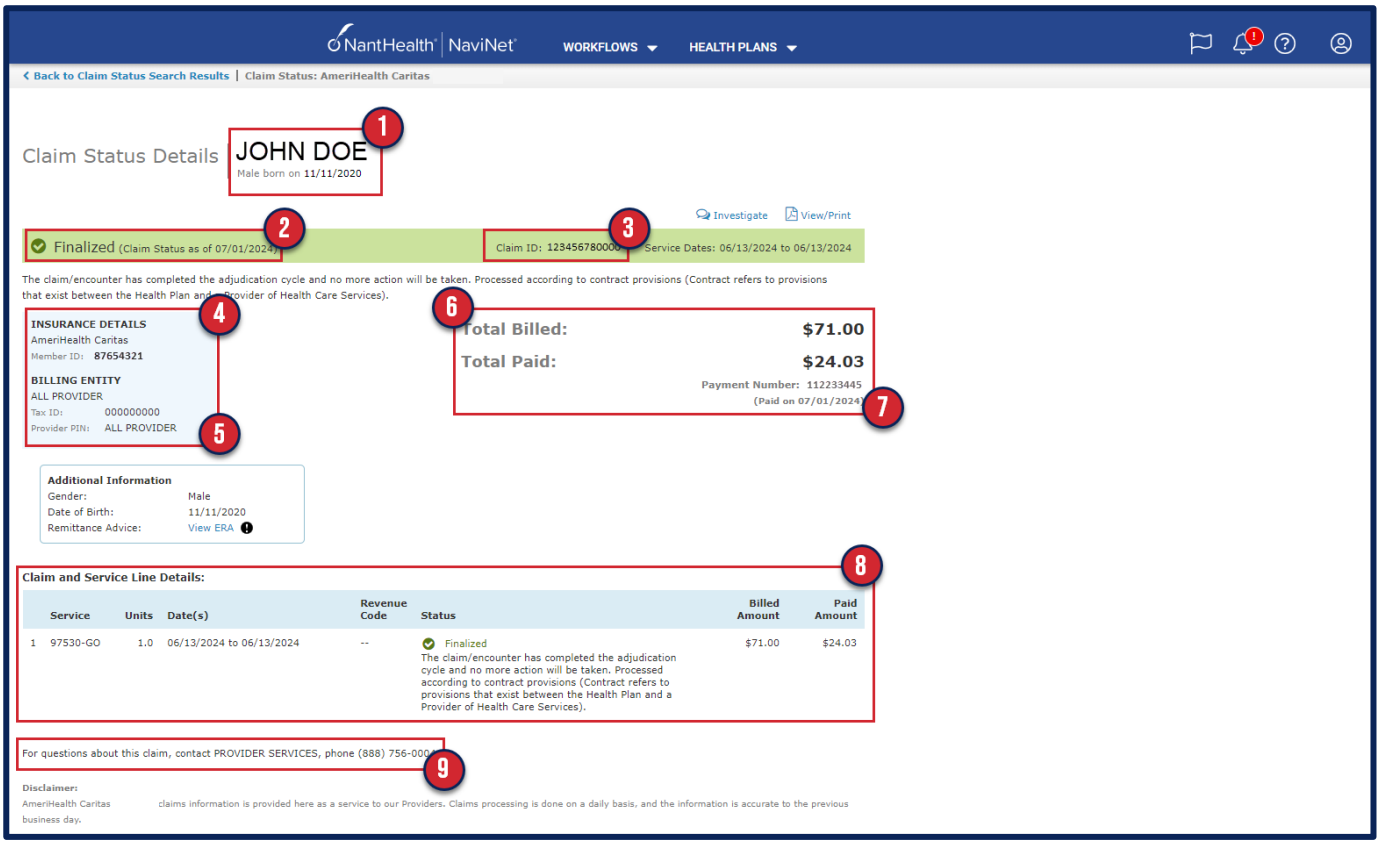




CLAIMS STATUS INQUIRY CONT'D.

The Claim Status Details screen will display once you select the claim. The following information can be found on this screen:

1. Name, Gender, and DOB
2. Claim Status
3. Claim ID
4. Insurance Details
5. Billing Entity
6. Total Billed and Total Paid
7. Payment Number
8. Claim and Service Line Details
9. Provider Services contact information

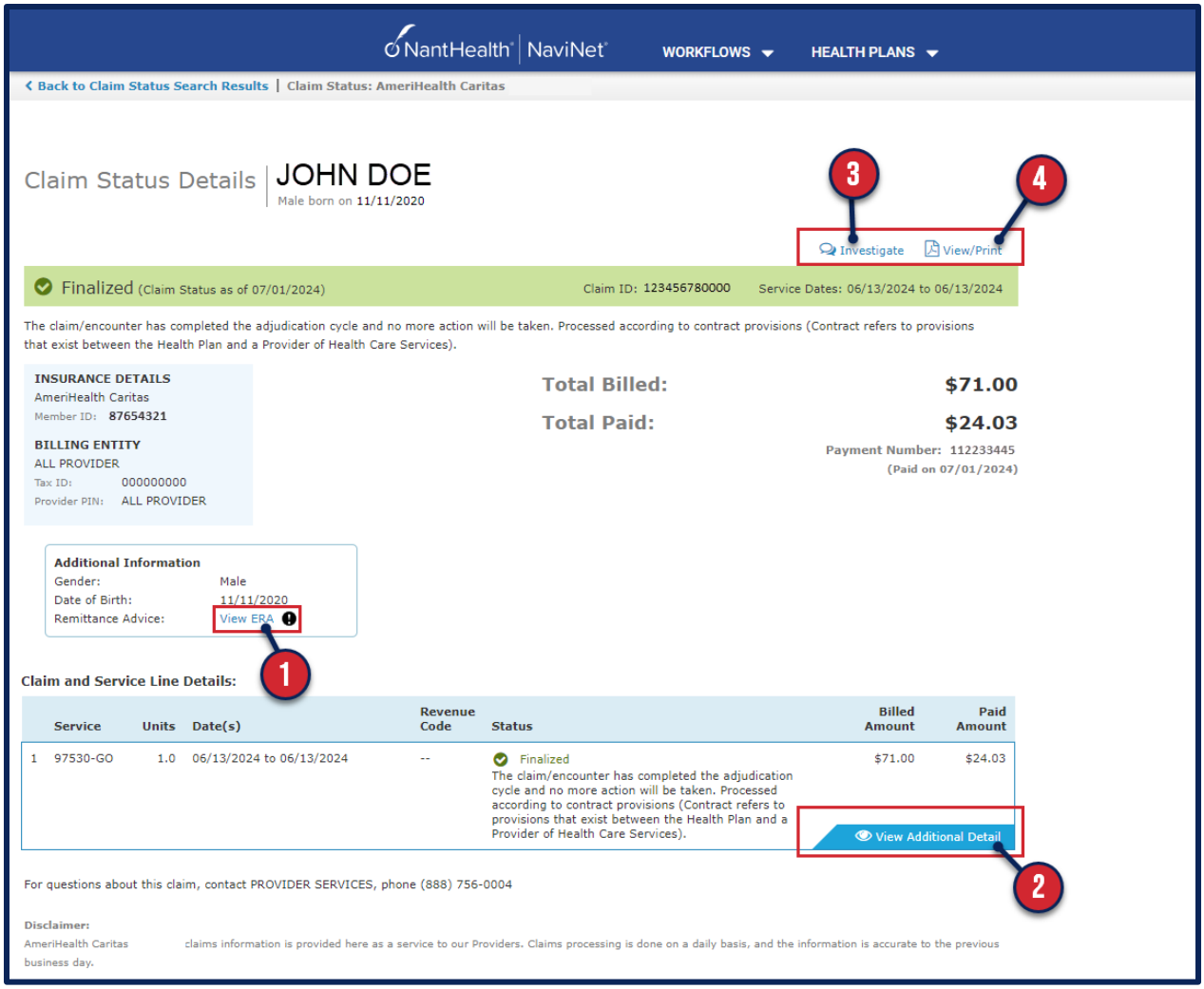


CLAIM STATUS INQUIRY CONT'D.

Additional Information Links

On the Claims Status Details page, you will find a few links that provide additional information about the claim.

1. **View ERA** – this link will download a PDF copy of the remittance advice.
2. **View Additional Detail** – this link provides specific information on the claim lines billed.
3. Investigate – You can request and initiate the claim investigation process.
4. **View /Print** – This option gives you the opportunity to print the Claim Status Detail.

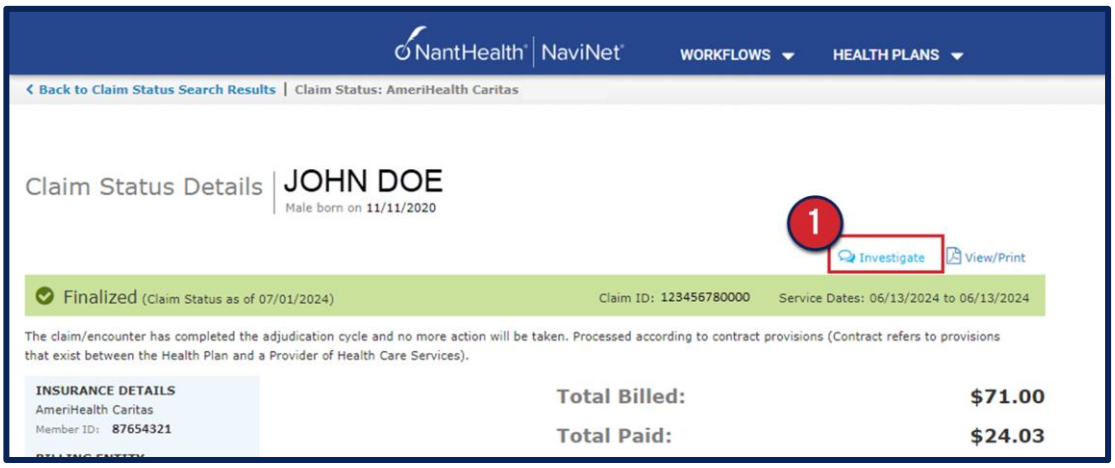


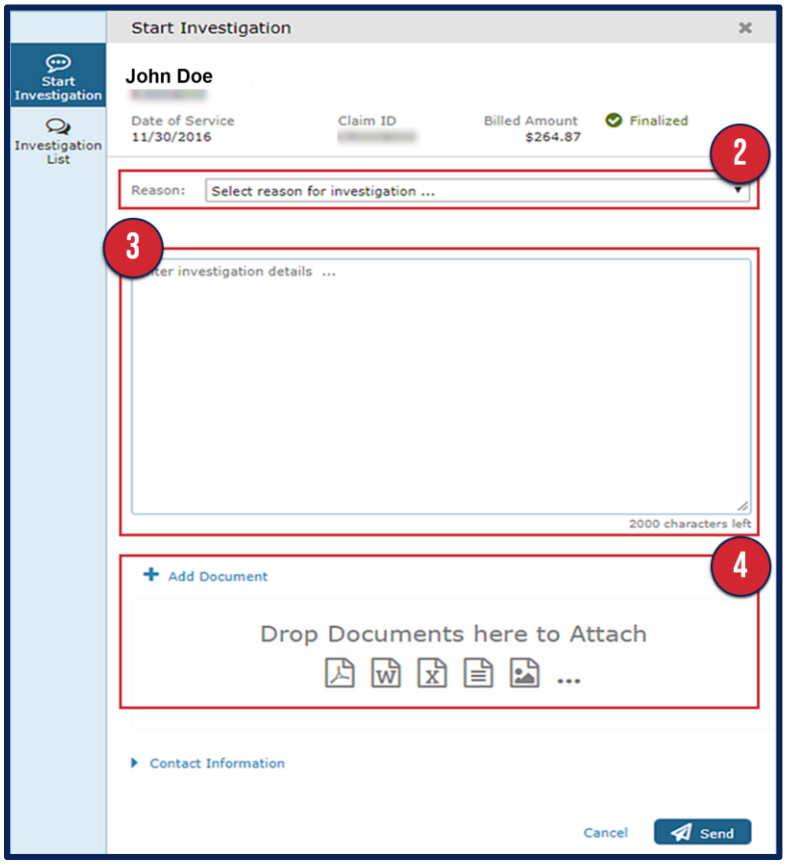
New Investigation

The Claim Inquiry function, also referred to in this guide as a Claim Investigation, allows ancillary, facility, and professional providers the ability to submit a claim inquiry on claims that were previously finalized.

To submit a claim:

1. Click Investigate on the Claims Status Detail page.
2. On the Start Investigation pop-up, select the Reason for the investigation.
3. Enter investigation details. Please be as specific as possible.
4. To Add an attachment to the investigation, click **Add Document** to choose a document, or drag and drop a document into the applicable field.



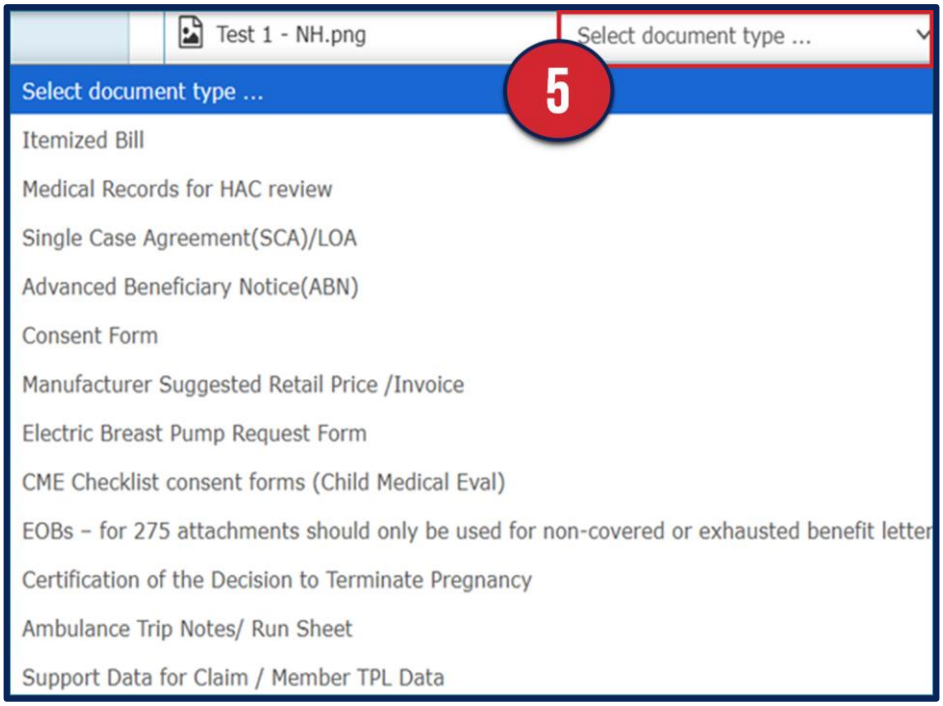


CLAIM INVESTIGATION CONT'D.

New Investigation Cont'd.

5. Select the document type from the dropdown menu.
6. Type your contact information.
7. Click Send.

The system sends the investigation message to the plan, and your message appears in the Investigation List pane.



Note: Email address is required, but notifications will NOT be sent via email.

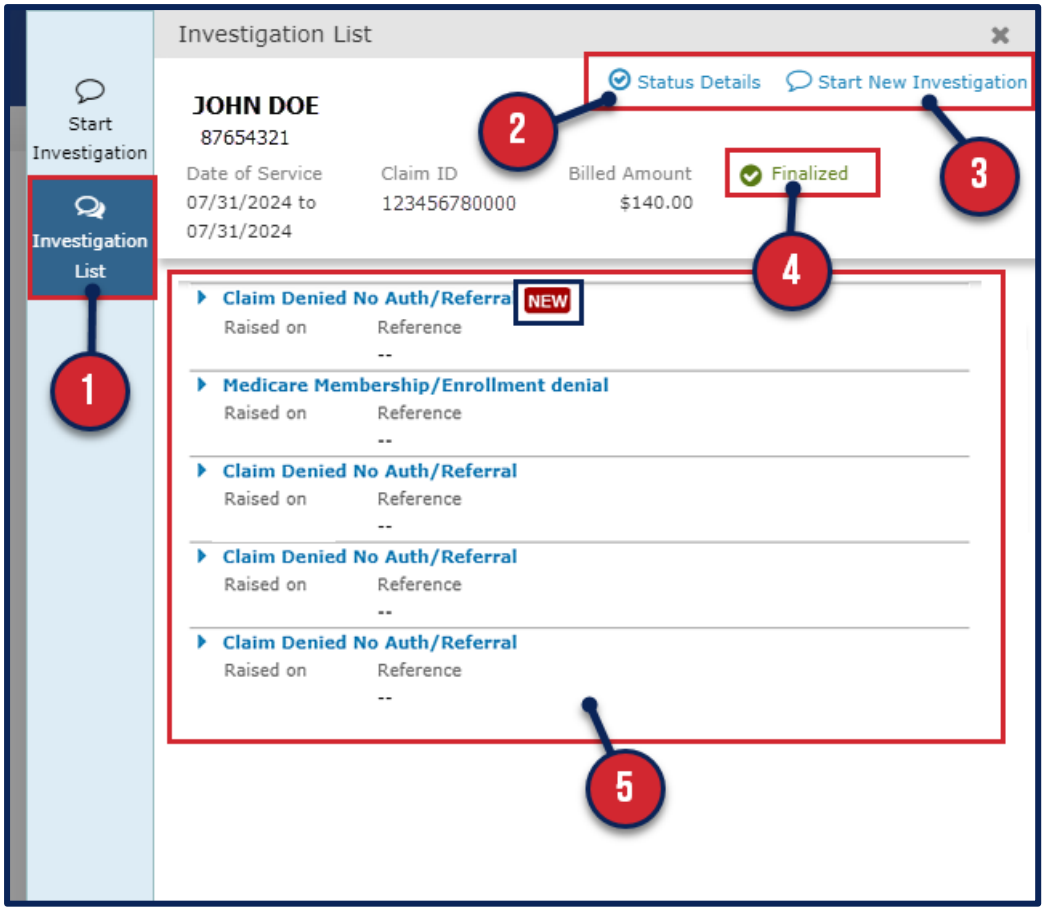
CLAIM INVESTIGATION CONT'D.

Investigation List

Your inquiry will now show on the investigation list.

Items that can be seen on the Investigation List:

1. **Investigation List Icon –** Click this icon to see the list of existing investigations.
2. **Status Details** – One the upper-left of the window is a blue Status Details link. Click this to be redirected to the claim details page.
3. **Start New Investigation—**The Start New Investigation link is at the upper right of the Investigation screen. Click this to create a new message for the health plan.
4. **Claim Status** – On the upper right of the Investigation screen, the status of the claim is displayed.
5. **Investigation Communications** – Click on an investigation to view the health plan response.
    - **NEW** Icon – this icon will appear next to the investigation with a health plan response that you have not yet viewed.

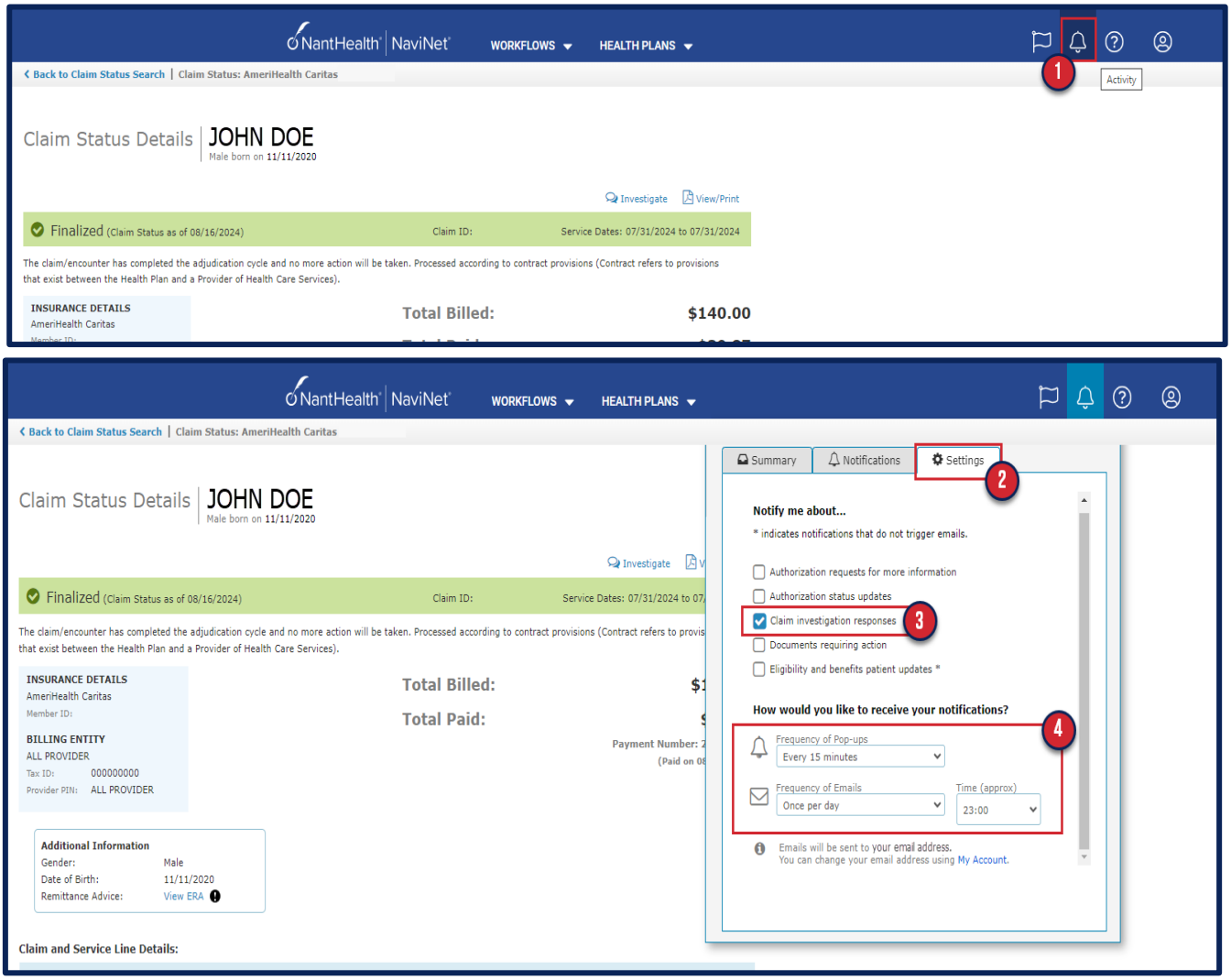


CLAIM INVESTIGATION CONT'D.

Enabling Claim Investigation Notifications

To enable Claim investigation notifications:

1. Click the Activity Icon (bell) on the Menu bar
2. Select the Settings tab
3. Check the box for Claim investigation responses
4. Select the frequency in which you would like to receive your notifications

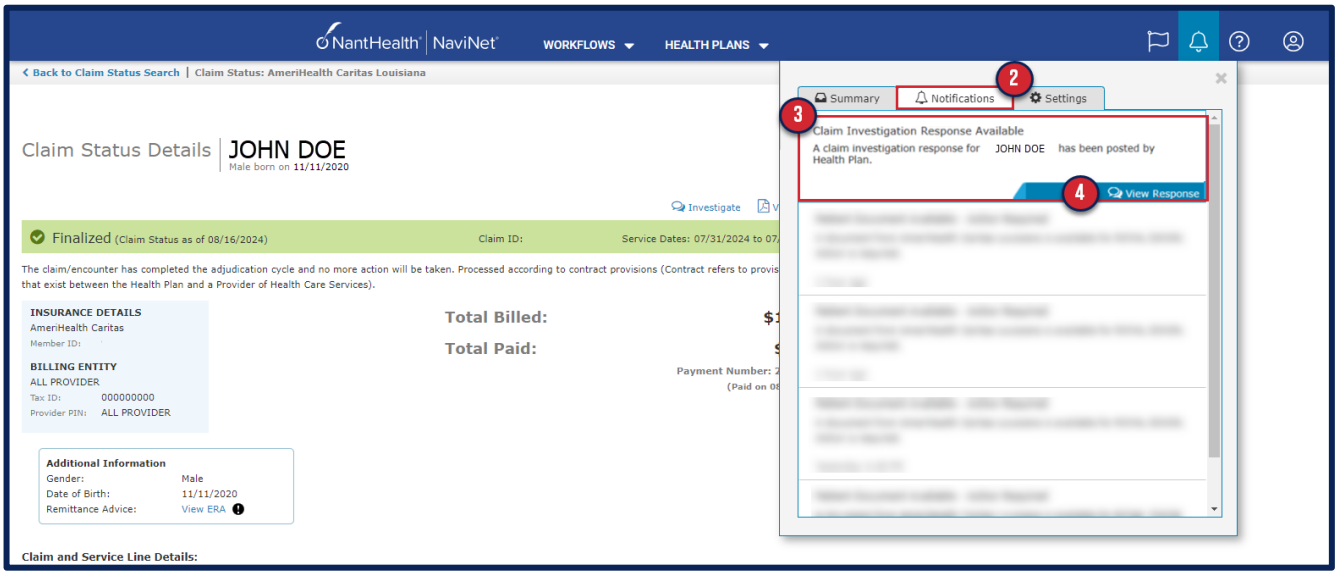


Note: Your e-mail is required to receive the notifications for the claim's investigation function

Notifications

To view the notifications:

1. Click the Activity Icon (bell) on the Menu bar
2. Select the Notifications tab
3. Select the notification you want to view
4. Click View Response to view Claim investigation sent to the health plan.



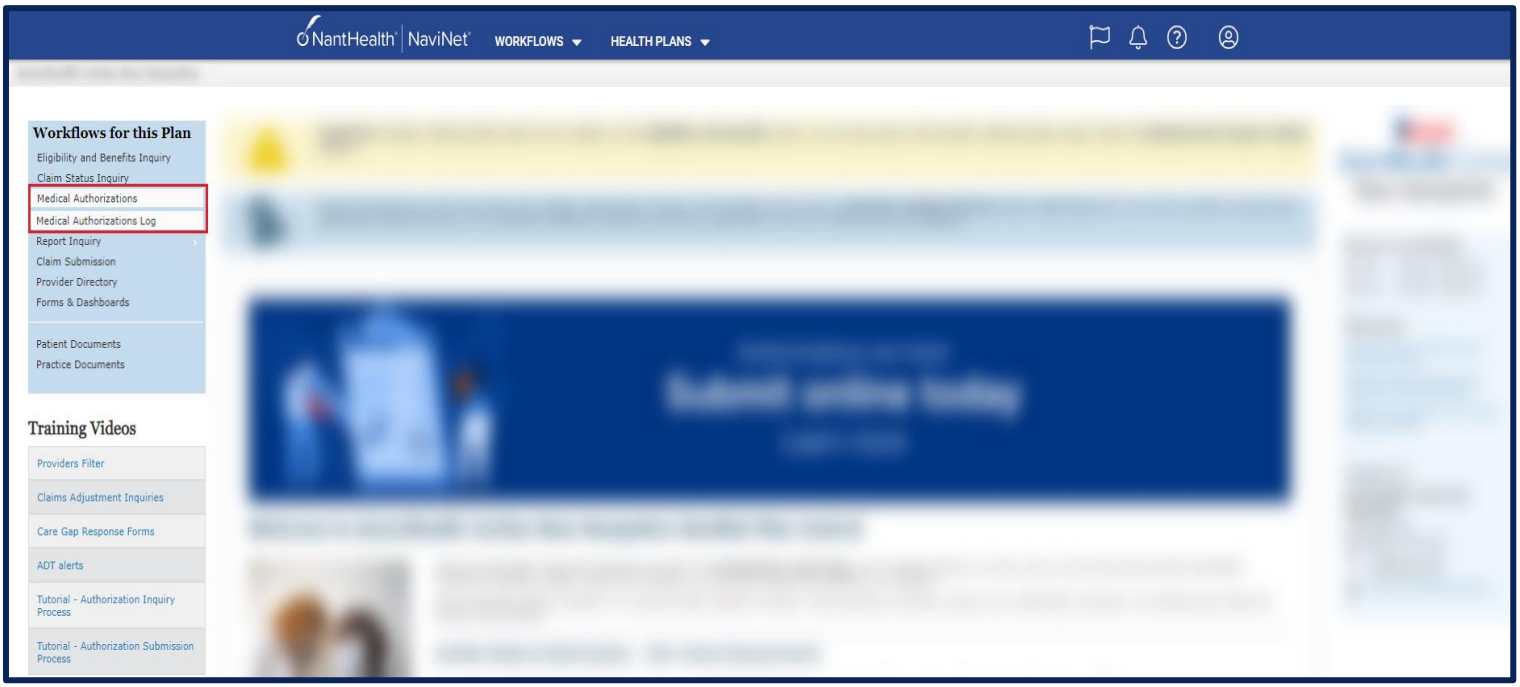
Note: Responses will be available to view for 7 days from the date of the notification.

MEDICAL AUTHORIZATIONS

The Medical Authorization workflow is a robust, intuitive, and streamlined online authorization workflow.

In addition to submitting and inquiring about existing Authorizations, you will be able to:

- Verify if No Authorization is required
- Receive Auto Approvals, in some circumstances
- Submit Amended Authorization
- Attach supplemental documentation
- Sign up for in-app status change notifications directly from the health plan
- Access a multi-payer Authorization log



Note: For additional information on submitting authorizations and the medical authorization log, please reference the NaviNet Medical Authorization Participation Guide located on the NaviNet page of most plan websites. If you cannot locate the guide, contact your Provider Network Management Account Executive.

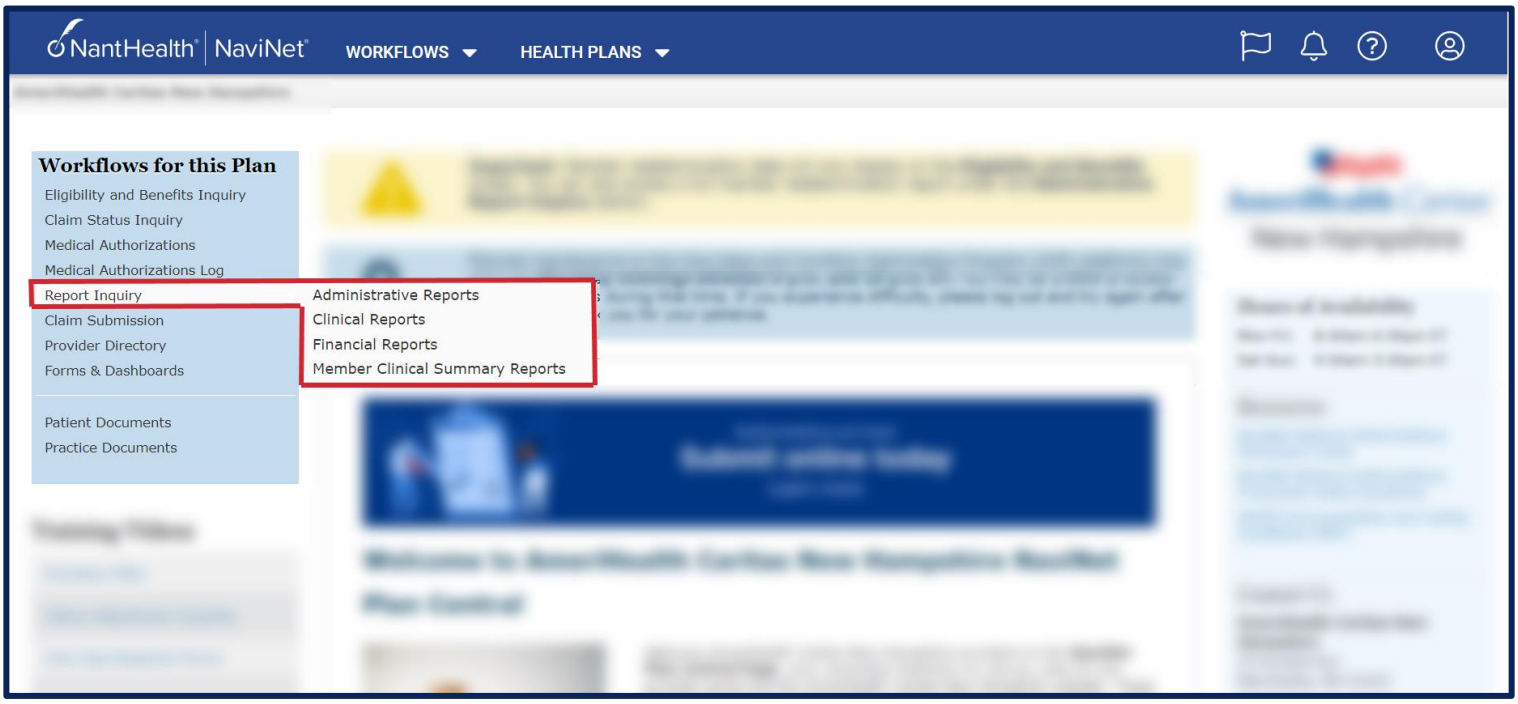
REPORT INQUIRY

Use Report Inquiry to access a variety of reports.

The following reports are available in this workflow. The types of reports available may vary by health plan:

- Administrative Reports
- Clinical Reports
- Financial Reports
- Member Clinical Summary Reports

Review the Reports section of this guide for more information on the available reports, including those listed above.



ADMINISTRATIVE REPORTS

Report Inquiry

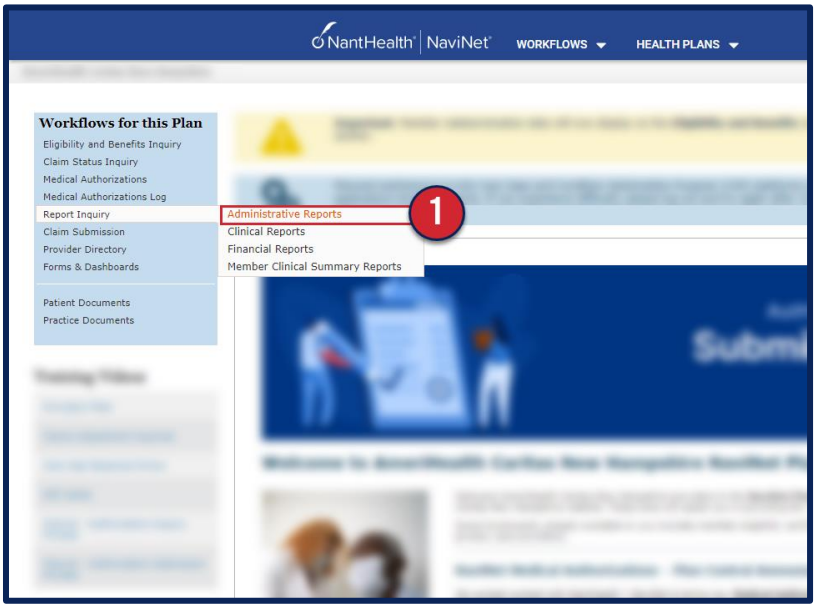
Numerous administrative reports are used. This may vary by health plan.

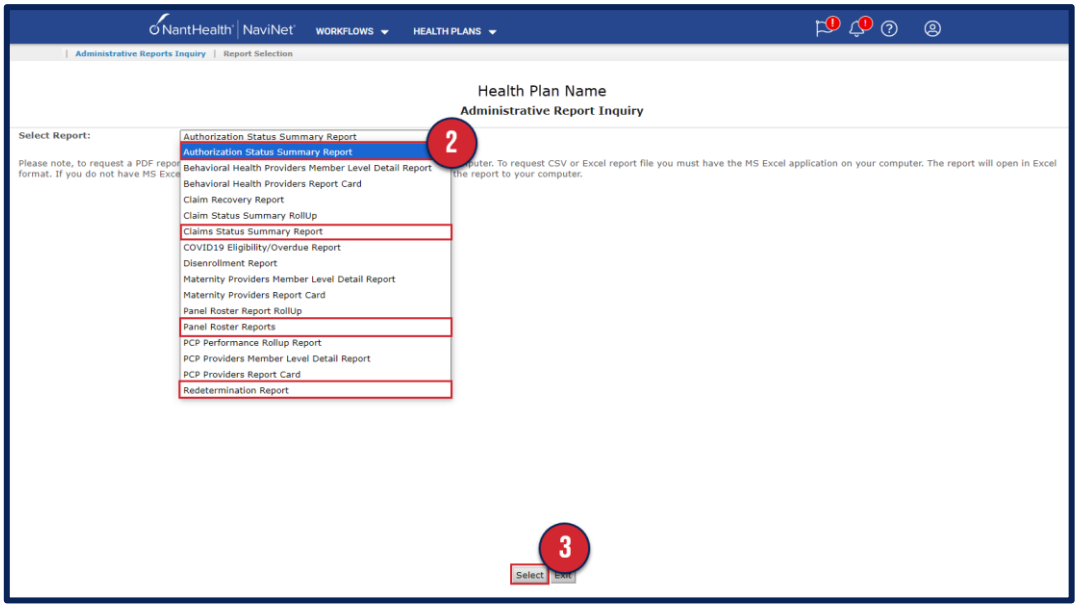
The most frequently used reports are:

- Authorization Status Summary
- Claim Status Summary
- Panel Roster
- Redetermination Report

To access any of these reports:

1. Select Administrative Reports from the Report Inquiry options in the Workflows for this Plan
2. Select the report you want to view from the drop-down
3. Click Select



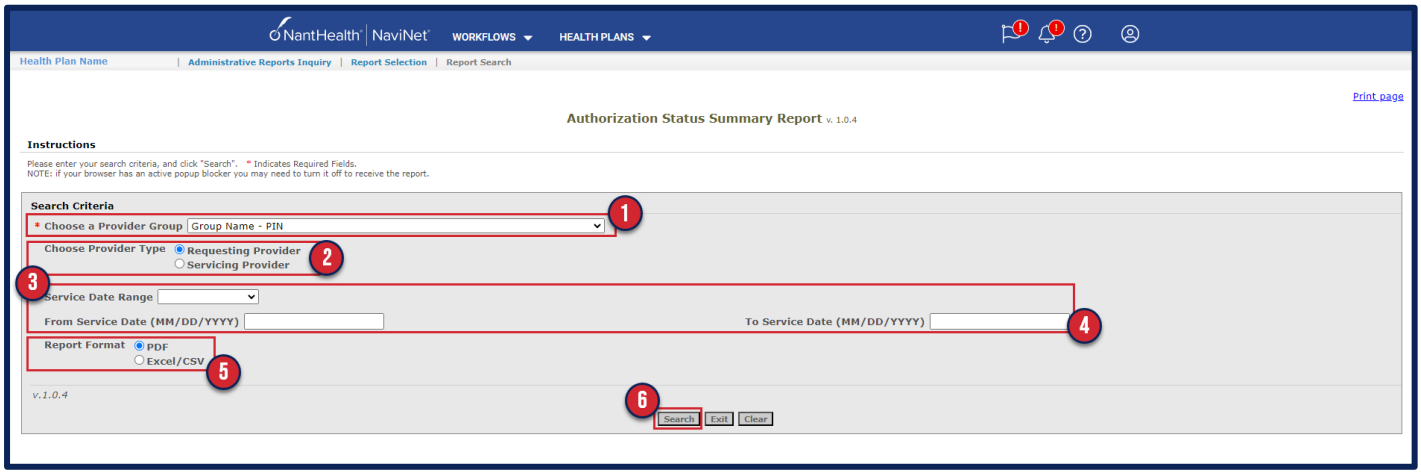


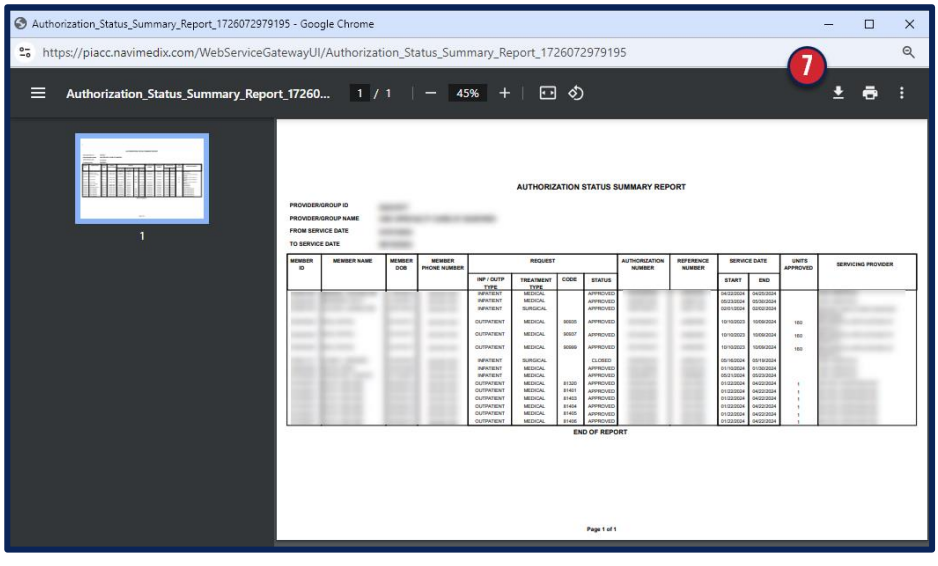
ADMINISTRATIVE REPORTS CONT'D.

Authorization Status Summary Report

You can request authorization summary reports directly in NaviNet, by either the requesting or servicing provider.

1. Select a Provider Group from the drop-down
2. Select the Provider Type
3. Select the Service Date Range
4. Enter the Service From and To Dates
5. Select Report Format (PDF is selected by default)
6. Click Search
7. An Authorization Summary Report will be generated based on the search criteria. The report will display in another window in the format selected. The example below is a PDF.

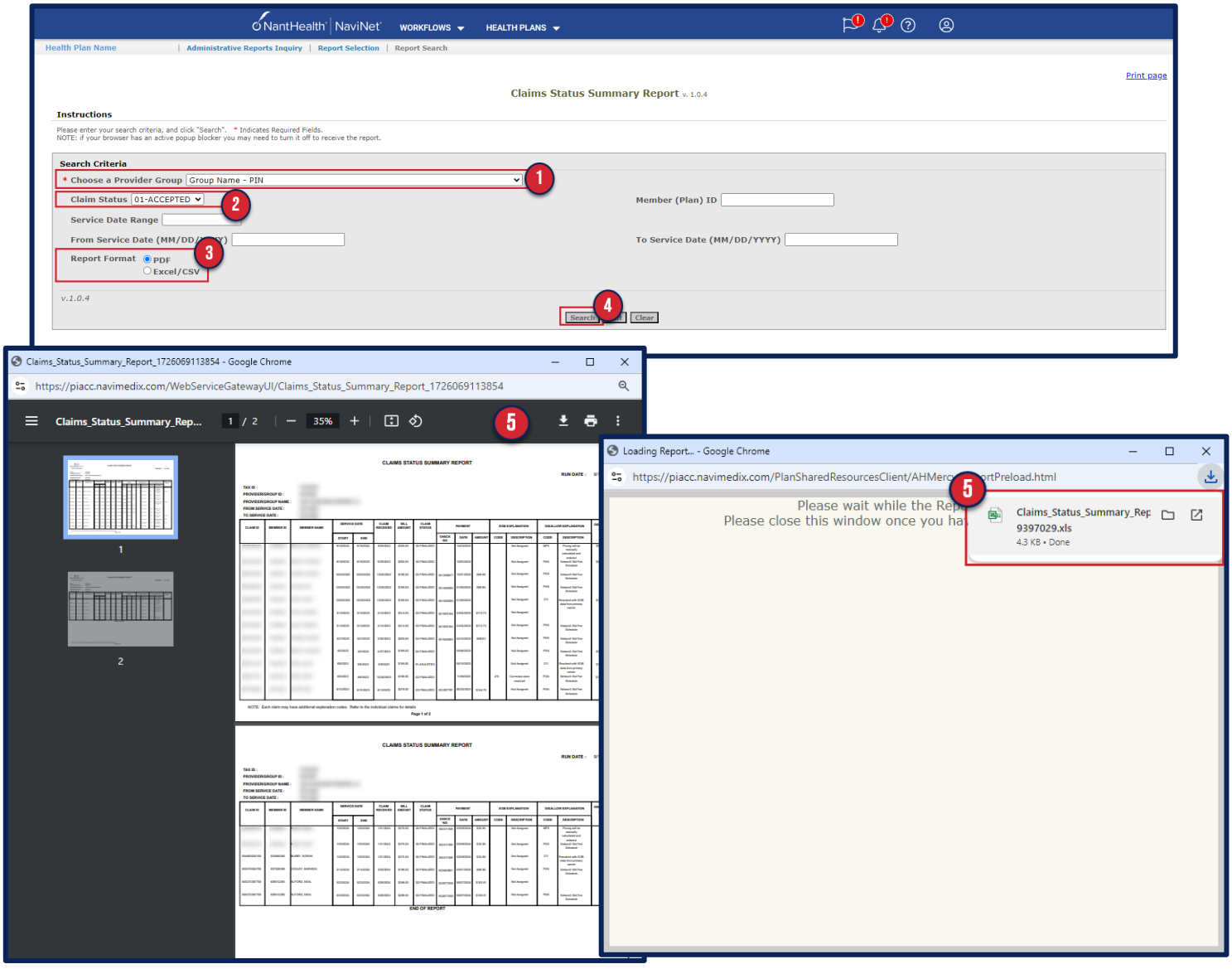




Claim Status Summary Report

You can request a full claim status report in PDF or Excel format.

1. Choose a Provider Group from the drop-down
2. Select Claim Status
3. Select the Report Format (PDF is selected by default)
4. Click Search
5. The Claim Status Summary will display in another window as a PDF or an Excel download.

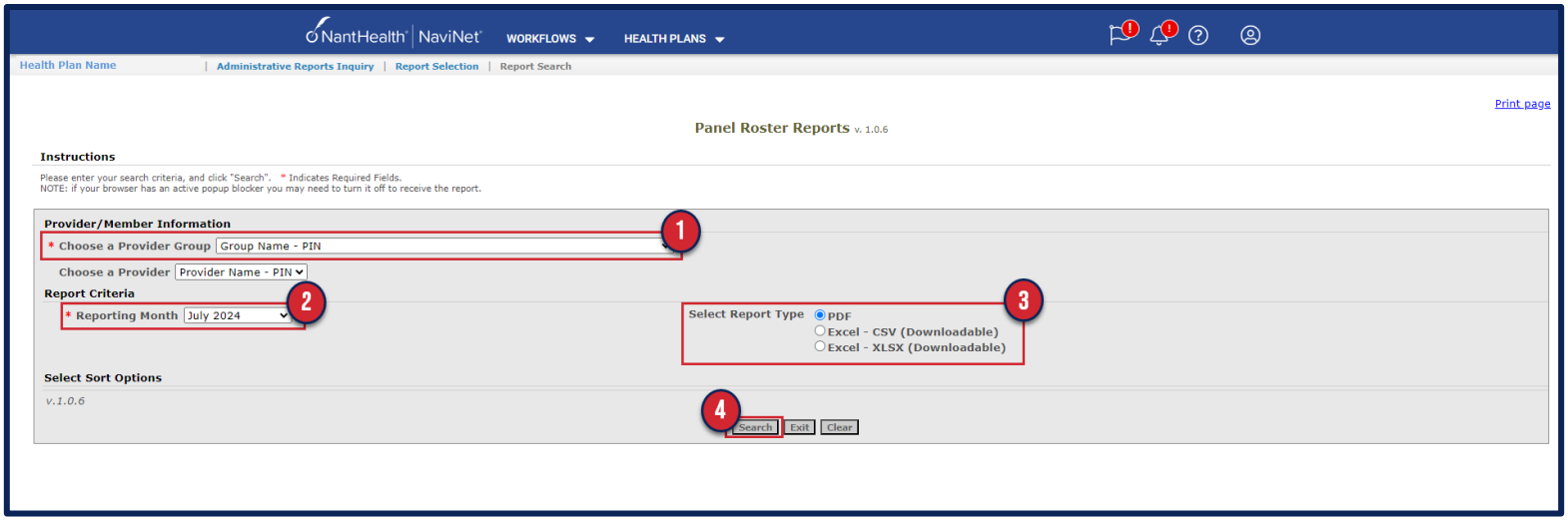


ADMINISTRATIVE REPORTS CONT'D.

Panel Roster Report

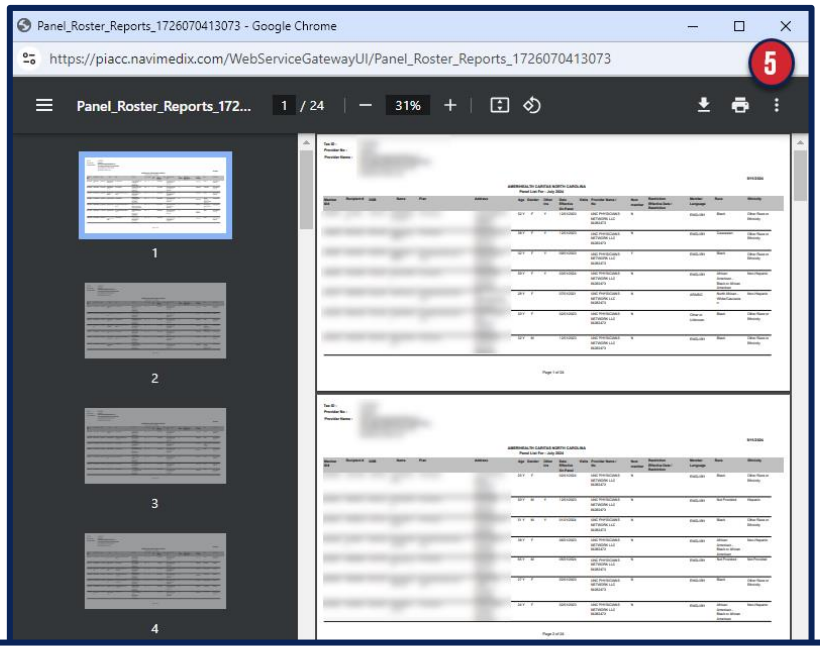
You can run a panel roster report directly from NaviNet.

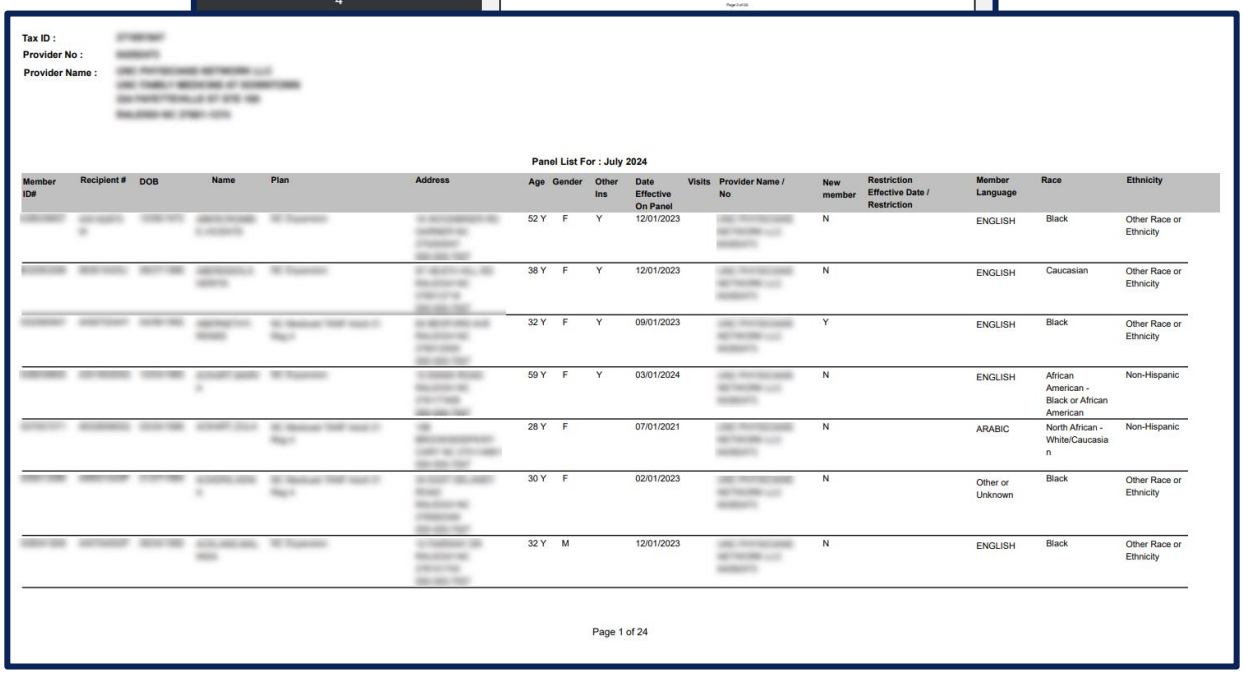
1. Select the Provider Group from the drop-down
    - Once the Group name is chosen, you have the option to also select a specific provider (practitioner) within the group. If you choose not to select a provider, you will receive the panel roster for ALL providers in this group.
2. Select the Reporting Month from the drop-down
3. Select the Report Type (PDF is selected by default)
4. Click Search



Panel Roster Report Cont'd.

5. The report will be displayed in another window in the format selected. The example below is a PDF.
    - The Panel Roster Report will provide you with your patient's Member ID, Medicaid Recipient ID, and Panel Effective Date, as well as basic demographic and contact information.





Tax ID :
Provider No :
Provider Name :

Panel List For : July 2024

Member ID#	Recipient #	DOB	Name	Plan	Address	Age	Gender	Other Ins	Date Effective On Panel	Visits	Provider Name / No	New member	Restriction Effective Date / Restriction	Member Language	Race	Ethnicity
						52 Y	F	Y	12/01/2023			N		ENGLISH	Black	Other Race or Ethnicity
						38 Y	F	Y	12/01/2023			N		ENGLISH	Caucasian	Other Race or Ethnicity
						32 Y	F	Y	09/01/2023			Y		ENGLISH	Black	Other Race or Ethnicity
						59 Y	F	Y	03/01/2024			N		ENGLISH	African American - Black or African American	Non-Hispanic
						28 Y	F		07/01/2021			N		ARABIC	North African - White/Caucasian	Non-Hispanic
						30 Y	F		02/01/2023			N		Other or Unknown	Black	Other Race or Ethnicity
						32 Y	M		12/01/2023			N		ENGLISH	Black	Other Race or Ethnicity

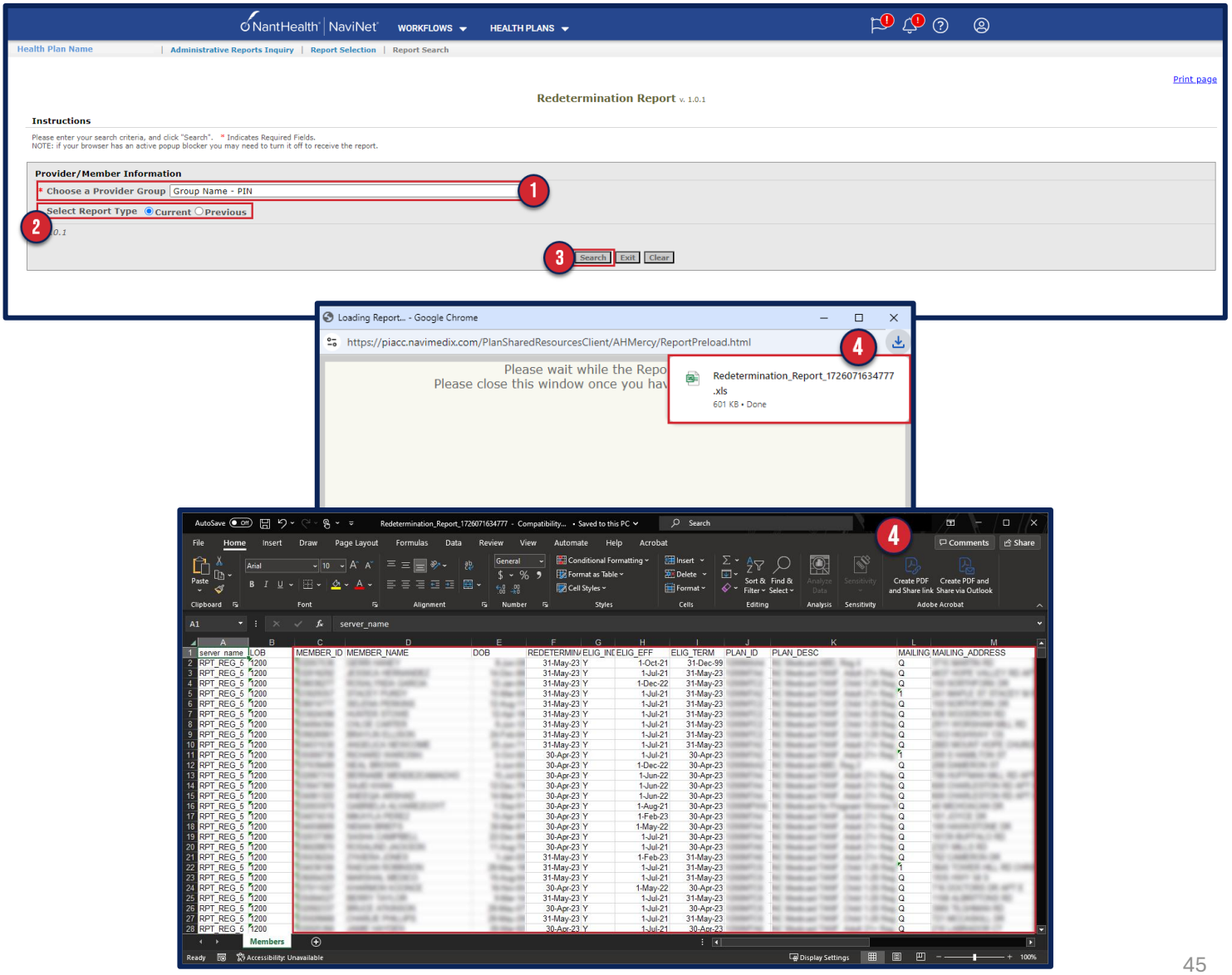
Page 1 of 24

ADMINISTRATIVE REPORTS CONT'D.

Redetermination Report

You can run a Redetermination Report to see a full list of members on the PCP's roster who have upcoming eligibility redetermination dates.

1. Choose your Provider Group from the drop-down
2. Select Report Type
3. Click Search
4. The report will open in another window and download an excel spreadsheet where the provider will be able to see the member's name, ID, Redetermination Date, Mailing Address, and any applicable plan details.



Clinical Reports

There are various clinical reports available through NaviNet that can assist your office in improving patient outcomes.

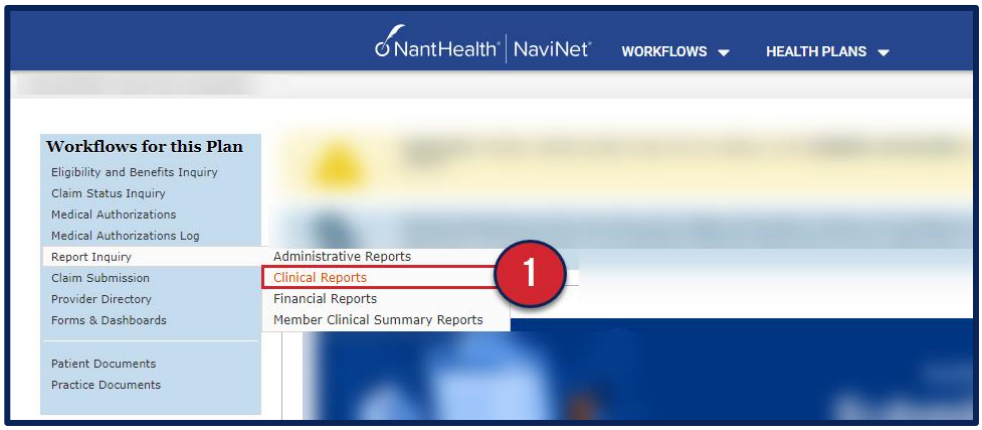
The reports that are available can vary from plan to plan. For the purposes of this user guide, Care Gap queries, Member Alert Standalone Care Gap Requests, and Hospital Admissions Reports are featured.

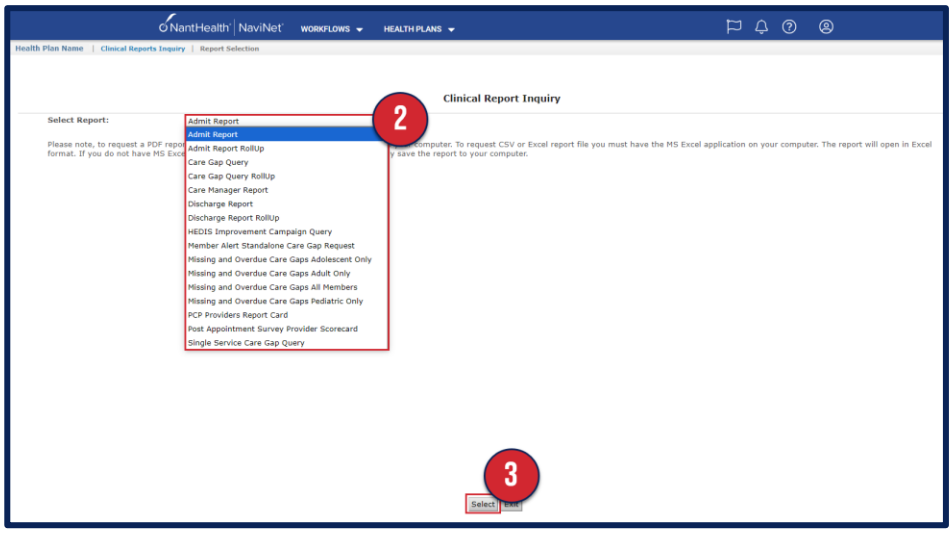
Additional reports that are available include, but are not limited to:

- Missing and Overdue Care Gaps for All
- Missing and Overdue Care Gaps Pediatric Only
- Missing and Overdue Care Gaps Adults Only

To access any of these reports:

1. Select Clinical Reports from the Report Inquiry options in the Workflows for this Plan
2. Select the report you want to view from the drop-down
3. Click Select



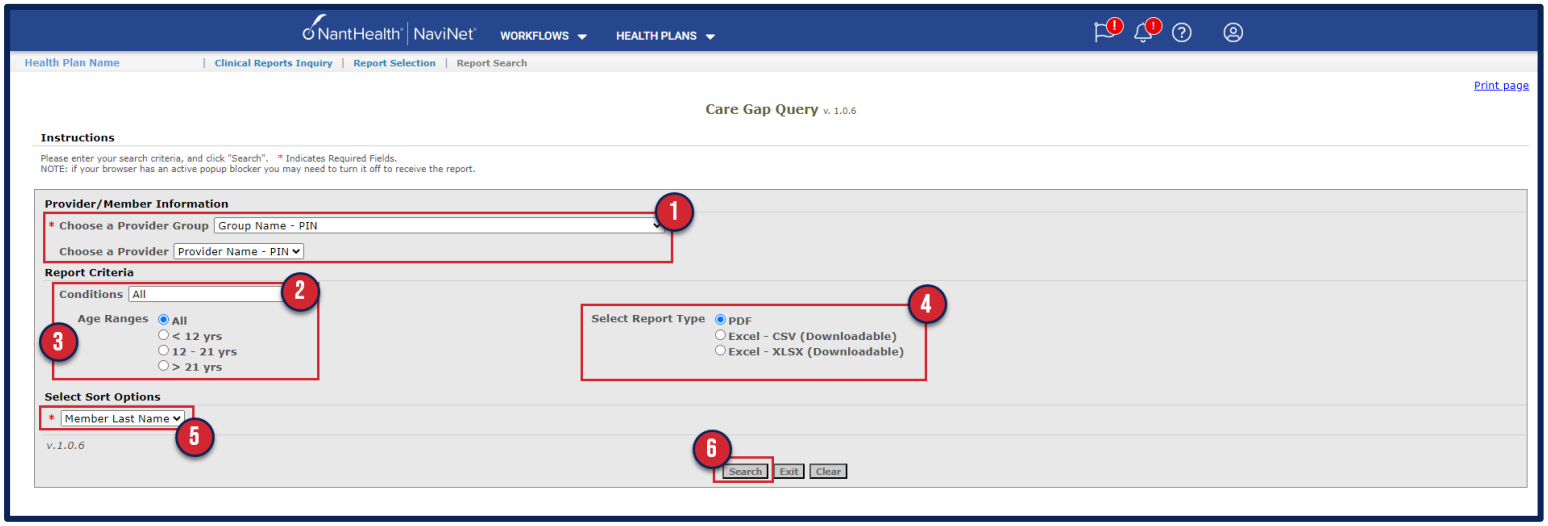


CLINICAL REPORTS CONT'D.

Care Gap Query

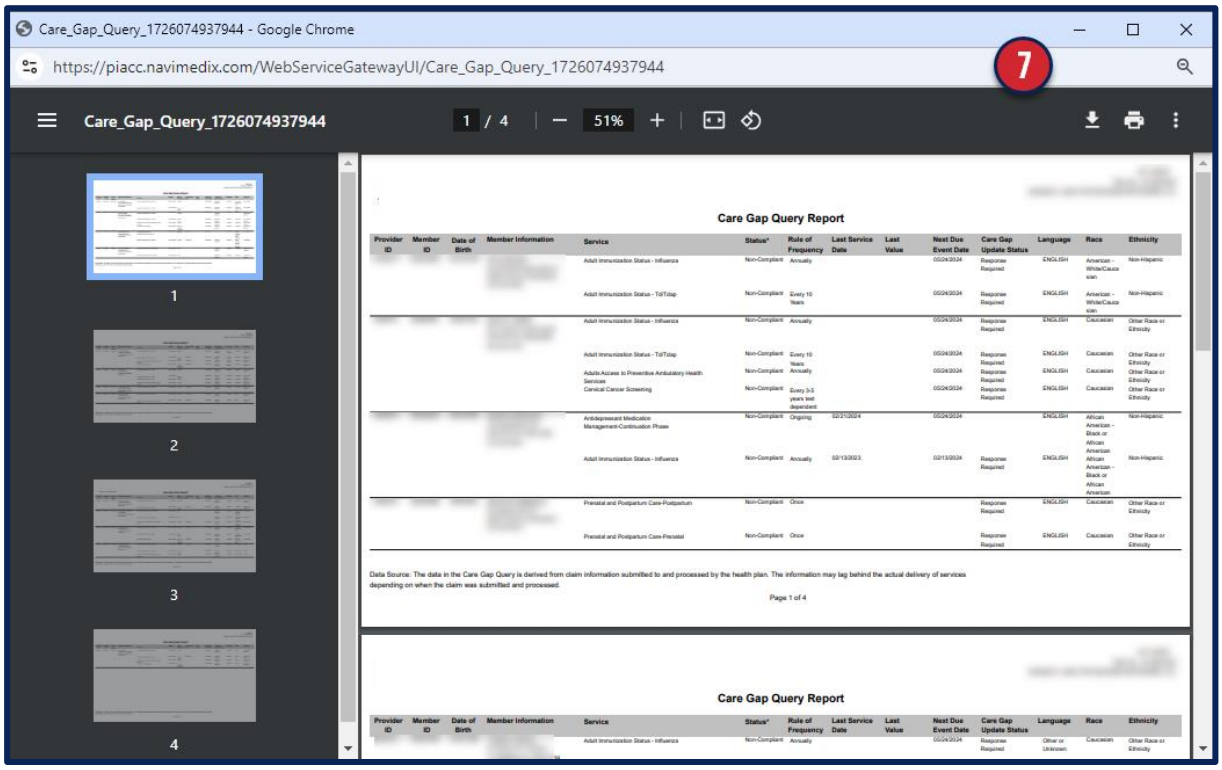
The Care Gap Query report is a customizable report that provides all the care gap information for the plan members in your practice.

1. Select a Provider Group
2. Select All or a specific condition
3. Select Age Range
4. Select Report Type (PDF is selected by default)
5. Select Sort Options
    - You can select by Member Last Name, Provider ID, Conditions or Service
6. Click Search



Care Gap Query Cont'd.

7. The report will display in another window in the format selected

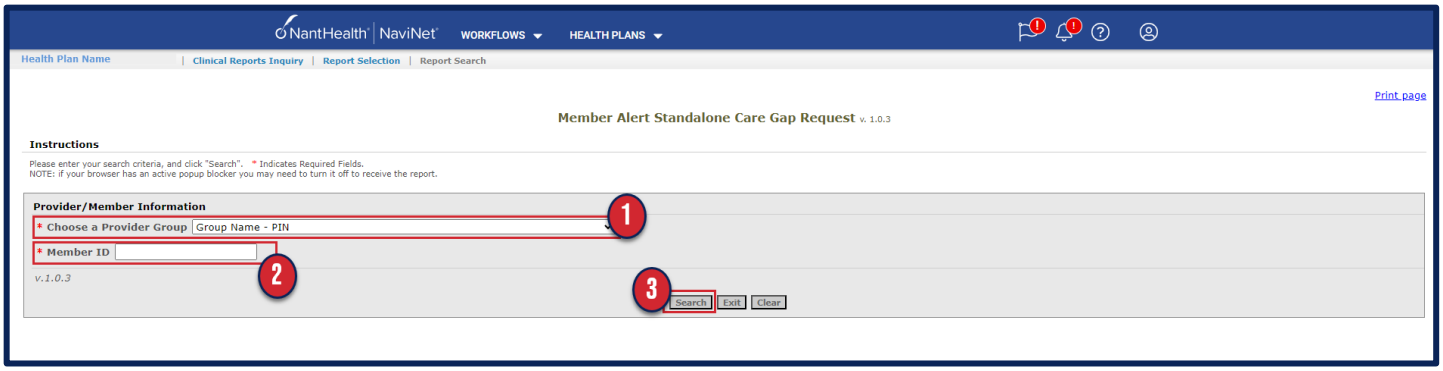


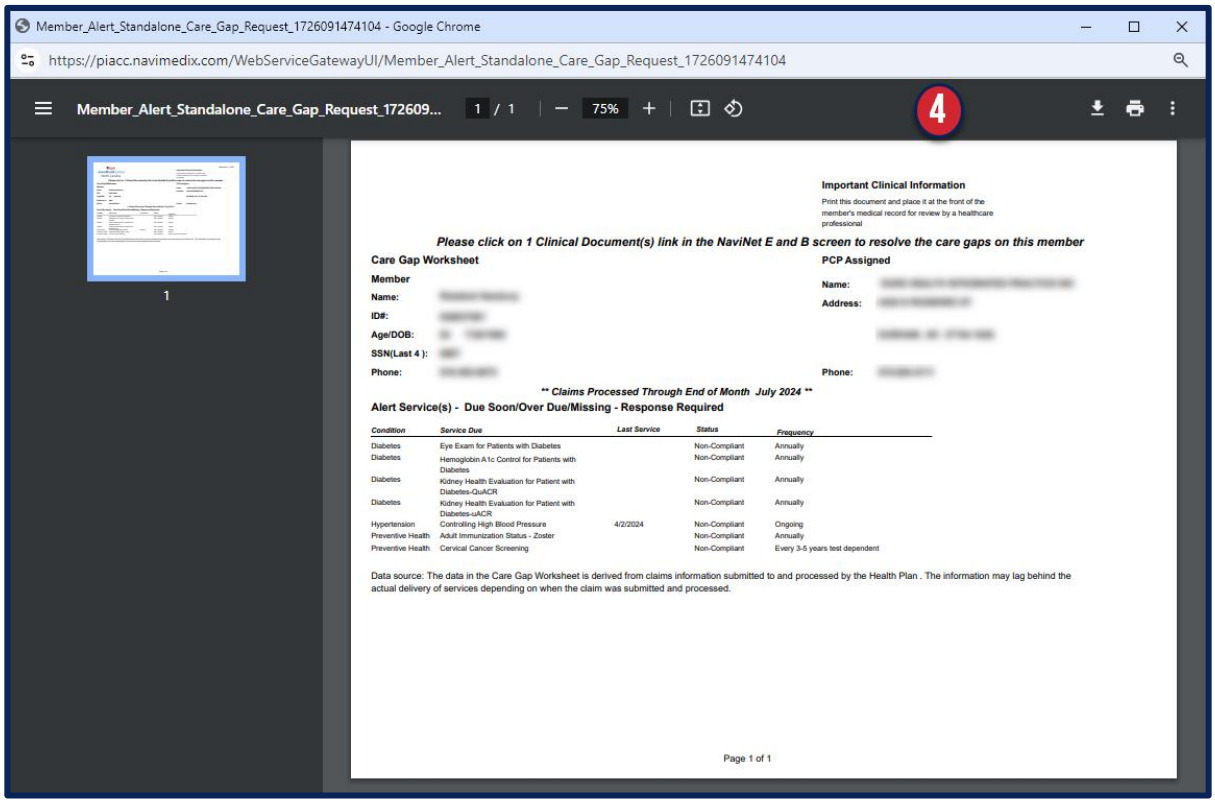
Note: You can resolve open Care Gaps directly in NaviNet using the Care Gap Response Form process. Please refer to the Care Gaps Response Form User Guide and or the video tutorial on your Plan Central Page for more details.

Member Alert Standalone Care Gap Request

You can view the member's Care Gap Worksheet referenced in the Patient Alert Details section, by accessing the Member Alert Standalone Care Gap Request.

1. Select a Provider Group
2. Enter the Member's ID
3. Click Search
4. The Care Gap Worksheet will display in another window

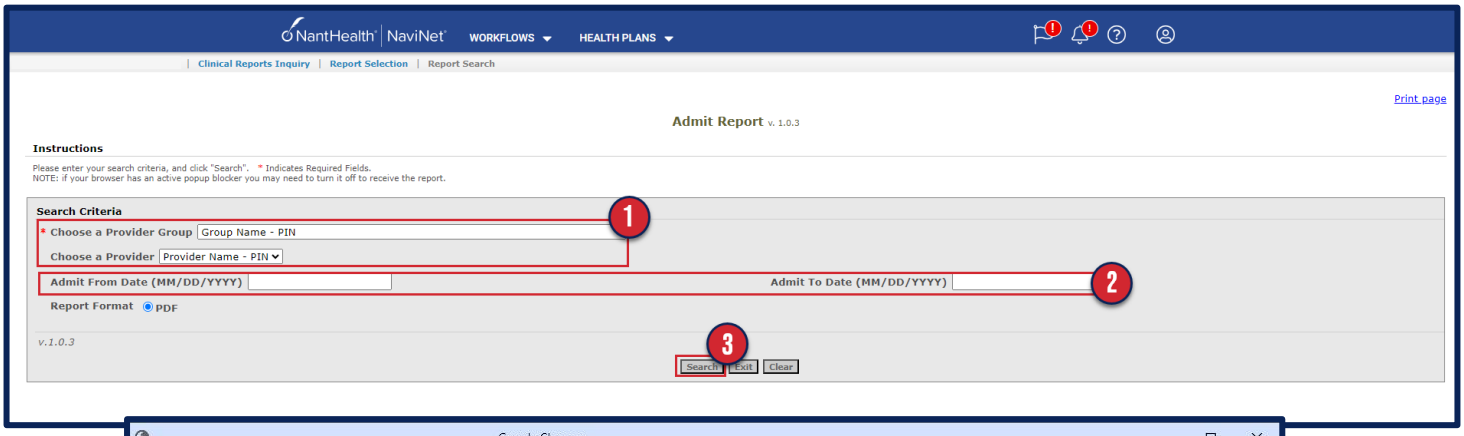


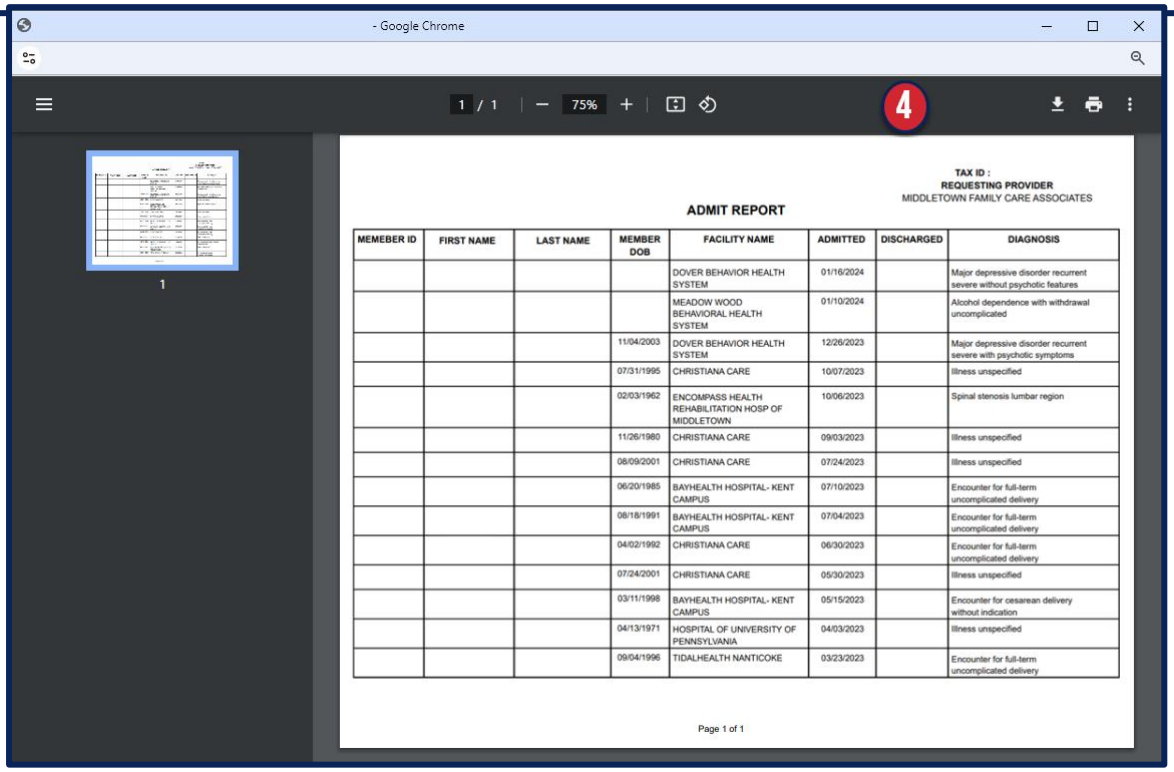


Admit Report

The Admit report contains information on the patients who have been admitted to the hospital.

1. Select a Provider Group
    - You can also select a specific Provider
2. Enter the Admit From and To Dates
3. Click Search
4. The report will display in another window





FINANCIAL REPORTS

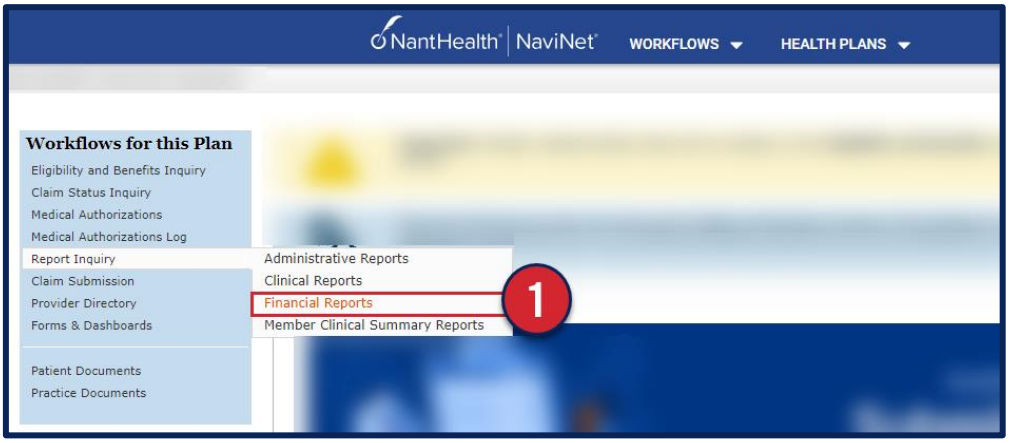
Various financial Reports are used, which vary by health plan. The Financial Reports provide information about the provider's adjusted claims within a date range.

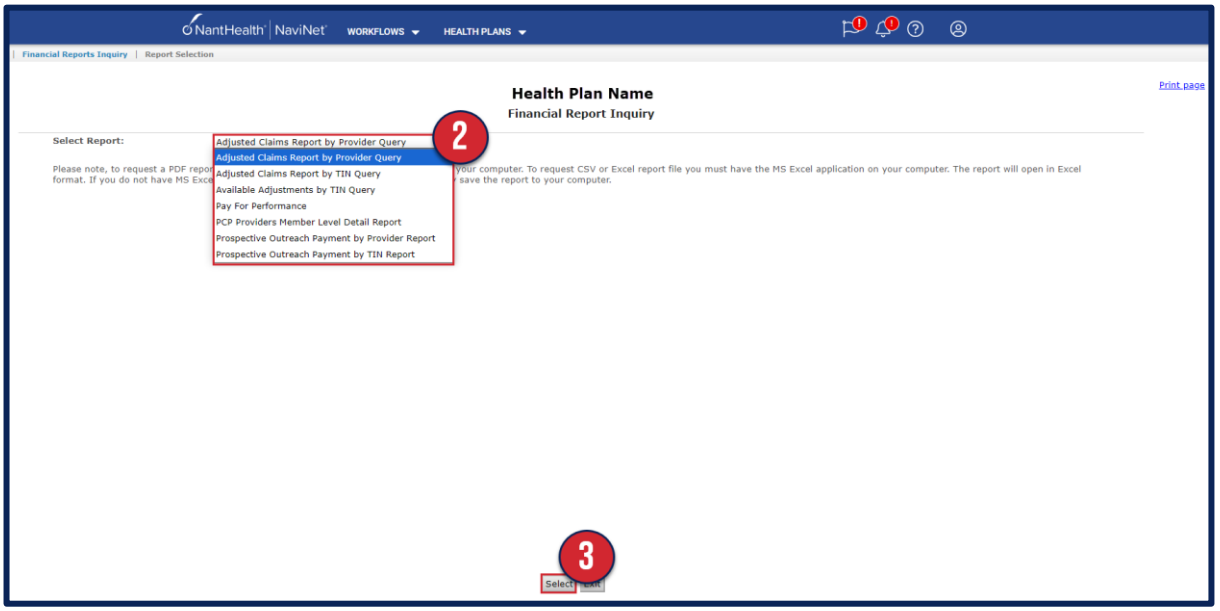
Some of the reports available are:

- Adjusted Claims Report Provider Query
- HEDIS QEP Report
- Pay For Performance
- Prospective Outreach Payment Report

To access any of these reports:

1. Select Financial Reports from the Report Inquiry options in the Workflows for this Plan
2. Select the report you want to view from the drop-down
3. Click Select

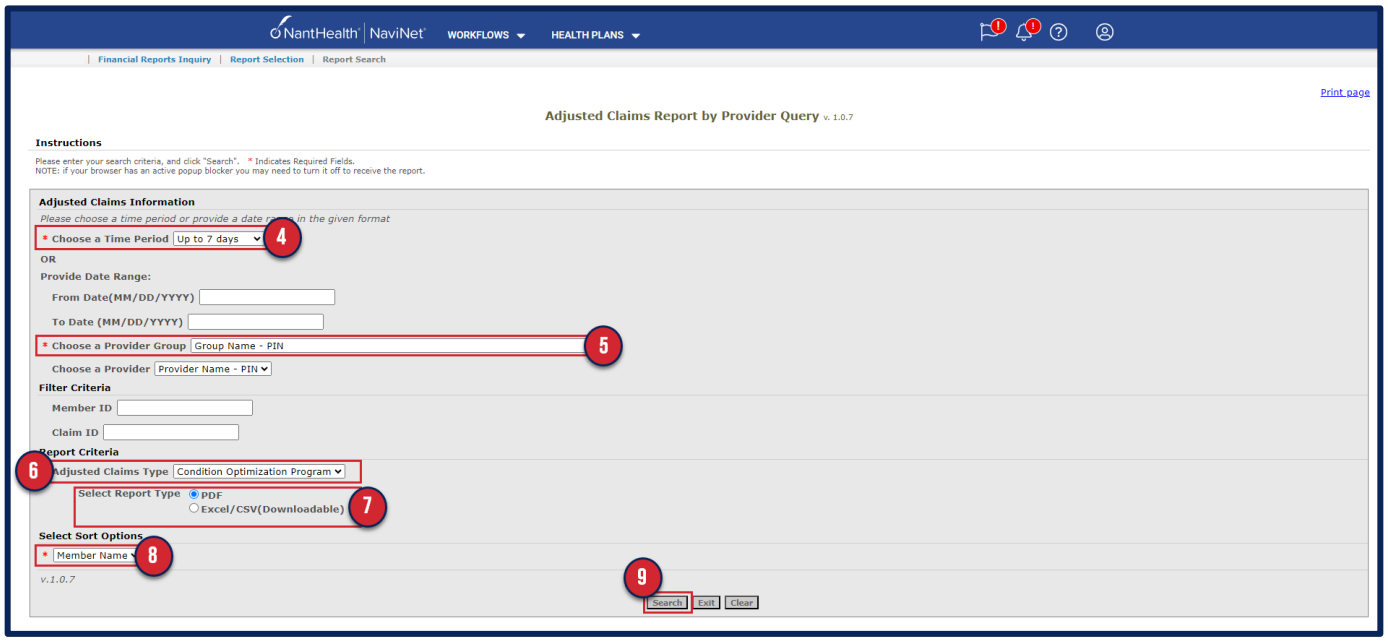


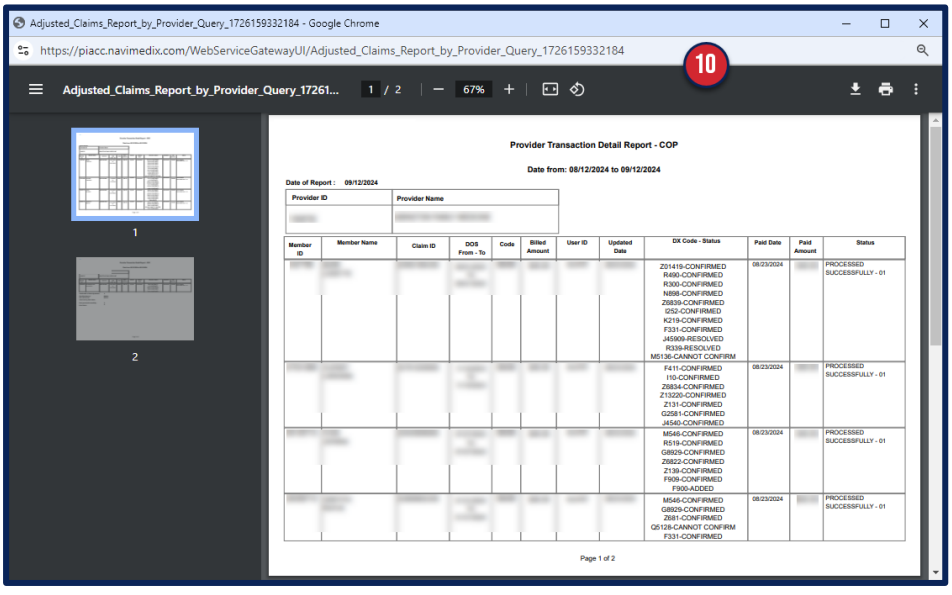


FINANCIAL REPORTS CONT'D.

For this example, the **Adjusted Claims Report by Provider Query** report was selected.

4. Select a Time Period or Enter a Date Range
5. Select the Provider Group
6. Select the Adjusted Claims Type
7. Select Report Type (PDF selected by default)
8. Select Sort Options
9. Click Search
10. The report will display in another window





ROLLUP REPORTS

The Rollup report functionality allows you to run specific NaviNet reports at the TIN level.

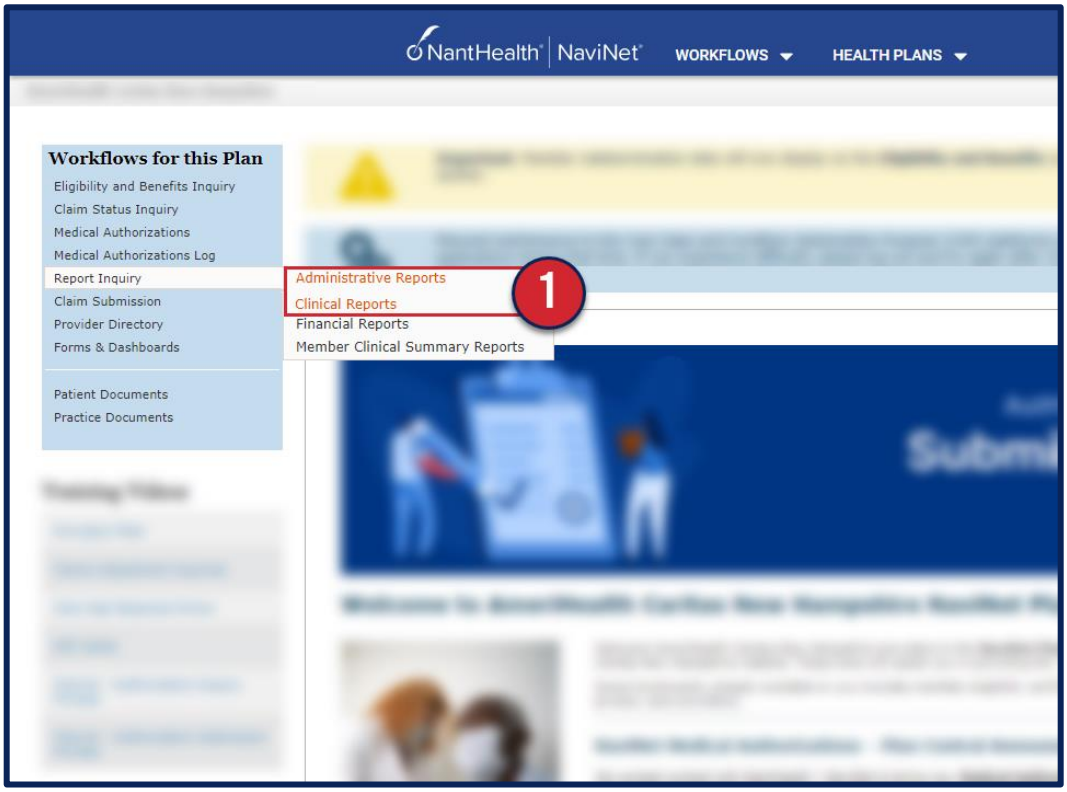
Instead of running a report for each Provider ID number that may exist for your group, you can now run ONE report with data consolidated for the practice at the TIN level.

The specific reports that can be run at the Rollup TIN level are:

- Claims Status Summary Rollup (found in Administrative Reports)
- Panel Roster Report Rollup (found in Administrative Reports)
- Admit Report Rollup (found in Clinical Reports)
- Care Gap Query Rollup (found in Clinical Reports)
- Discharge Report Rollup (found in Clinical Reports)

To create a Rollup report in NaviNet:

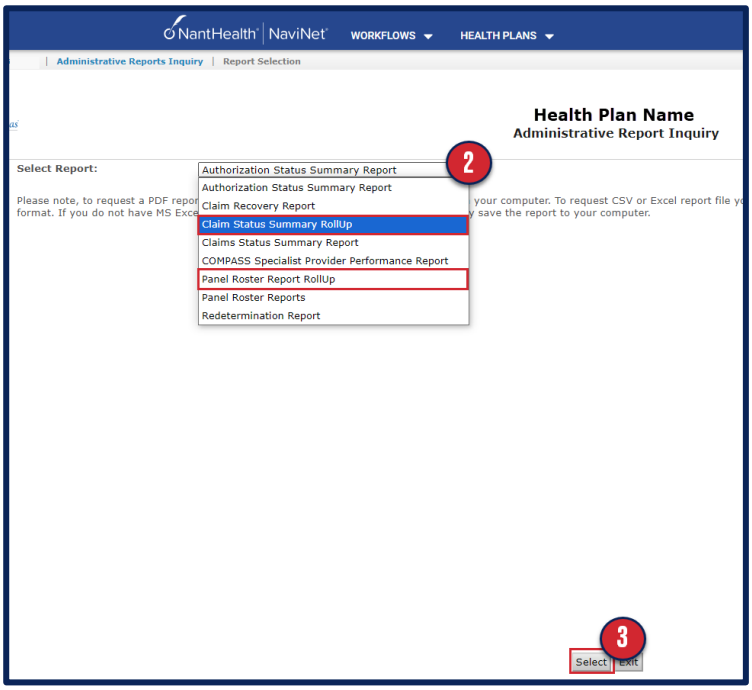
1. Hover over Report Inquiry and Select either Administrative Reports or Clinical Reports within the Workflows for this Plan menu

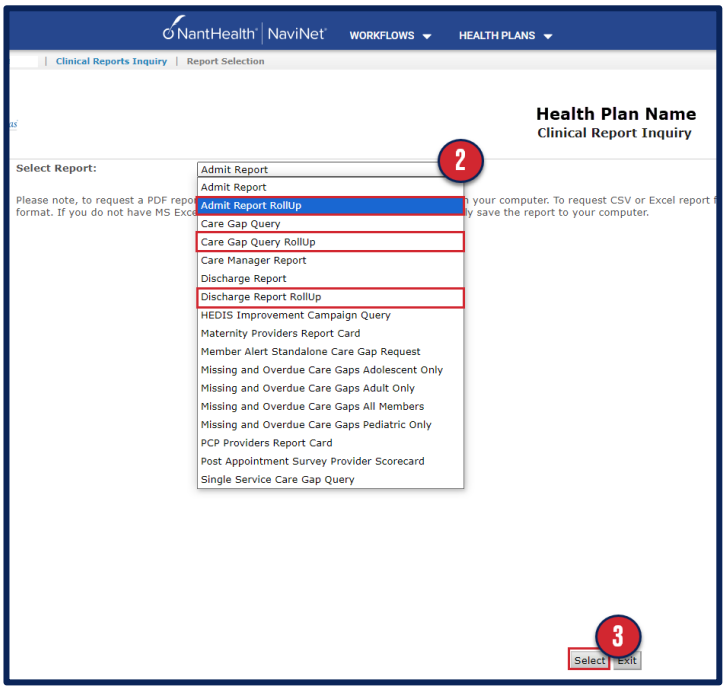


ROLLUP REPORTS CONT'D.

To create a Rollup report in NaviNet cont'd:

2. Select the specific report you would like to run
3. Click Select
4. Select ANY of the Provider Group options from the drop-down
5. Click Search





MEMBER CLINICAL SUMMARY REPORTS

The Member Clinical Summary report provides a snapshot of personal health information.

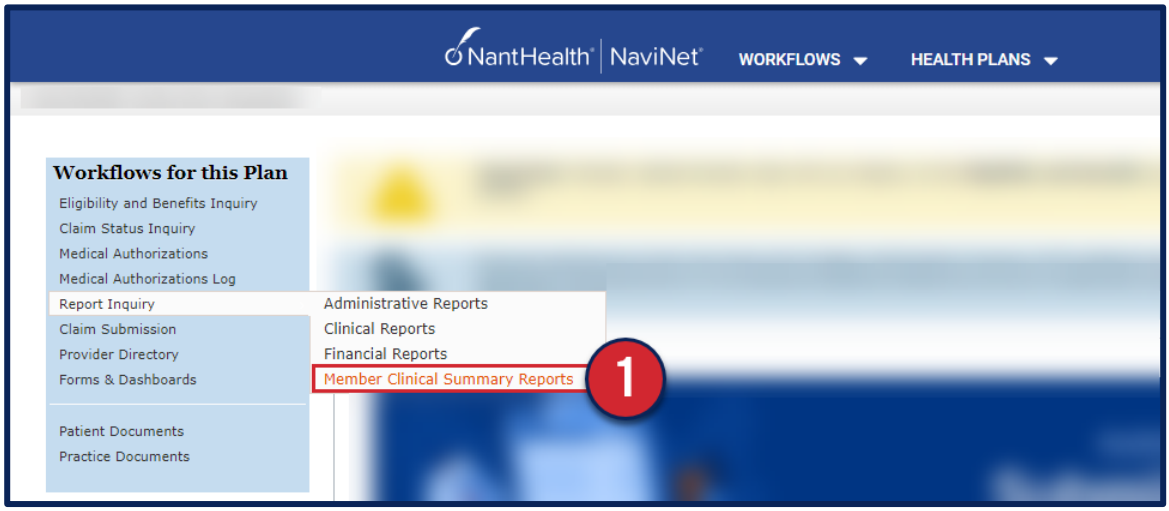
The report captures the following claims-based data:

- Patient and provider demographics.
- Recently filled medications.
- Chronic conditions.
- Gaps in care.
- ER visits.
- Inpatient admission

This tool allows you to view, capture, and share the most relevant demographic and clinical facts about your patients. The valuable information contained in these reports represents a tremendous opportunity to improve the quality and continuity of care for your patients.

To access this report:

1. Select Member Clinical Summary Reports from the Report Inquiry options in the Workflows for this Plan

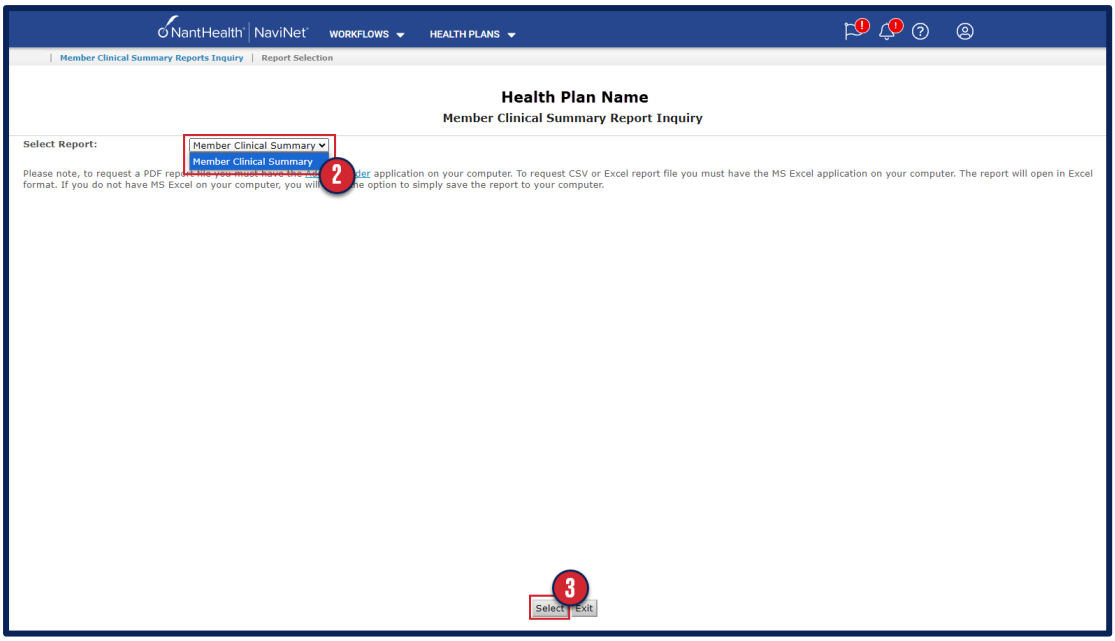


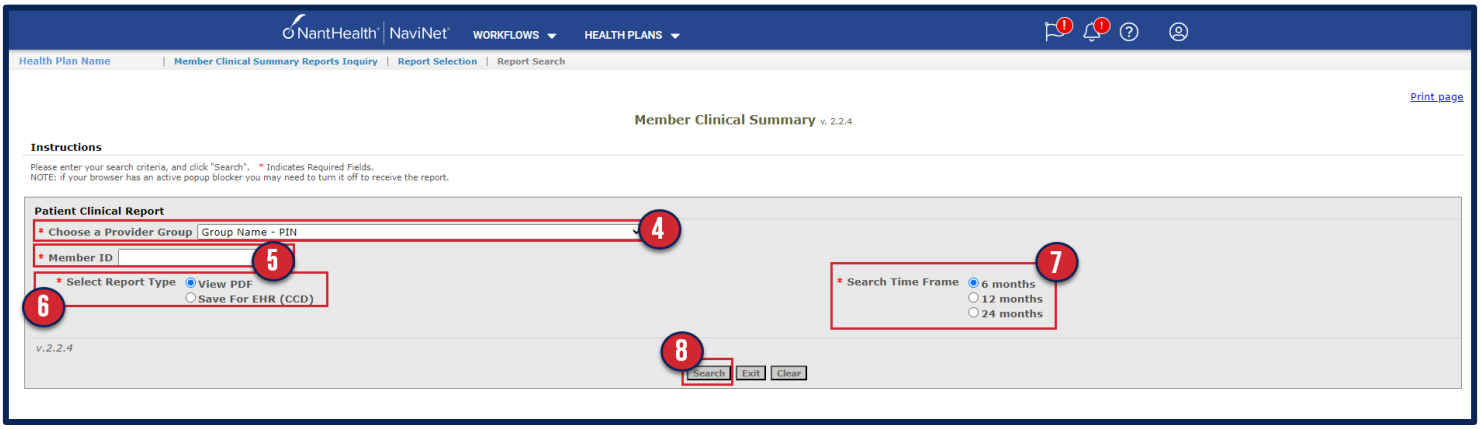
Note: To use Member Clinical Summary Reports, your NaviNet Security Officer must grant security access.

MEMBER CLINICAL SUMMARY REPORTS CONT'D.

To access this report:

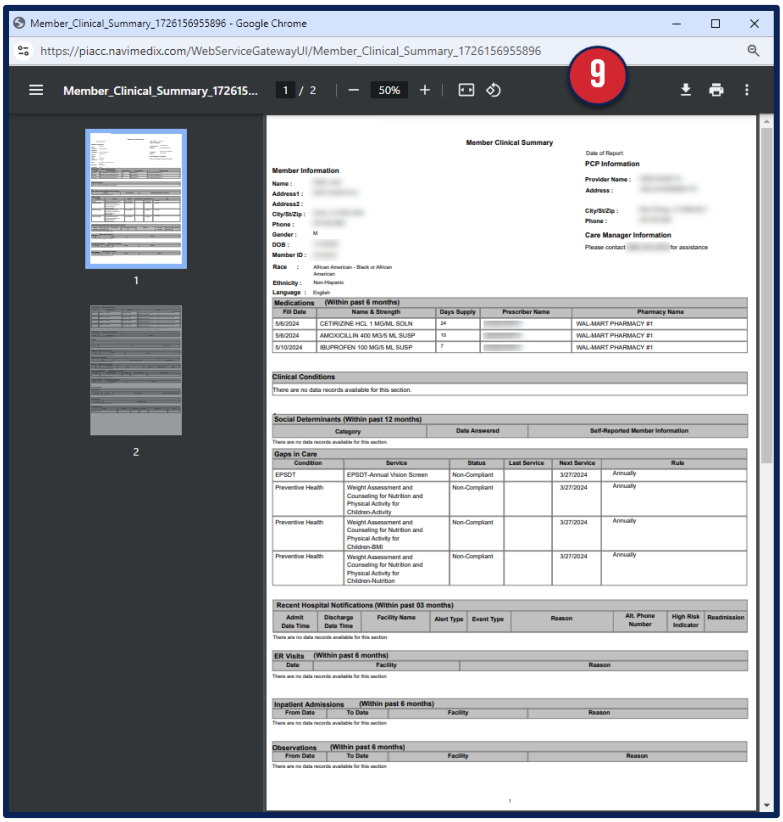
2. Once the Report Inquiry screen displays, select Member Clinical Summary from the drop-down
3. Click Select
4. Select a Provider Group
5. Enter the Member ID
6. Select Report Type (PDF is selected by default)
7. Select Time Frame (6 months selected by default)
8. Click Search

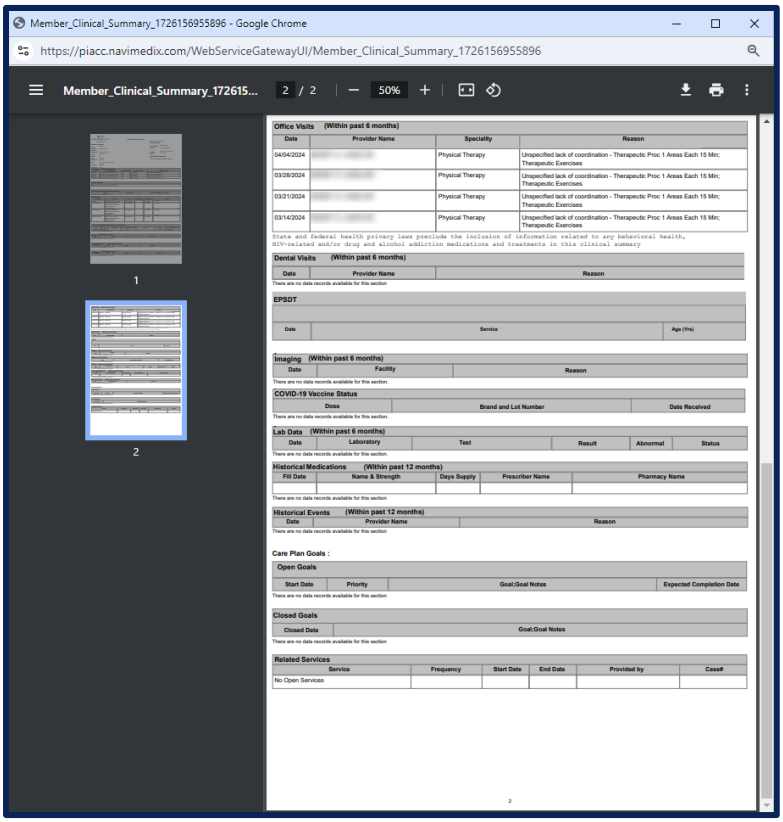




MEMBER CLINICAL SUMMARY REPORTS CONT'D.

9. The Member Clinical Summary report will be displayed in another window.
   This report provides important clinical information about a member within the Search Time Frame selected such as:
   - Medications prescribed (within the past 6 months)
   - Chronic Conditions
   - Gaps in Care (based on diagnosis compared to clinical recommendations)
   - ER Visits (Within the past 6 months)
   - Inpatient Admission (Within the past 6 months)
   - Office Visits (Within the past 6 months)





DIRECT ENTRY/MANUAL CLAIM SUBMISSION

ACFC provides options for you to key-in (direct entry) or manually submit claims, at no cost via the NaviNet portal.

Use **Claim Submission** to submit direct entry/manual claims.

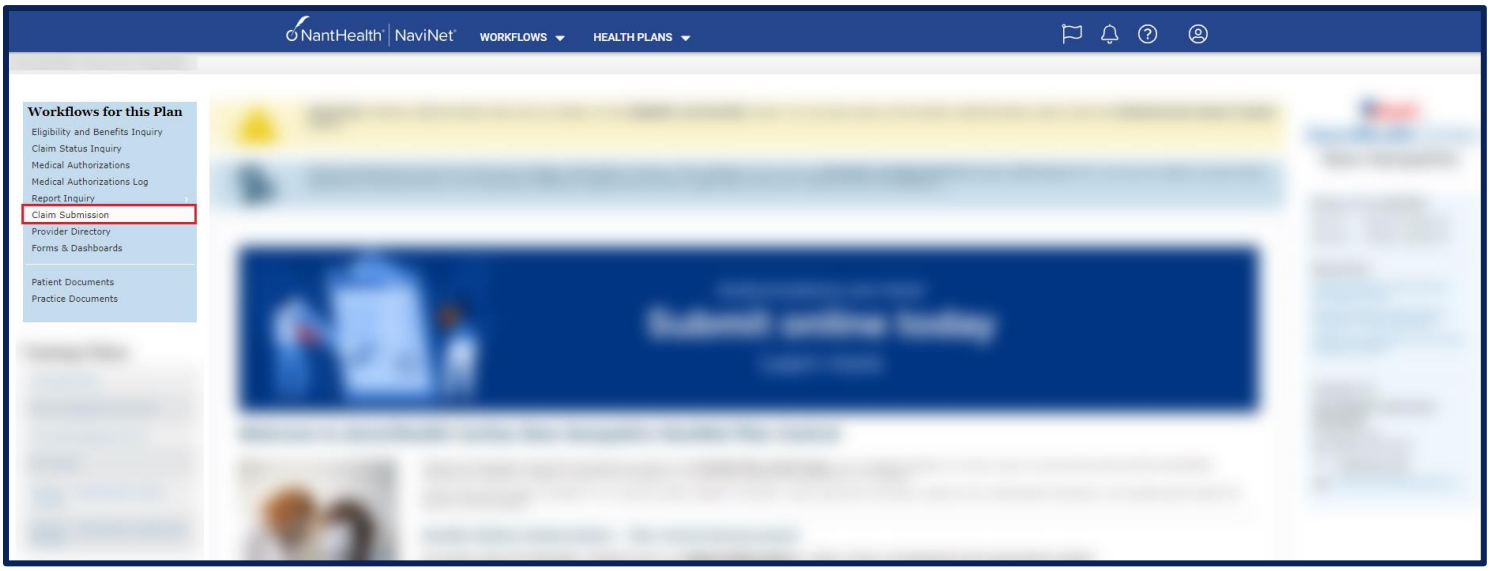
- You can access this transaction from NaviNet, but it's hosted by a third party, Optum.

Claim Submission Vendors

In addition to electronic claims submission via Optum, ACFC has partnered with the following vendors to submit claims:

- Availity – Electronic Claims
- PCH Global – Manual/Direct Entry Claims

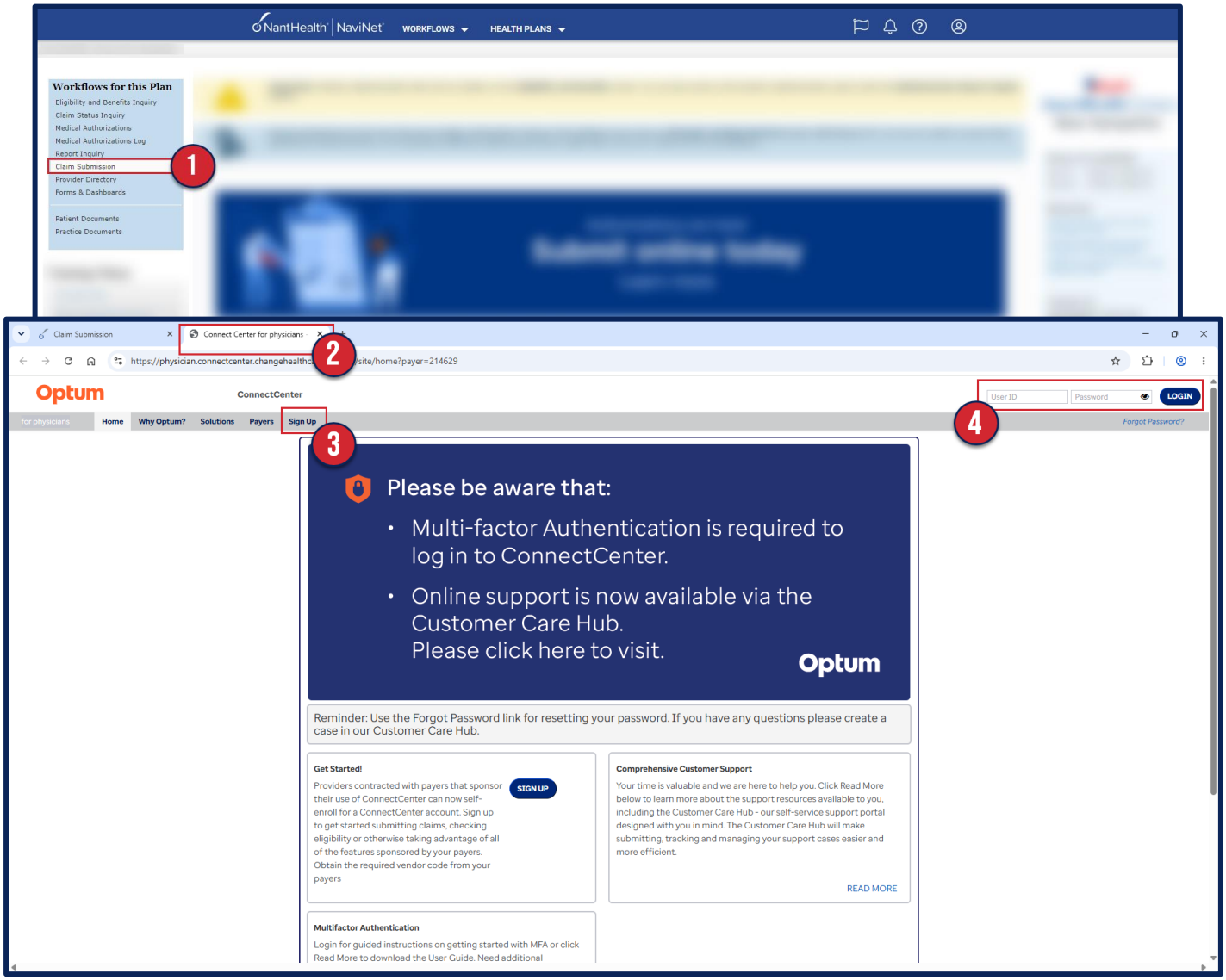
Please refer to the Claim Submission Job Aid for more details.



DIRECT ENTRY/MANUAL CLAIM SUBMISSION CONT'D.

To submit a claim:

1. Click on Claim Submission from the Workflows for this Plan
2. The Optum ConnectCenter page will display in another window
3. Click "Sign Up" to enroll in electronic submissions or
4. Login using your Optum account credentials



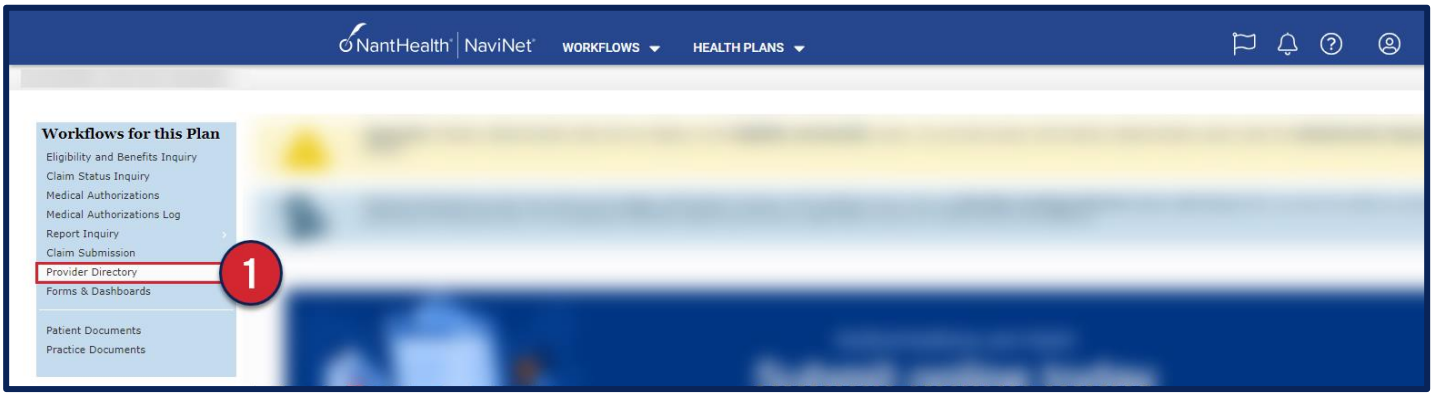
Note: To view and generate a Remittance Advice, access the ECHO Health provider payment portal at http://www.providerpayments.com.

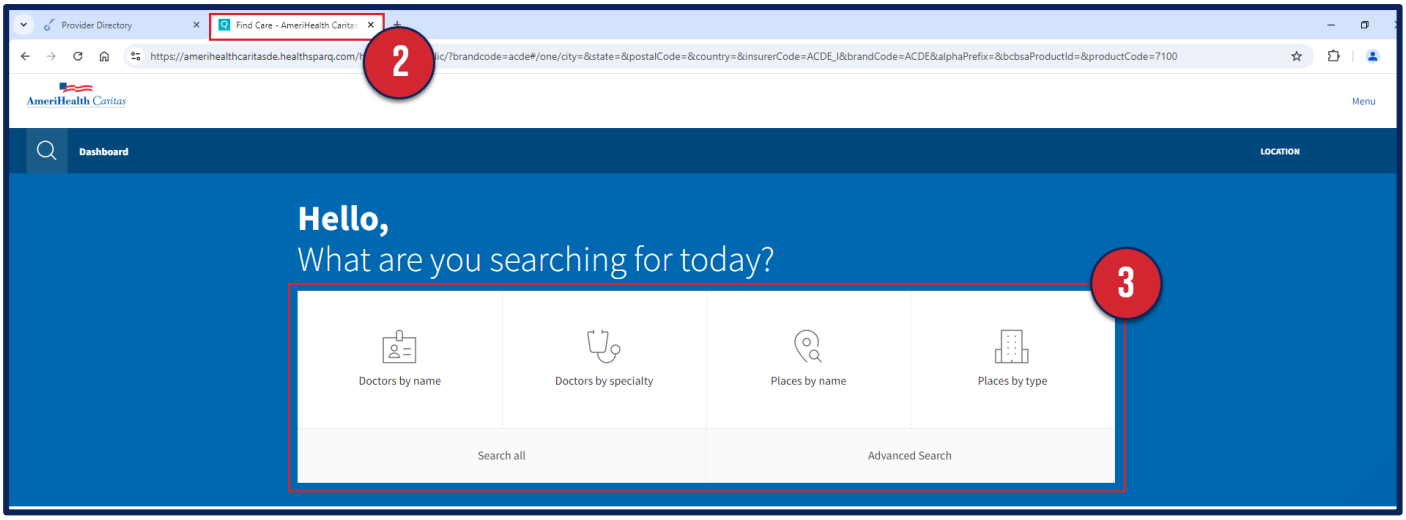
PROVIDER DIRECTORY

The Provider Directory will search the Plan's participating practitioners, facilities, pharmacies, DME suppliers, behavioral health, and vision care providers. It also provides directory tools to perform specific searches for maternity and urgent care.

To view information about a doctor, hospital, or other participating provider:

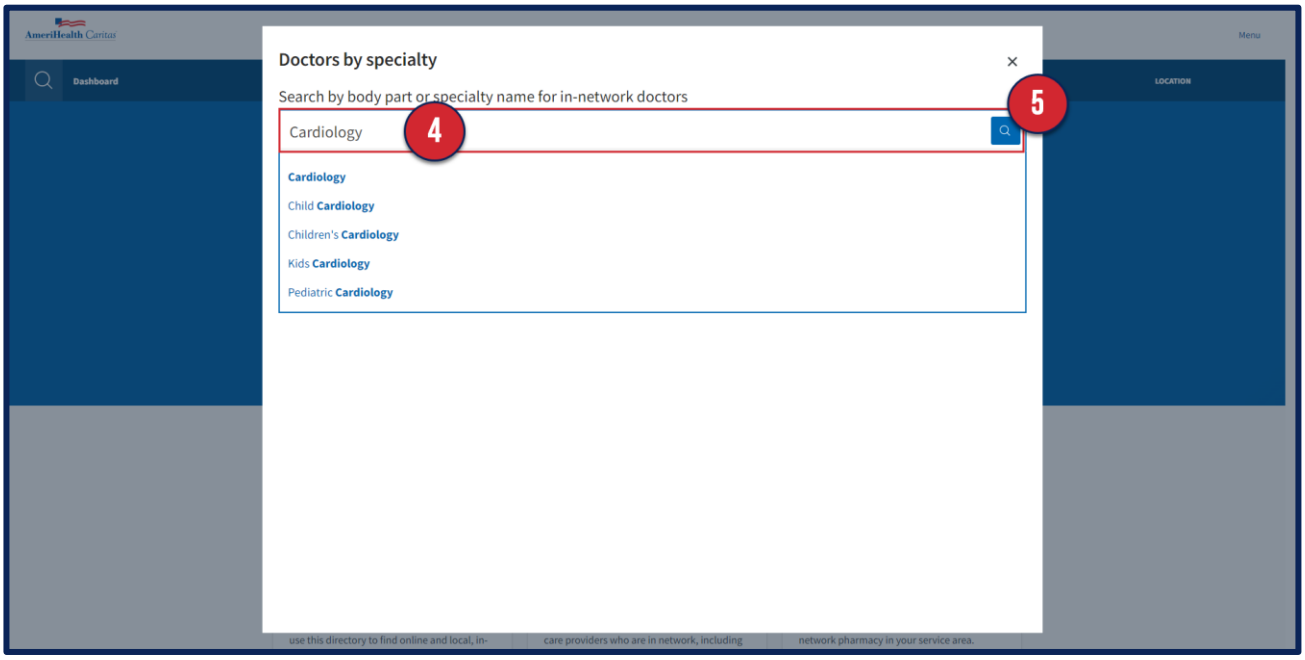
1. Click Provider Directory from the Workflows for this Plan
2. The Provider Directory dashboard will display in a new window
3. Select what you want to search for from the options. For this example, the option of Doctors by specialty was selected.

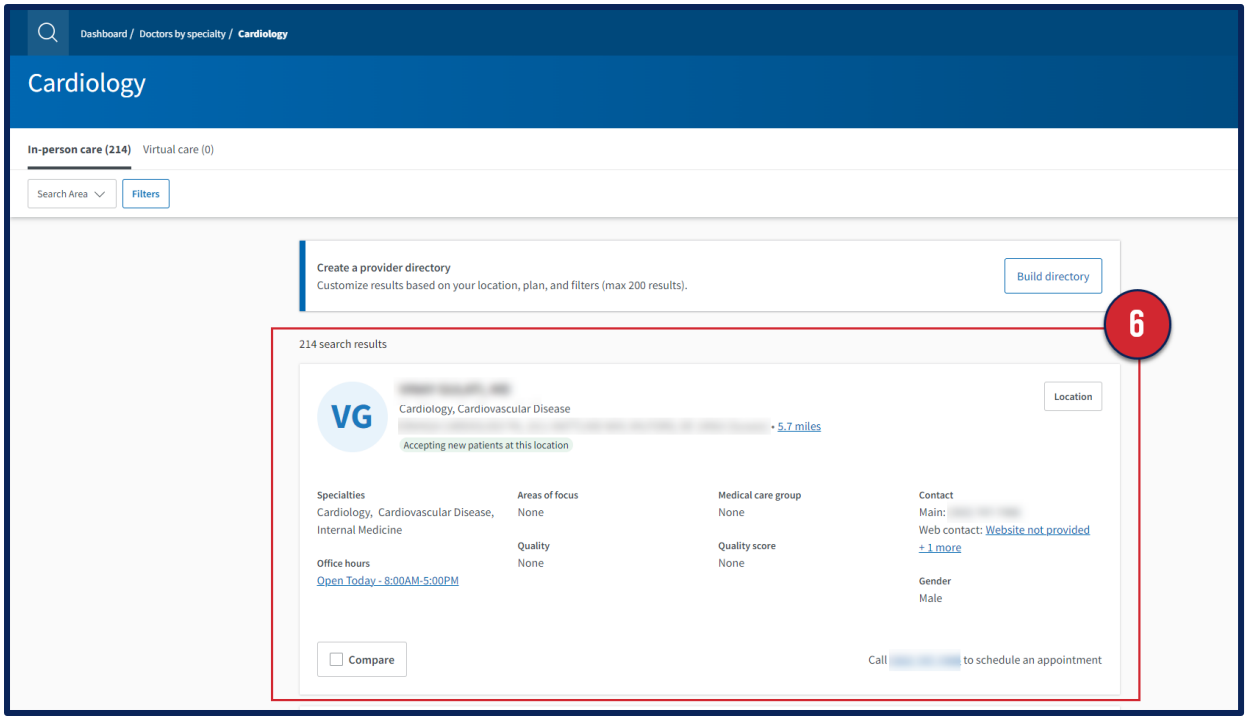




PROVIDER DIRECTORY CONT'D.

4. Enter the specialty in the field provided
5. Click the magnifying glass or click the Enter key on your keyboard
6. The search results will display





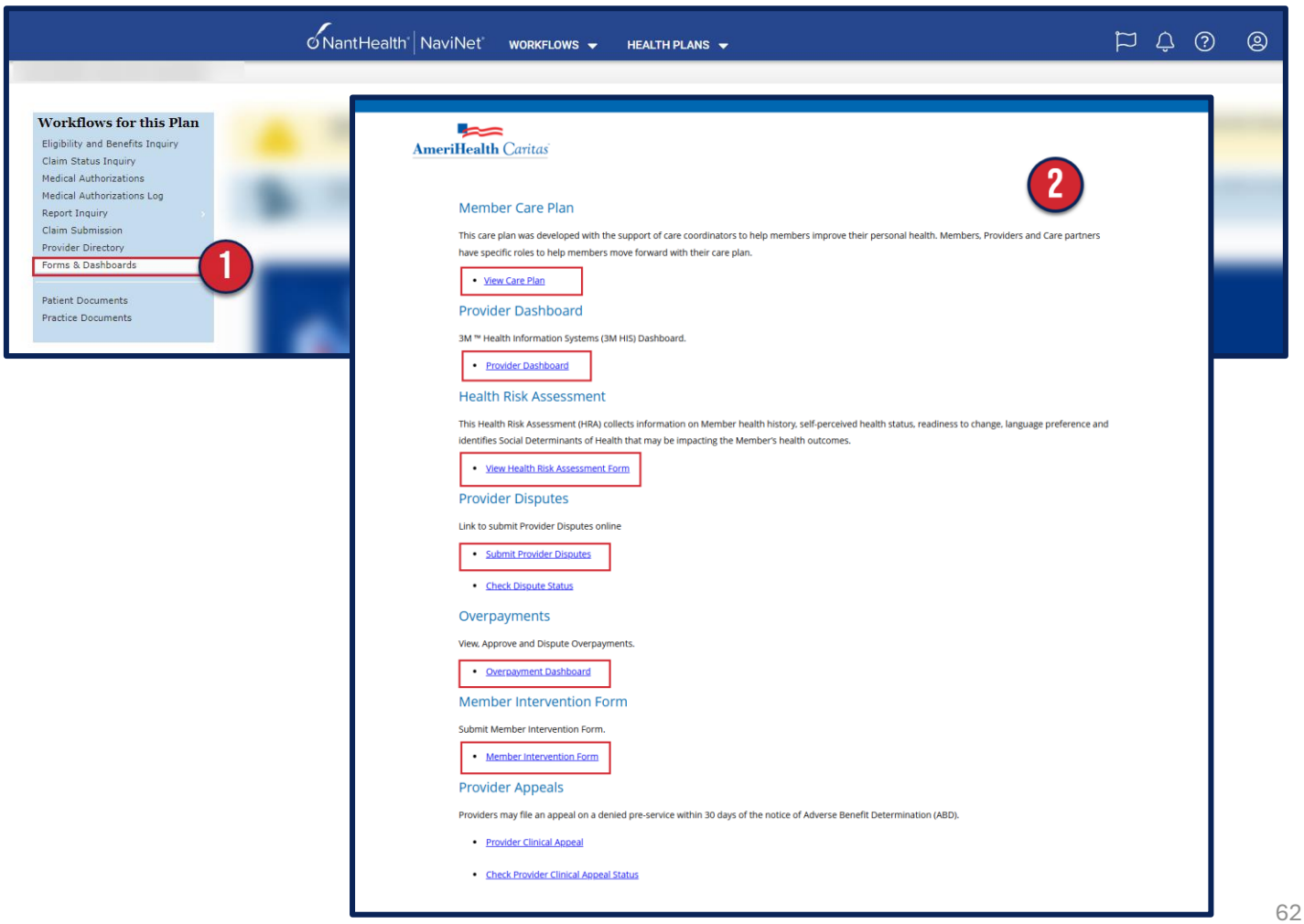
FORMS AND DASHBOARDS

This section varies by health plan. The standard items featured under Forms and Dashboards are:

- Member Care Plan
- Provider Dashboard
- Health Risk Assessment
- Provider Claim Dispute
- Overpayments
- Member Intervention Form

To access any of these items:

1. Click Forms & Dashboard from the Workflows for this Plan
2. Click the hyperlinked bullet under each item

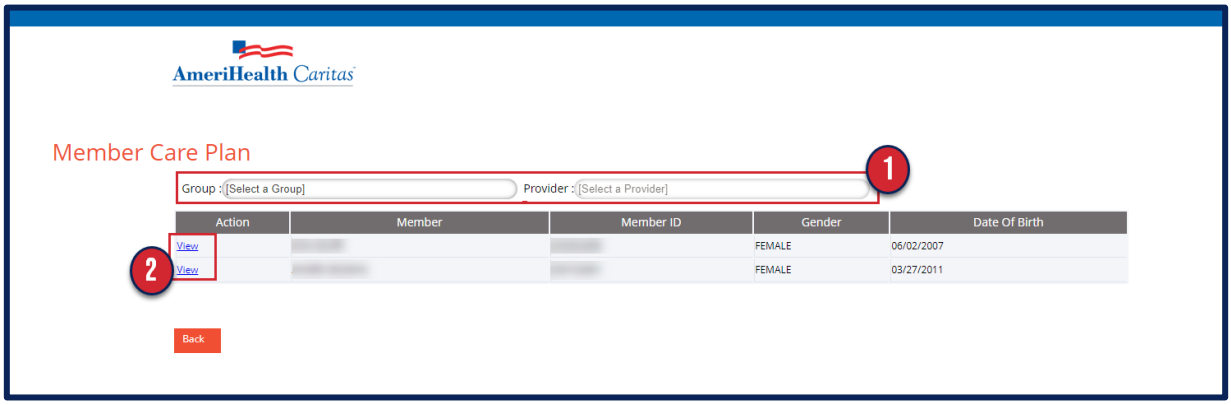


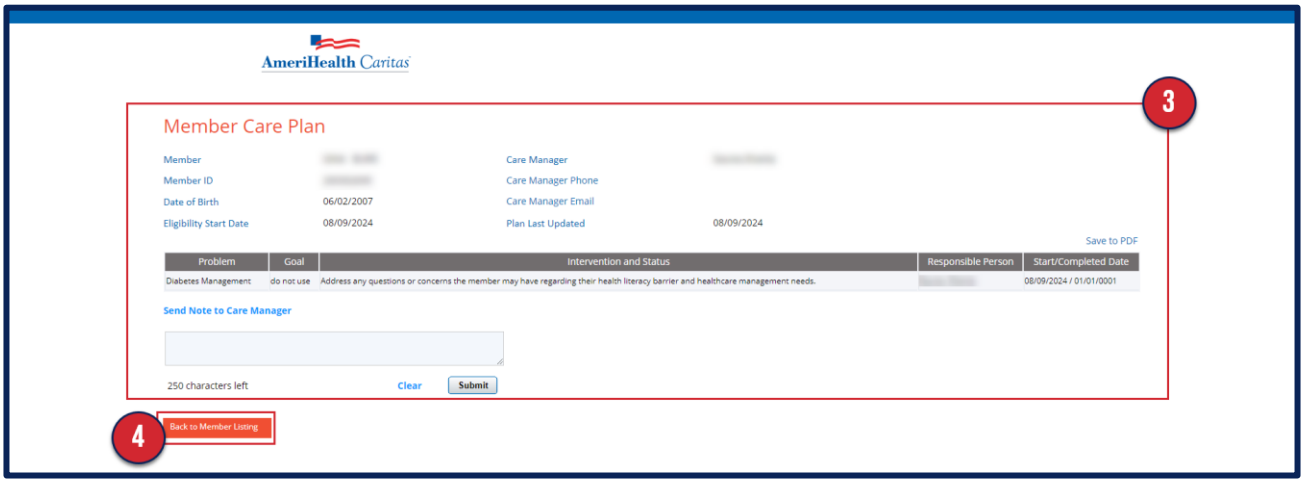
The Member Care Plan

This care plan was developed with the support of care coordinators to help members improve their personal health. Members, Providers, and Care partners have specific roles to help members move forward with their care plan.

Guidelines for viewing a Member Care Plan in NaviNet

1. Select a Group and a Provider from the drop-down fields.
2. Click View under the Action column for the desired member.
3. The Care Plan for the member will be displayed.
    - This information may be saved by selecting Save to PDF
4. Click the Back to Member Listing button to return to the Member Care Plan screen.





Provider Dashboard

Another important resource for you is Solventum. The Solventum Health Information Systems dashboard tool can be launched from within Navinet's Provider Portal. Clicking on the 'Provider Dashboard' hyperlink will launch Solventum without having to enter a password. Your Solventum account must be set up with your Navinet user ID for this to work.

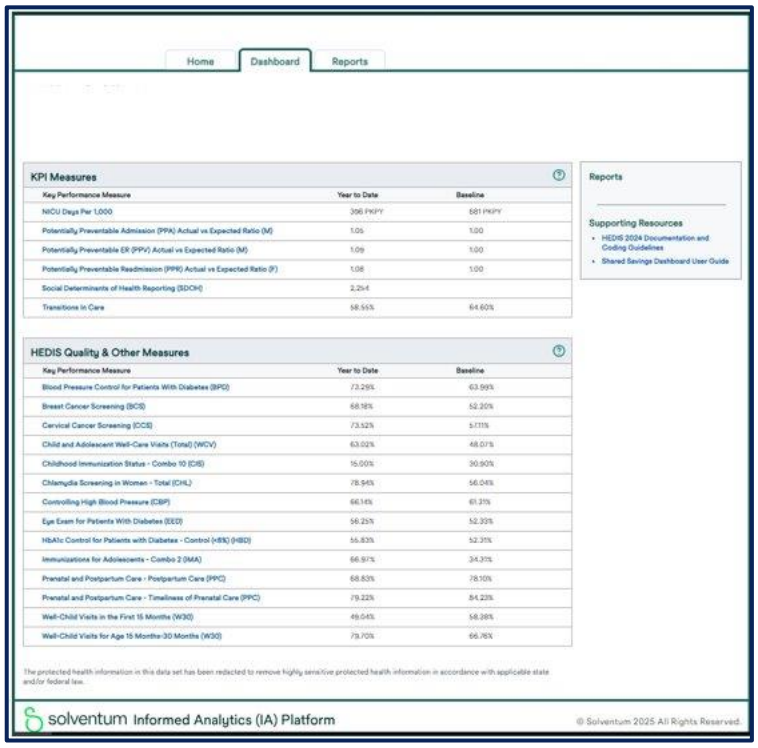
Provider Resources

AmeriHealth has worked with Solventum (formerly 3M Health Information Systems) since 2010 to support value-based contracting. Solventum's proprietary clinical designations and potentially preventable events are shared with Primary Care Physicians and Behavioral Health providers via Solventum's web-based dashboard platform.

PerformPlus Value-Based Dashboards and Reports Powered by Solventum are refreshed monthly and available 24/7.

Available dashboards:

- **TC:** Supports our network-wide True Care and Total Cost of Care programs.
- **Medical Home:** PCP-based dashboard that contains information on Solventum's proprietary designations compared to expected/benchmarks, with member actionable lists.
- **Behavioral Health:** Similar to the Medical Home dashboard but includes BH-focused HEDIS performance rates.
- **Shared Savings:** Custom dashboards that include the metrics included in shared savings providers' agreements



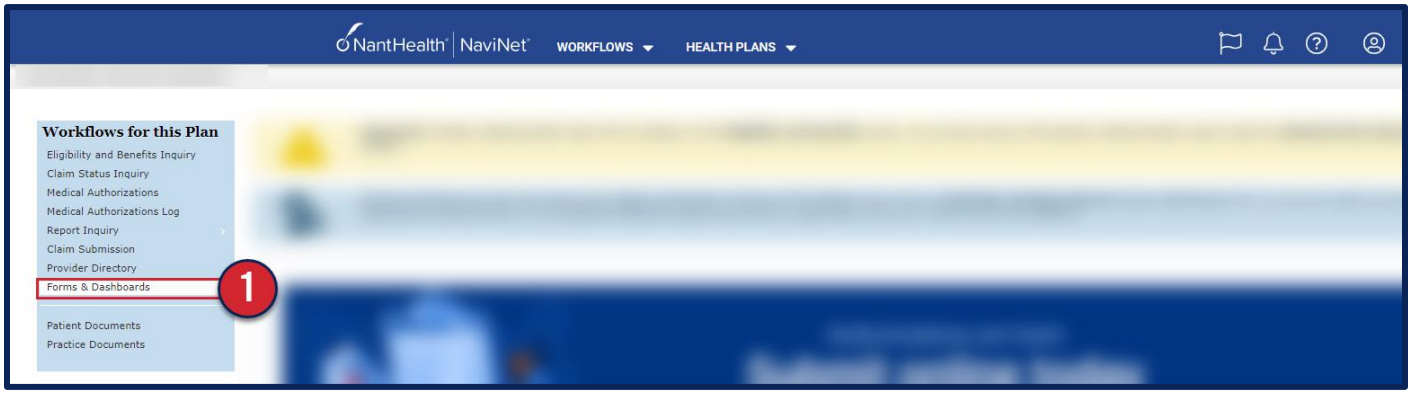
Shared Savings Dashboard Example

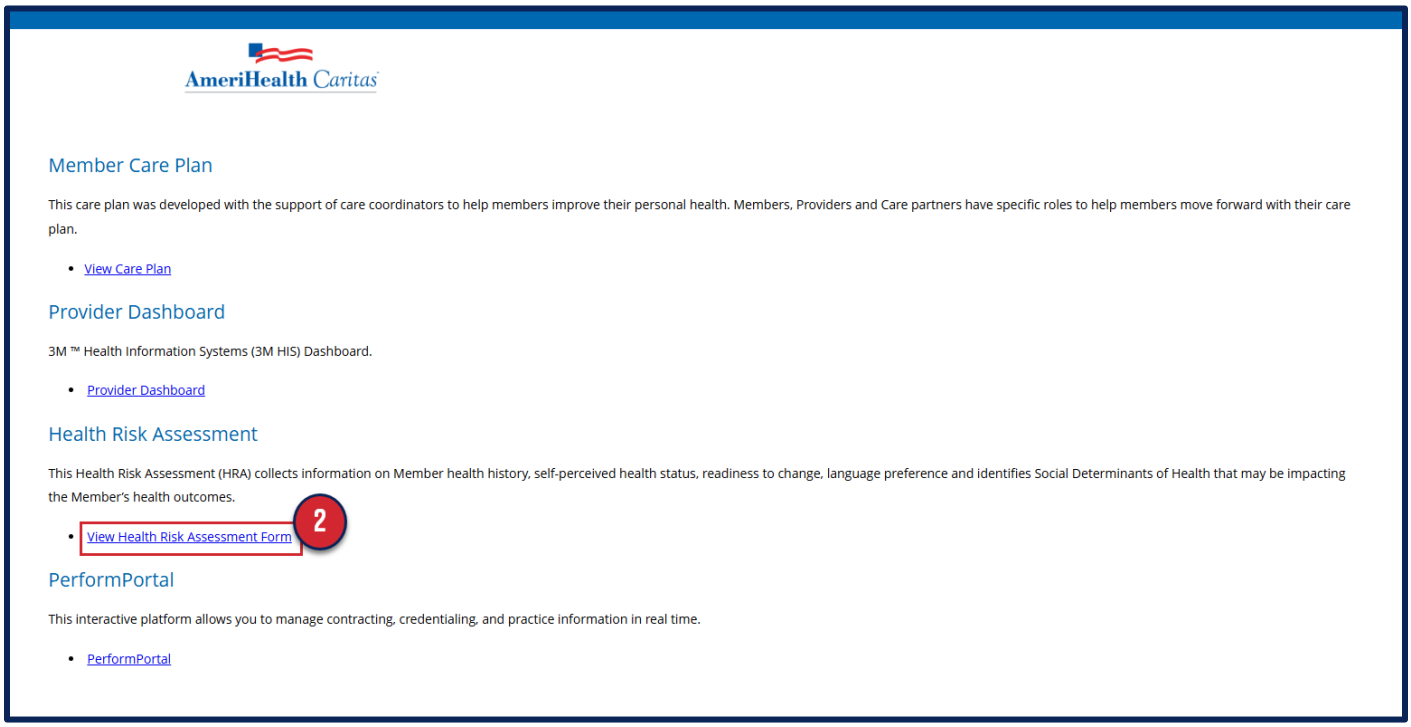
Health Risk Assessment

You may want to view assessments for your patients.

To view assessments:

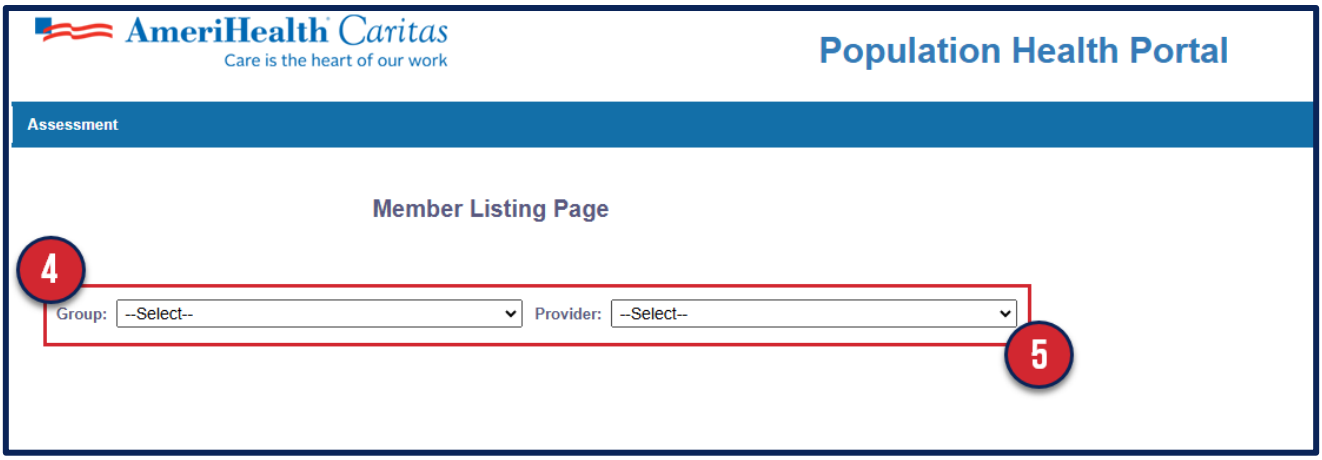
1. Click Forms & Dashboard from the Workflows for this Plan
2. A new window will display, click the hyperlinked bullet, View Health Risk Assessment Form.





FORMS AND DASHBOARDS CONT'D.

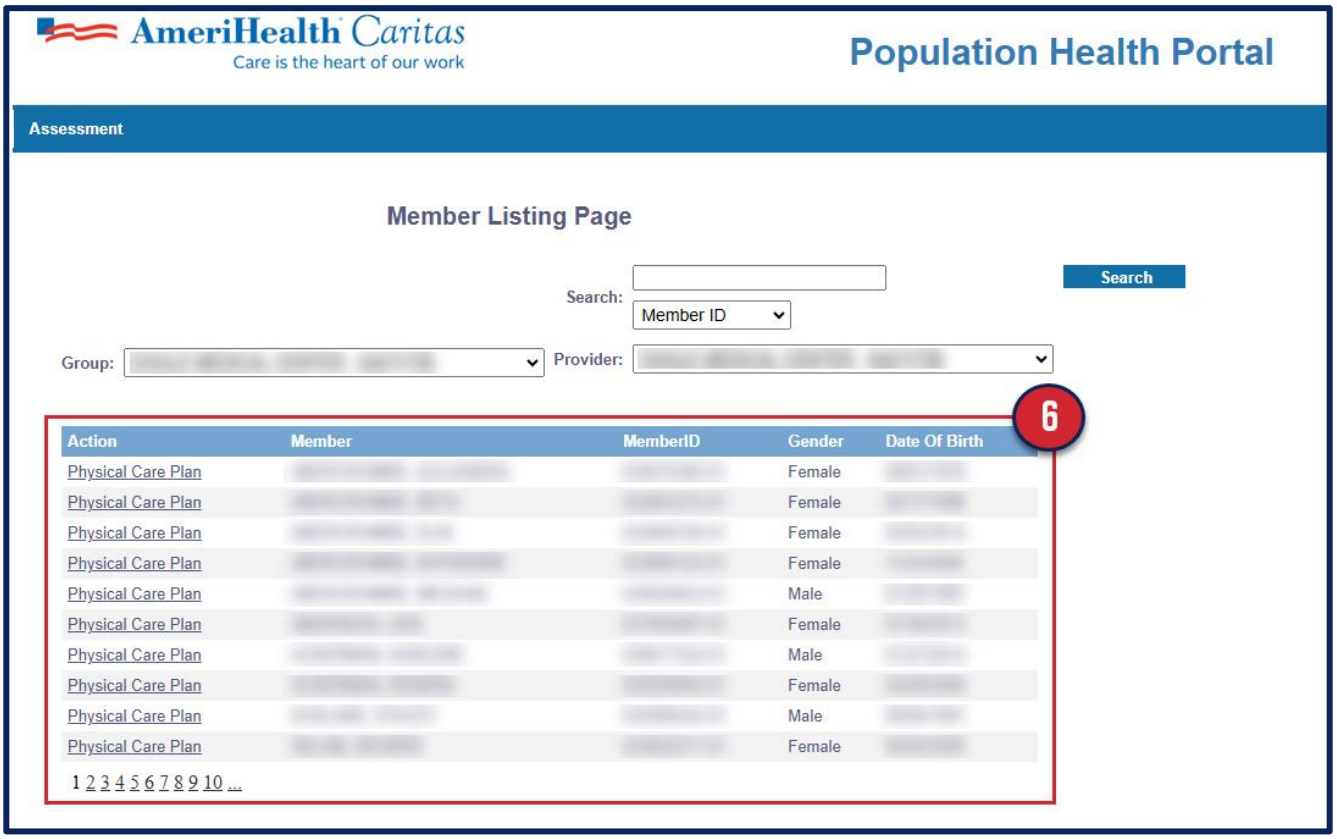
3. On the Population Health Portal page, click Assessment.
4. From the Member Listing page, select the Group from the drop-down.
5. Select the Provider from the drop-down.

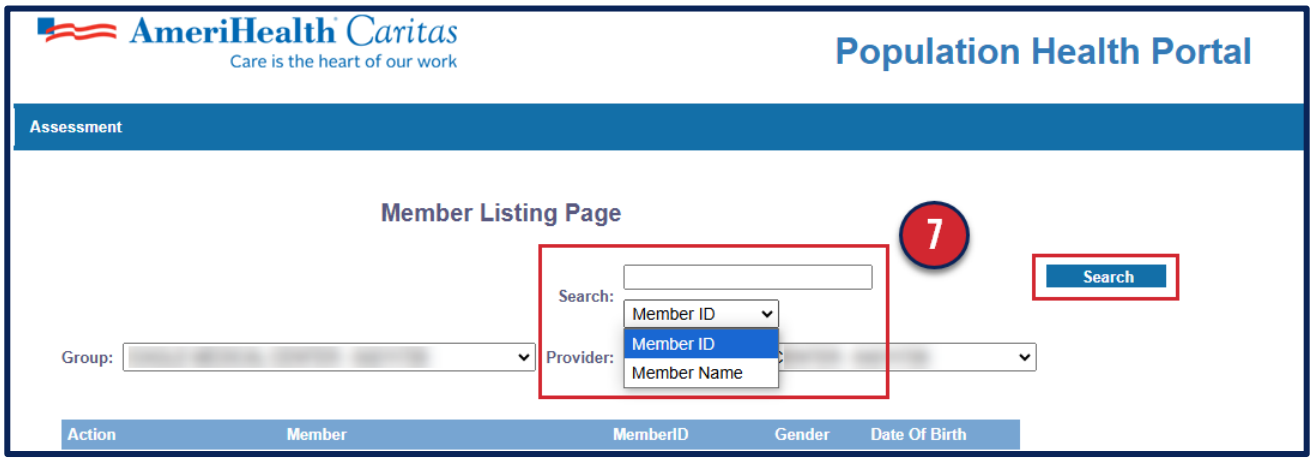


FORMS AND DASHBOARDS CONT'D.

6. A list of members will display.
7. You can also search for members by Member ID or Member Name.

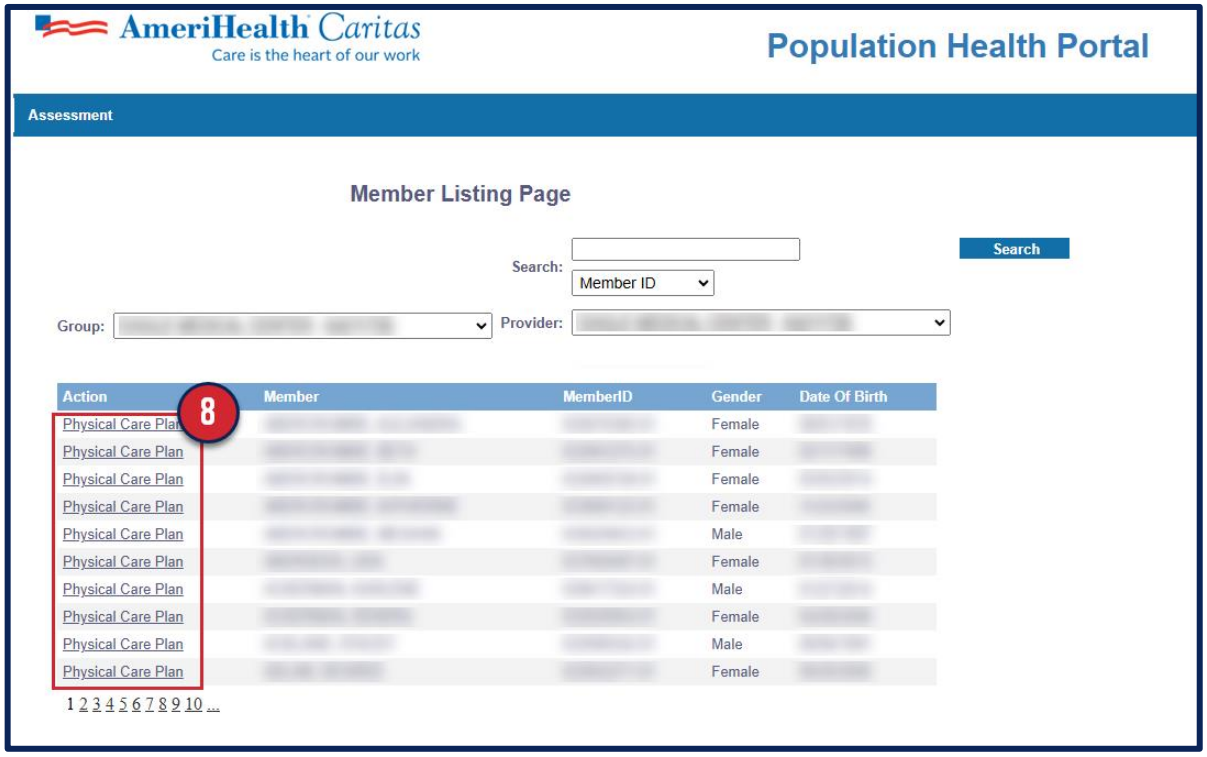
- Select either option from the Search drop-down, then enter the applicable information (member's name or member's ID) into the empty field and click Search.

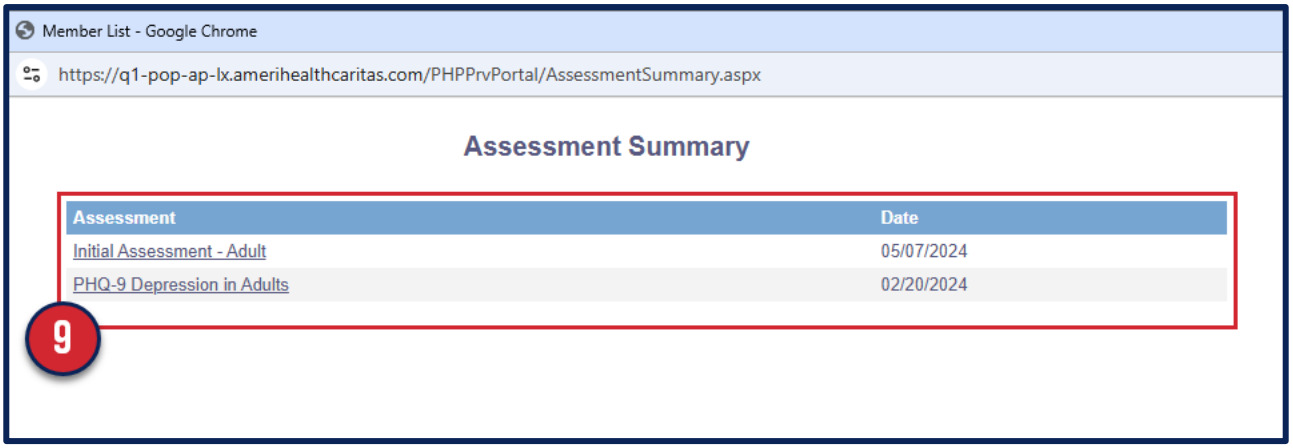




FORMS AND DASHBOARDS CONT'D.

8. Once the member is located, click on Physical Care Plan, under the Action column.
9. The Assessment Summary will display in a separate window for you to select the assessment you wish to view.





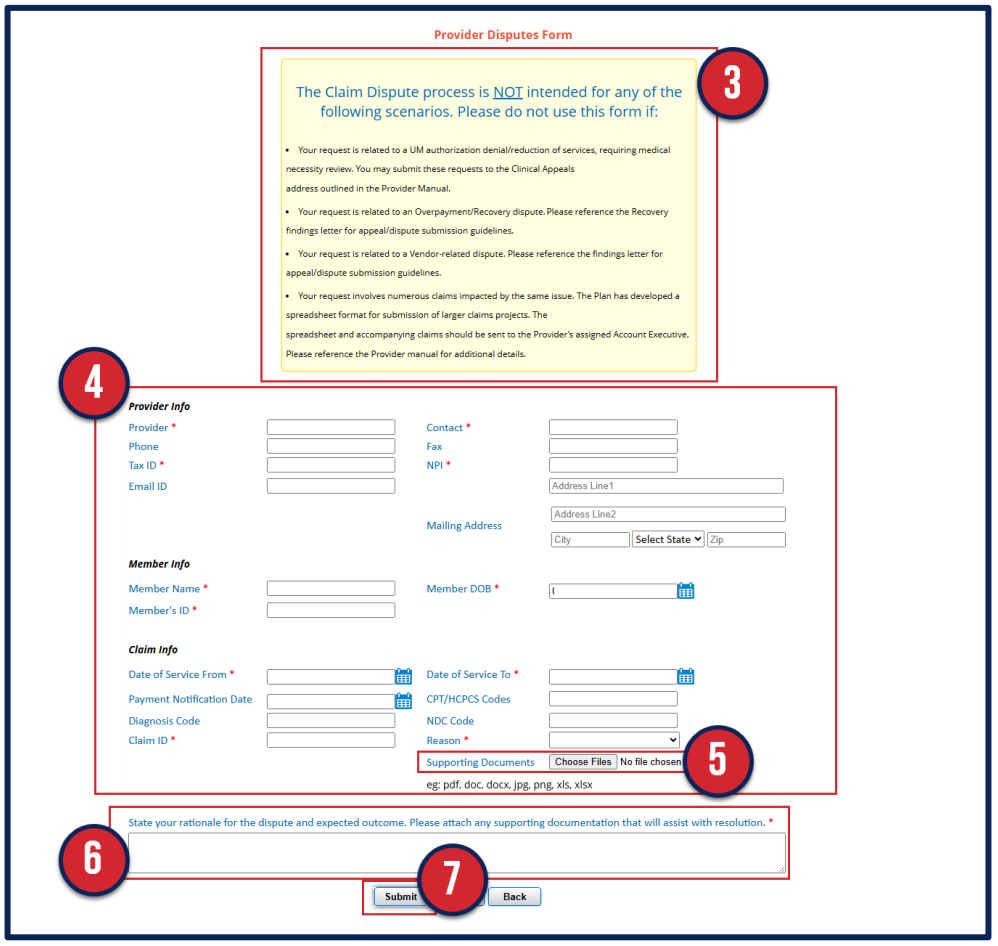
Note: If the Assessment Summary does not display after selecting the assessment, ensure that the popup blocker is disabled.

Provider Claim Dispute

A claim dispute* is a request from a Healthcare Provider to change a plan decision regarding claim payment or denial for services already provided. A provider dispute is not a pre-service appeal, or an appeal of a denied or reduced authorization. Disputes are generally administrative in nature and do not include decisions concerning medical necessity.

Submitting the Provider Claim Disputes Form in NaviNet:

1. Click **Forms & Dashboard** from the Workflows for this Plan.
2. In the new window that displays, click the hyperlinked bullet, **Submit Provider Disputes.**
3. The Provider Claim Dispute form will display, along with a disclaimer of when this form should not be used (highlighted in yellow).
4. Complete the required fields on the form.
5. Attach supporting documents.
6. State the rationale that will assist in the resolution.
7. Click the Submit button (at the bottom of the screen).



*** Note:** Also referred to as Complaints, Appeals, or Grievances.

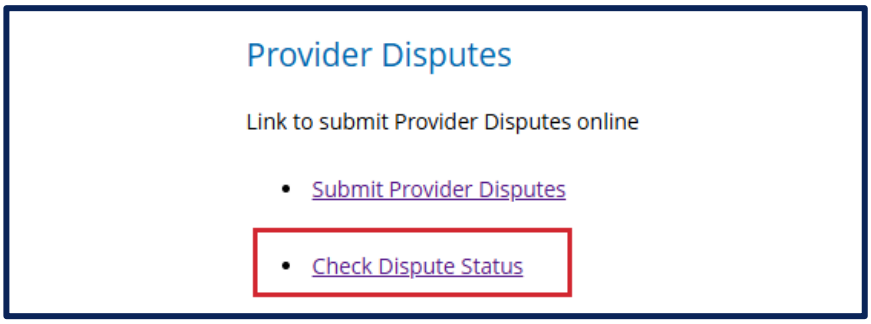
Submitting the Provider Claim Disputes Form in NaviNet Cont'd.

8. Once the form is submitted, a receipt message will appear, detailing the resolution timeframe and contact information.
9. Click OK.

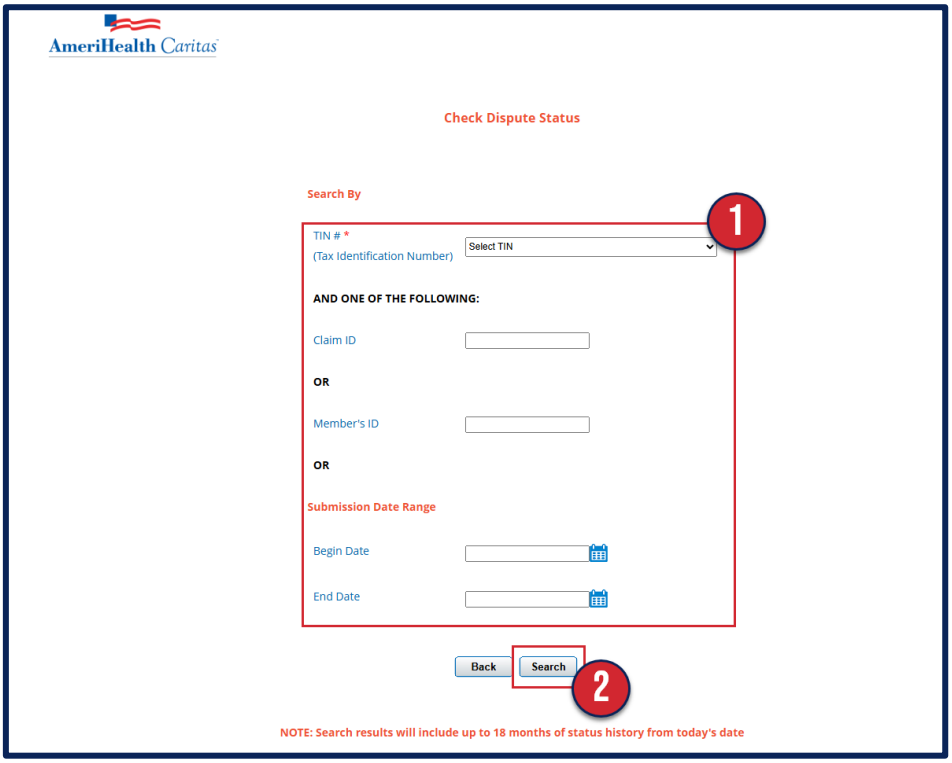
The completed form will be sent to the appropriate team for follow-up.

Check Dispute Status

You can also check the status of your dispute by clicking on the Check Dispute Status link.



The Check Dispute Status form will display. The search criteria will be based on the provider's NaviNet login information.



1. Perform a search by using the Tax Identification Number (TIN) and one of the following data elements:
    - Claim ID or
    - Member ID or
    - Submission Date Range – Begin Date and End Date
2. Click the Search button.

*** Note:** You will be able to view 18 months of status history based on the date the claim dispute is received.

Check Dispute Status Cont'd.

The search will return one of the following statuses:

- In Progress
- Overturned
- Upheld
- Voided

It will also include the date the determination letter was uploaded into the system.

A copy of the determination letter will be available under Patient Documents.

Check Dispute Status

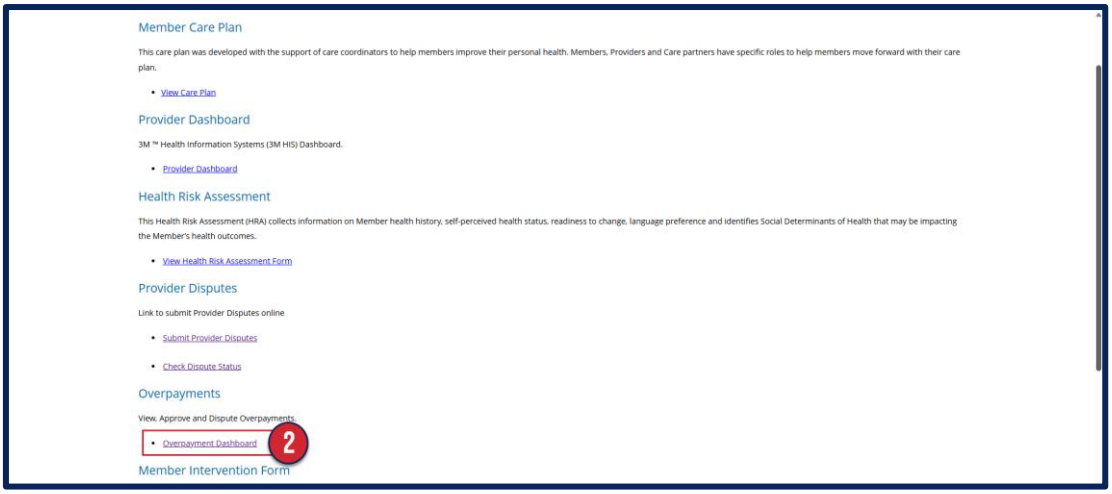
Member ID	Member Name	Claim ID	Service Start Date	Service End Date	Dispute/Appeal Receive Date	Status	Completion Date	Decision Letter Upload Date	Voided Reason	Voided Service Form Number
[redacted]	[redacted]	[redacted]	2023-10-12	2023-10-13	2025-10-16	Upheld	2025-10-17	2025-10-17		
[redacted]	[redacted]	[redacted]	2023-10-12	2023-10-13	2025-10-16	Overturned	2025-11-05			
[redacted]	[redacted]	[redacted]	2023-10-12	2023-10-13	2025-10-21	Upheld	2025-11-05	2025-11-05		
[redacted]	[redacted]	[redacted]	2023-10-12	2023-10-13	2025-10-21	Voided	2025-11-05		SHOV Scanning Error*	
[redacted]	[redacted]	[redacted]	2023-10-12	2023-10-13	2025-10-30	Upheld	2025-10-30	2025-10-31		
[redacted]	[redacted]	[redacted]	2023-10-12	2023-10-13	2025-10-30	In Progress				
[redacted]	[redacted]	[redacted]	2023-10-12	2023-10-13	2025-11-03	Voided	2025-11-05		Duplicate Request*	
[redacted]	[redacted]	[redacted]	2023-10-12	2023-10-13	2025-11-03	In Progress				
[redacted]	[redacted]	[redacted]	2023-10-12	2023-10-13	2025-11-03	In Progress				
[redacted]	[redacted]	[redacted]	2023-10-12	2023-10-13	2025-10-10	In Progress				
[redacted]	[redacted]	[redacted]	2023-10-12	2023-10-13	2025-10-10	In Progress				
[redacted]	[redacted]	[redacted]	2023-10-12	2023-10-13	2025-10-13	In Progress				

Claims Overpayment Recovery

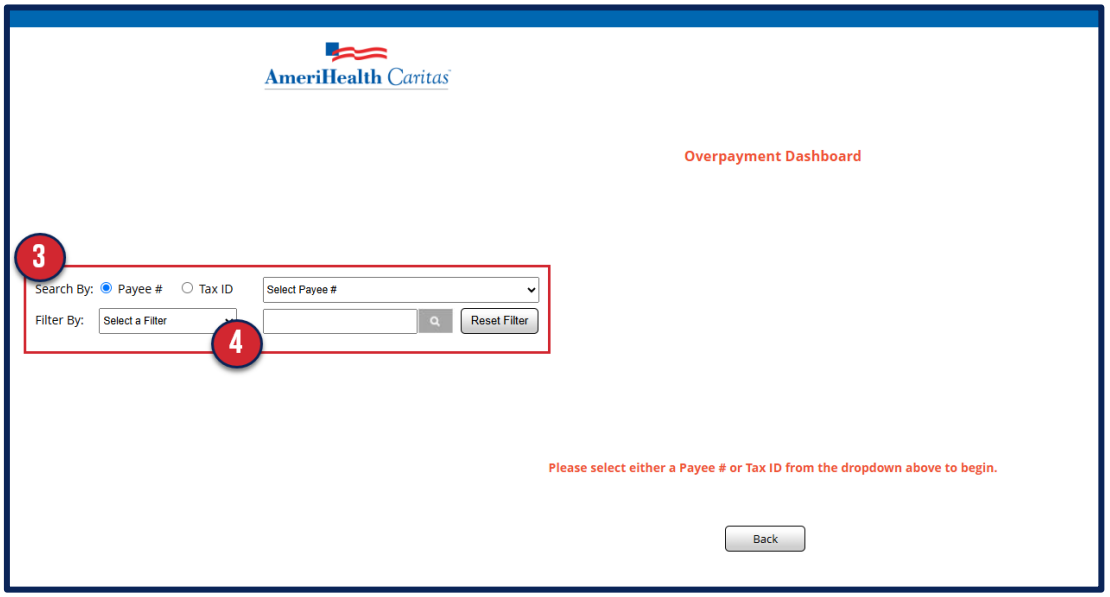
View, Approve, and Dispute Overpayments.

To view the dashboard:

1. Click **Forms & Dashboard** from the Workflows for this Plan.
2. In the new window that displays, click the hyperlinked bullet, **Overpayment Dashboard.**



3. Select the search criteria.
   - Payee (displays the Provider Group name and ID)
   - Tax ID (displays the Tax entity name and ID)
4. You can narrow the search by using the Filter By option to search for a specific overpayment by the Project ID, Claim ID, or Patient Account #.

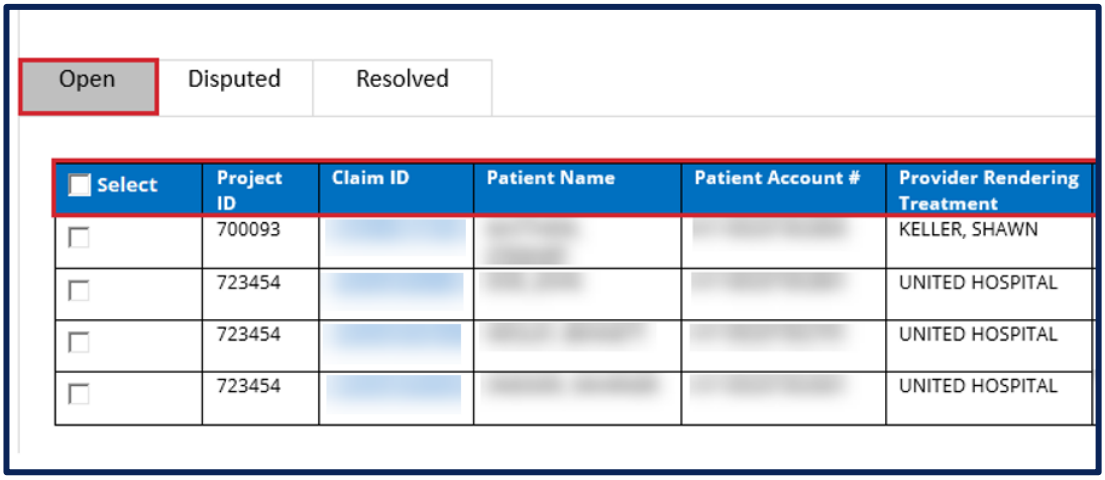


FORMS AND DASHBOARDS CONT'D.

Dashboard Tabs

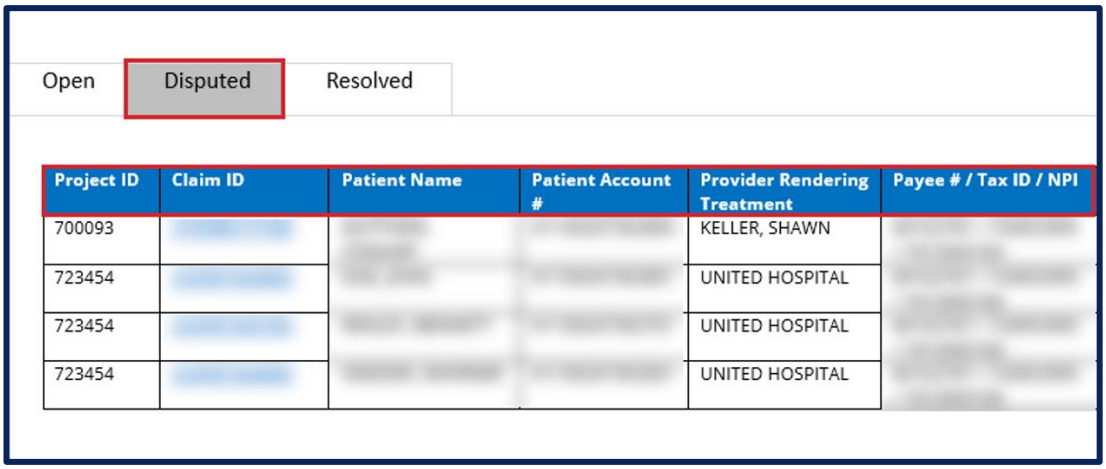
Open Tab

When the search is performed, **Open** claims will show in the initial results. You can choose to view Disputed or Resolved claims by clicking on the appropriate tab.



Disputed Tab

Previously disputed claims will appear here with a Determination Due date. The plan will respond within the stated time noted in the confirmation message.



Resolved Tab

The Resolved Tab display will show multiple Resolution statuses based on the actions taken.

- Overpayments submitted from the Open Tab will appear in the Resolved Tab.
- If no action is taken in Open Tabs and the due date has expired, records will be moved to the Resolved tab, and the recovery of overpayments will begin.

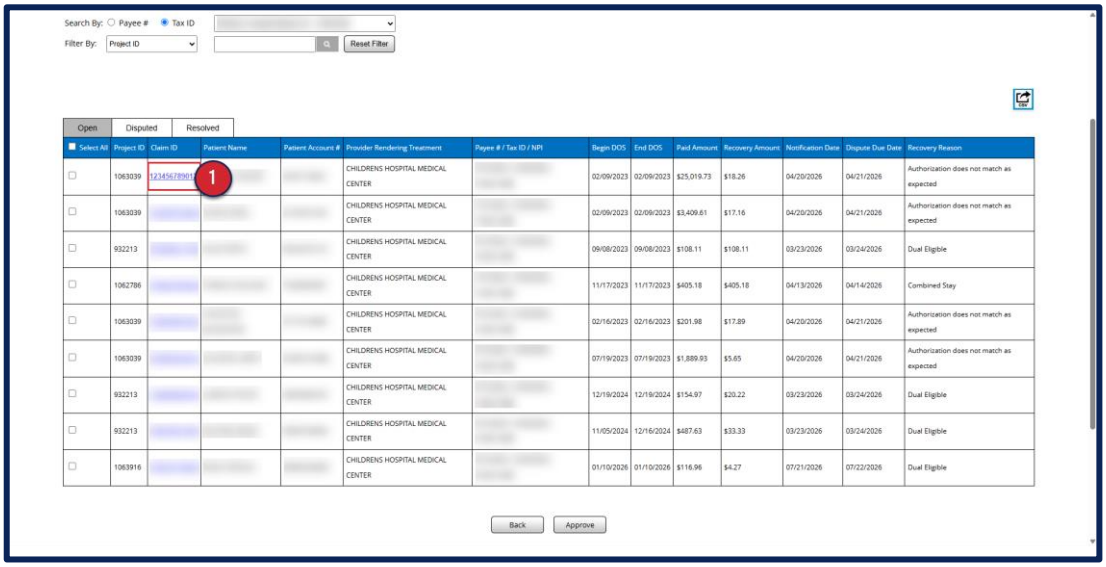
Resolving Claim Overpayments

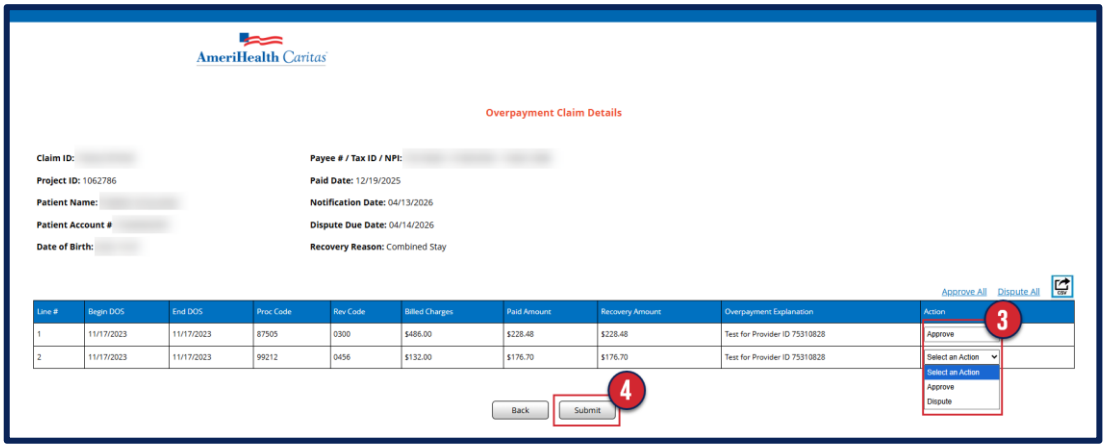
From the Open Tab, you have two options to resolve claim overpayments:

1. Check the individual box(es) for the claim(s) you would like to review.
2. Check the **Select All** box to select all the claims.

Selecting the Claim ID link Option

1. Click on the Claim ID link to access the Claims Details page.
2. Each claim line of the selected claim will be displayed.
3. Select an Action (Approve or Dispute) from the drop-down menu.
    - Different actions can be selected for each claim line
4. Click Submit.





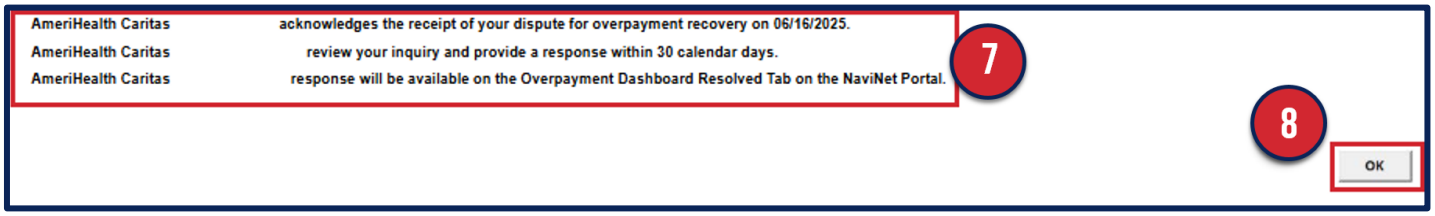
Note: The Overpayment Claim Detail screen will only appear when clicking on the Claim ID link, not when checking the box.

Selecting the Claim ID link Option Cont'd.

You will be taken to the **Review & Submit Overpayment Details** screen.

The **Approve** and/or Dispute summary will be displayed, along with options to reprocess the claim or send a check.

5. Upload any supporting documents and add comments to assist with the resolution.
6. Click Submit or the Back button to make changes.
7. The acknowledgment of receipt message will display.
8. Click Ok.



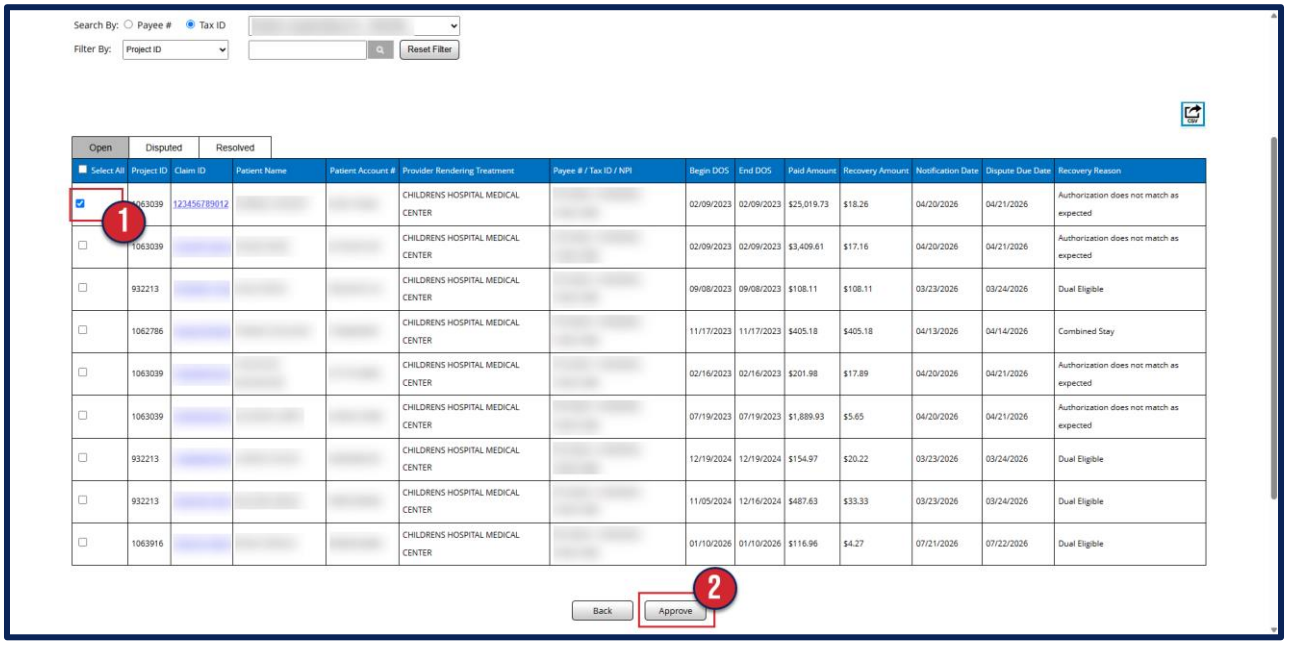
Note: The option to attach documents and provide comments will display only if the claim line(s) are being disputed.

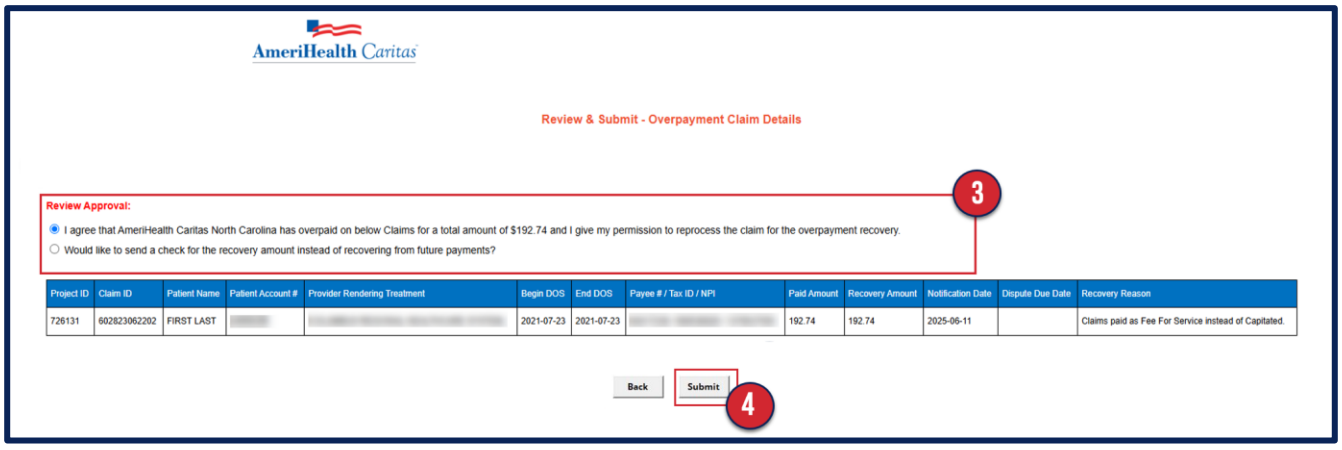
Selecting the Select All Option

1. Check the Select All box to display the associated items with the project.
2. Click Approve.

The Review & Submit Overpayment Claim Details screen will display.

3. Select one of the two approval options:
    - Reprocess the claim (recovered from future payments)
    - Mail a check to the plan
4. Click Submit.



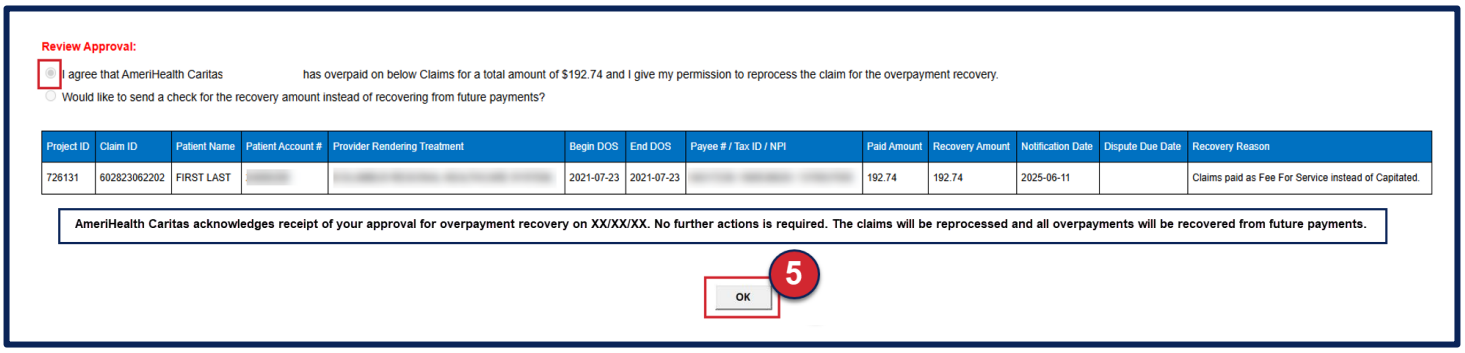


Selecting the Select All Option Cont'd.

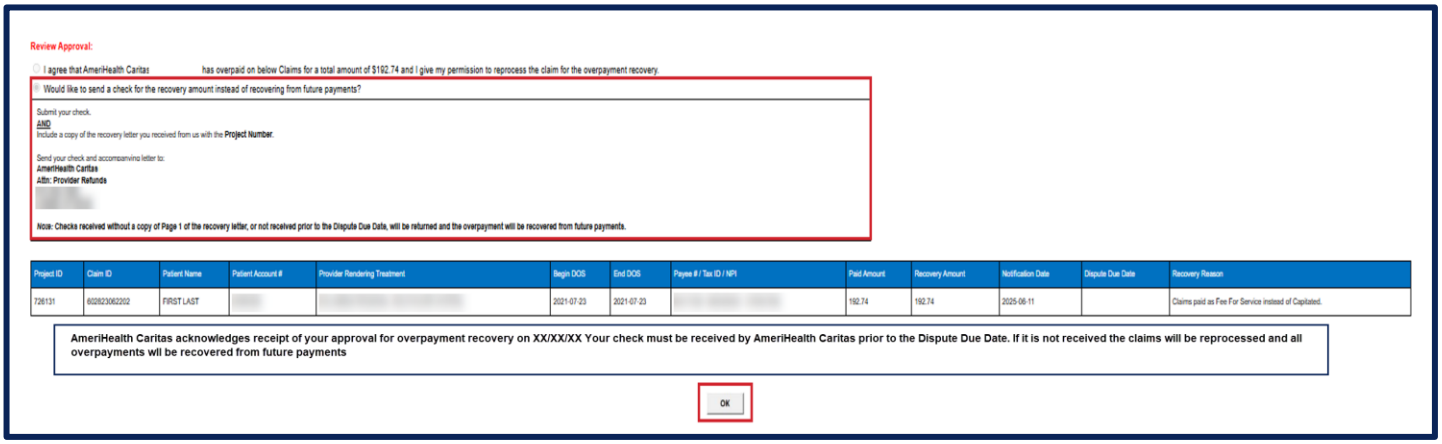
The Approval Confirmation message will be displayed.

5. Click Ok.

Reprocess the claim option:



Mail a check option:

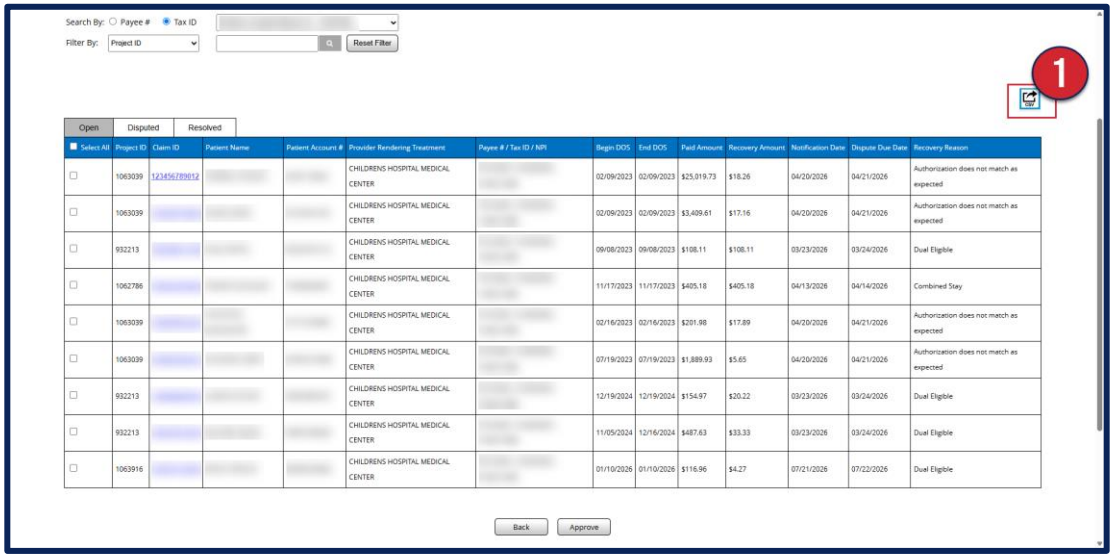


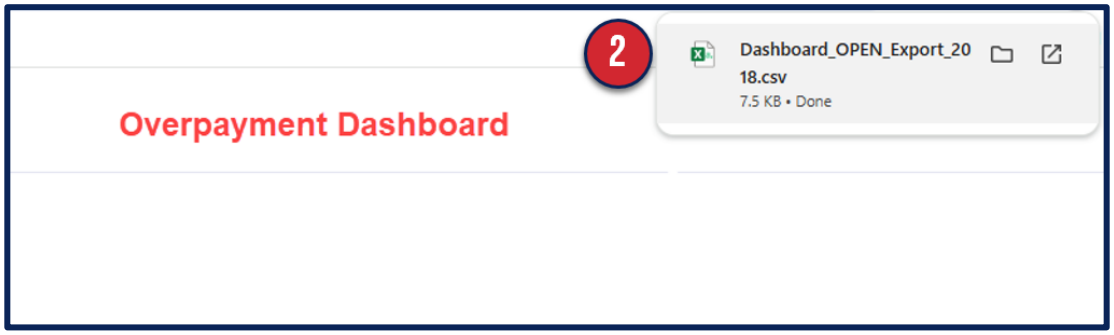
Note: Overpayment requests will be resolved within 14-30 days from the date of submission.

Overpayment Reports

To run a report from the Overpayment Dashboard:

1. Click the **CSV icon** on the Overpayment Dashboard page and click Enter.
2. The system can generate Excel spreadsheets for each of the three overpayment categories.
    - Open
    - Dispute
    - Resolved

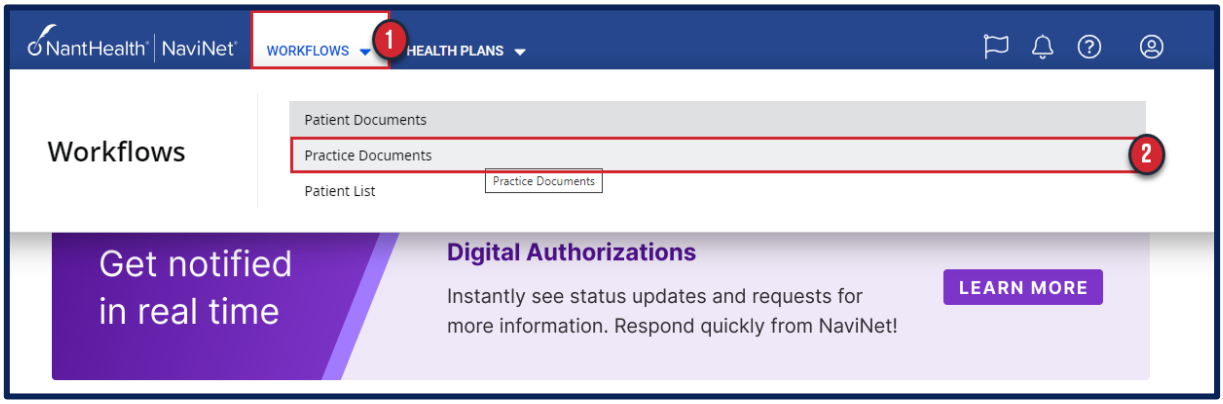




Accessing Recovery Letters

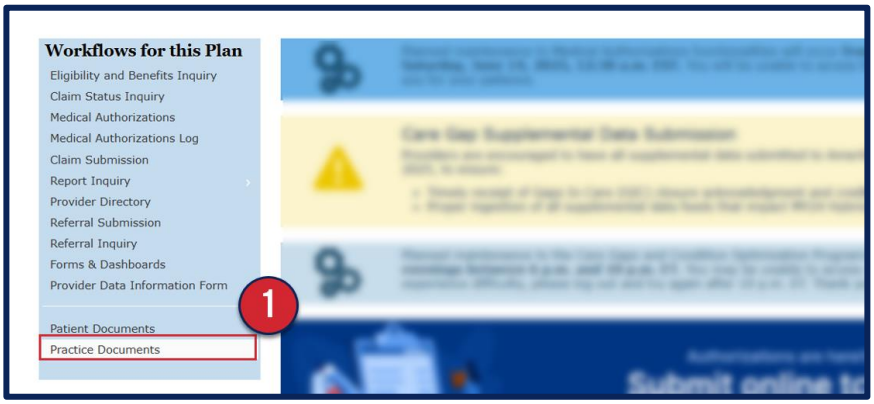
To access the Recovery Letters via the Practice Documents workflow:

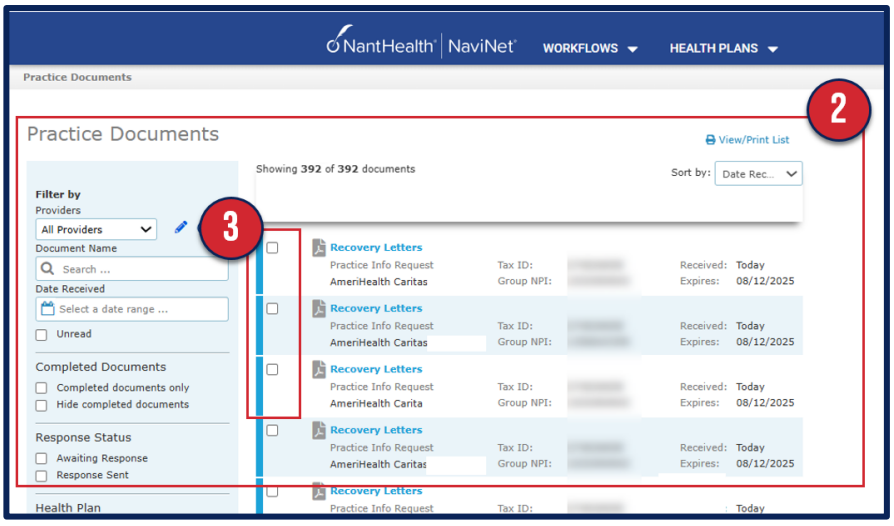
1. Click the **Workflows** from the menu bar.
2. Select **Practice Documents**



To access the Recovery Letters via the Plan Central page:

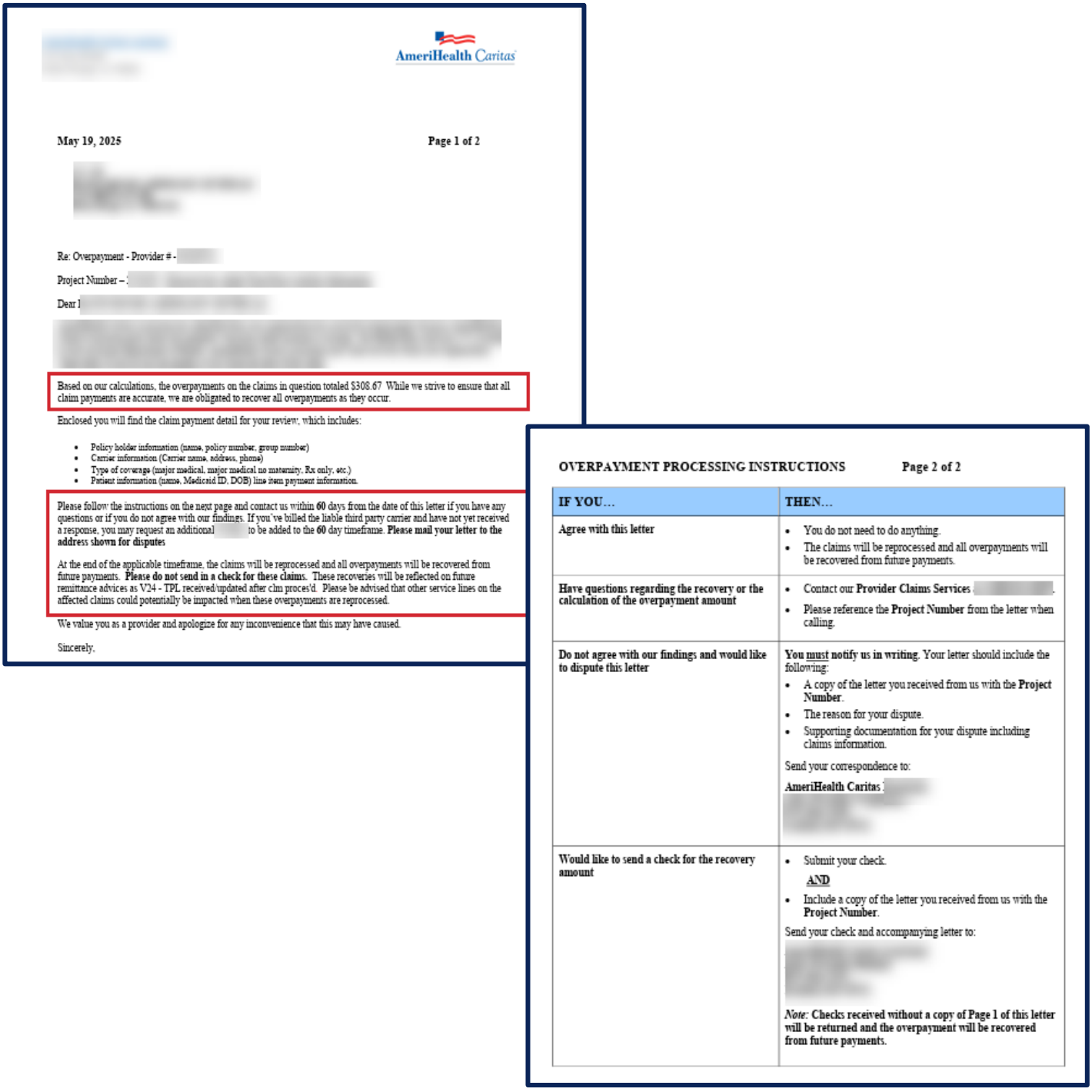
1. Click the **Practice Document** link.
2. The **Practice Documents** page will appear.
3. Check the box to select the appropriate **Recovery Letter** from the list.





Recovery Letter

The recovery letter will contain overpayment details and instructions on how the provider can approve or dispute the overpayment.



AmeriHealth Caritas

May 19, 2025 Page 1 of 2

[redacted]

Re: Overpayment - Provider # - [redacted]

Project Number – [redacted]

Dear [redacted]

[redacted]

Based on our calculations, the overpayments on the claims in question totaled $308.67 While we strive to ensure that all claim payments are accurate, we are obligated to recover all overpayments as they occur.

Enclosed you will find the claim payment detail for your review, which includes:

- Policy holder information (name, policy number, group number)
- Carrier information (Carrier name, address, phone)
- Type of coverage (major medical, major medical no maternity, Rx only, etc.)
- Patient information (name, Medicaid ID, DOB) line item payment information.

Please follow the instructions on the next page and contact us within **60** days from the date of this letter if you have any questions or if you do not agree with our findings. If you've billed the liable third party carrier and have not yet received a response, you may request an additional [redacted] to be added to the **60** day timeframe. **Please mail your letter to the address shown for disputes**

At the end of the applicable timeframe, the claims will be reprocessed and all overpayments will be recovered from future payments. **Please do not send in a check for these claims.** These recoveries will be reflected on future remittance advices as V24 - TPL received/updated after clm proces'd. Please be advised that other service lines on the affected claims could potentially be impacted when these overpayments are reprocessed.

We value you as a provider and apologize for any inconvenience that this may have caused.

Sincerely,

OVERPAYMENT PROCESSING INSTRUCTIONS **Page 2 of 2**

IF YOU…	THEN…
Agree with this letter	• You do not need to do anything. • The claims will be reprocessed and all overpayments will be recovered from future payments.
Have questions regarding the recovery or the calculation of the overpayment amount	• Contact our **Provider Claims Services** [redacted]. • Please reference the **Project Number** from the letter when calling.
Do not agree with our findings and would like to dispute this letter	**You must notify us in writing.** Your letter should include the following: • A copy of the letter you received from us with the **Project Number**. • The reason for your dispute. • Supporting documentation for your dispute including claims information. Send your correspondence to: **AmeriHealth Caritas** [redacted]
Would like to send a check for the recovery amount	• Submit your check. **AND** • Include a copy of the letter you received from us with the **Project Number**. Send your check and accompanying letter to: [redacted] *Note:* **Checks received without a copy of Page 1 of this letter will be returned and the overpayment will be recovered from future payments.**

Let Us Know – Member Intervention Form

The health plans are committed to assisting health plan providers in engaging members and supporting their health and well-being. If you identify members who need help managing their health, please notify the plan so they can offer timely assistance through the Let Us Know Program.

You can *Let Us Know* if a member requires support by completing the Member Intervention Form via the NaviNet Provider Portal. The form can be used to assist members with issues such as:

- Missed appointments
- Behavioral health needs
- Medication noncompliance
- Care management engagement
- Developmental screening concerns
- Emergency room misutilization
- Understanding plan benefits
- Social determinants of health
- Tobacco cessation referrals

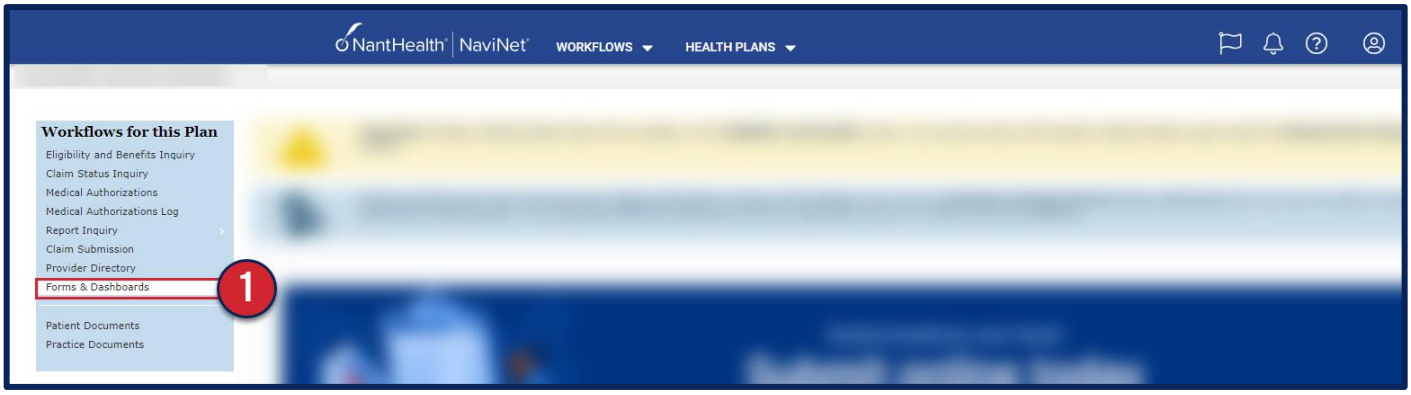
Routing and Support

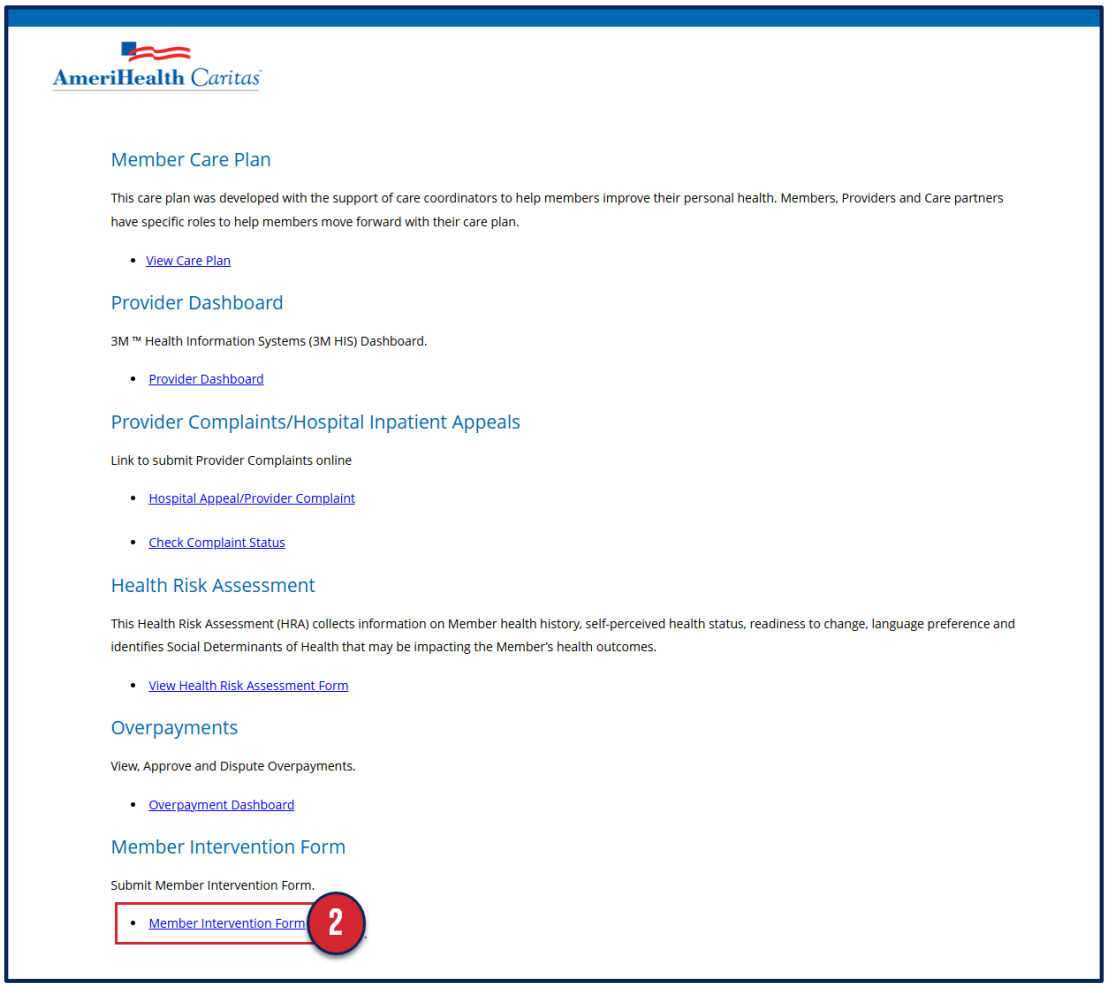
Once submitted, the Member Intervention form is routed directly to the Rapid Response Outreach Team (RROT) to address any identified concerns.

- A Care Connector from the RROT will contact you within 48 to 72 hours to confirm receipt and to ensure understanding of the request.
- Outreach will then be made to the member, and upon successful contact, all requested interventions will be completed.
- Upon completion, you will be notified of the outcome, whether successful or unsuccessful.

Submitting the Member Intervention Form in NaviNet

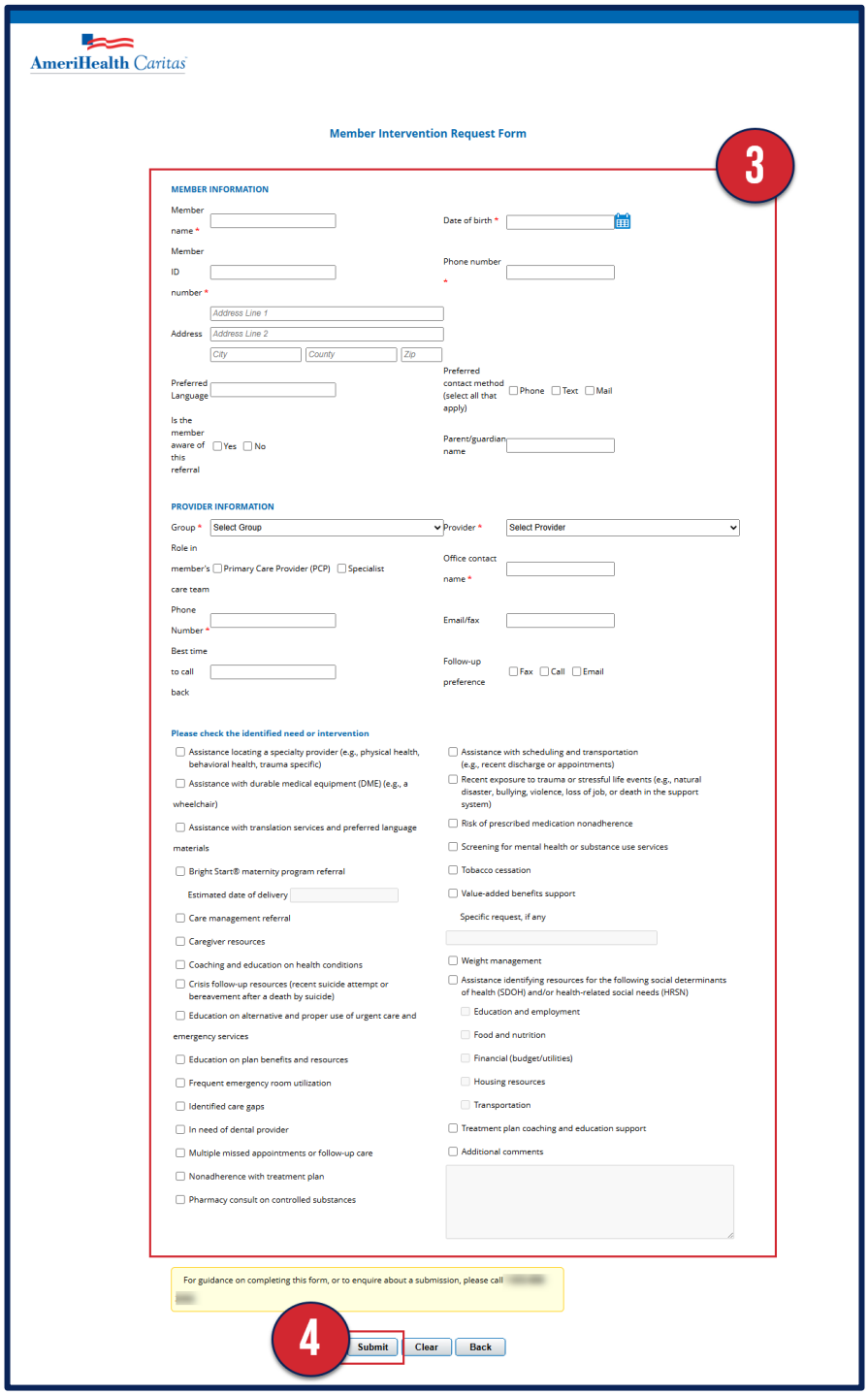
1. Click **Forms & Dashboard** from the Workflows for this Plan.
2. In the new window that displays, click the hyperlinked bullet, **Member Intervention Form.**





FORMS AND DASHBOARDS CONT'D.

3. Fill out all relevant fields on the form.
4. Click Submit.
5. After submission, a confirmation message will appear: Member intervention form Submitted (not pictured).



Patient and Practice Documents

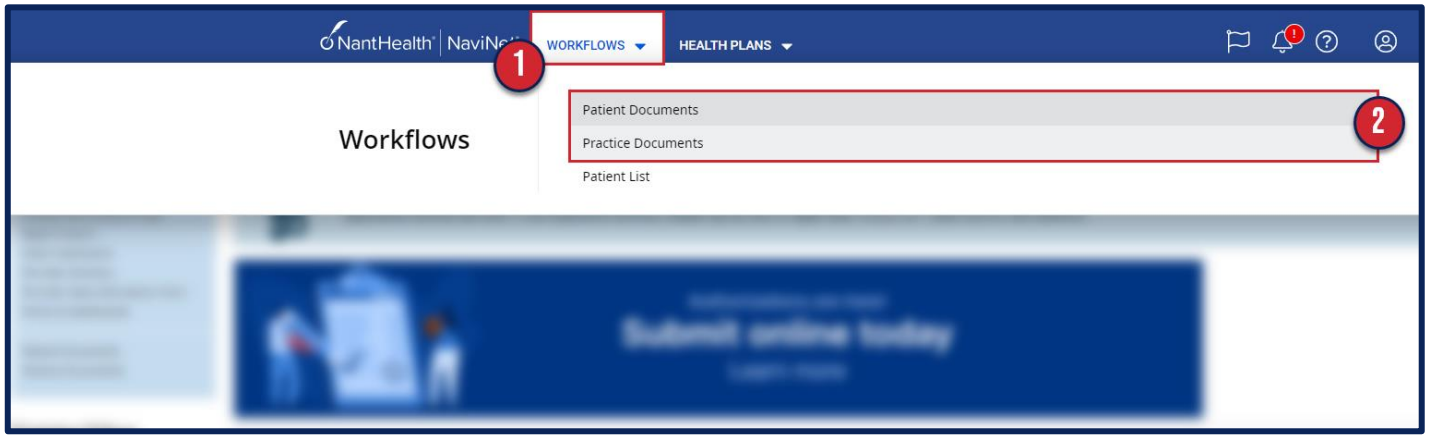
In the Patient or Practice Documents workflows, you can view and access documents submitted on behalf of all providers associated with your office. The patient's health plan provides these documents. Many of them are questionnaires or forms that require an uploaded response.

Some of the documents you can find under the Patient or Practice Documents Workflows are:

- Care Gap Response Forms
- ADT Alerts
- Authorization Letters
- Condition Optimization Program (COP)
- Dispute Letters

To access the Patient or Practice Documents:

1. Click Workflows from the NaviNet toolbar
2. Select either the Patient or Practice Documents workflow



Provider Filter

You can specify a list of providers whose documents you prefer to see and save the list to be used by default anytime you access the Patient or Practice Document dashboards.

The following topics will be covered in this section:

- **Provider Filter Options** – Learn about the options in this drop-down menu.
- **Provider Filter Panel** – Learn about the three views of the panel and the actions you can take on each view.
- **Provider Details View** – Review what the Provider Details screen looks like once selected.
- **Search for Providers to Select** – Find out how to search for a specific provider.
- **Select and save your Default Providers** – Follow these steps to save your default list of providers.
- **Select and Save Providers** (for one-time use) – Follow these steps to select providers whose documents you want to view during the current session.

Provider Filter Options

In the Filter by section of the Practice or Patient Document dashboard, you can select an option from the Providers drop-down list or click the Pencil icon to select Providers to filter the documents by.

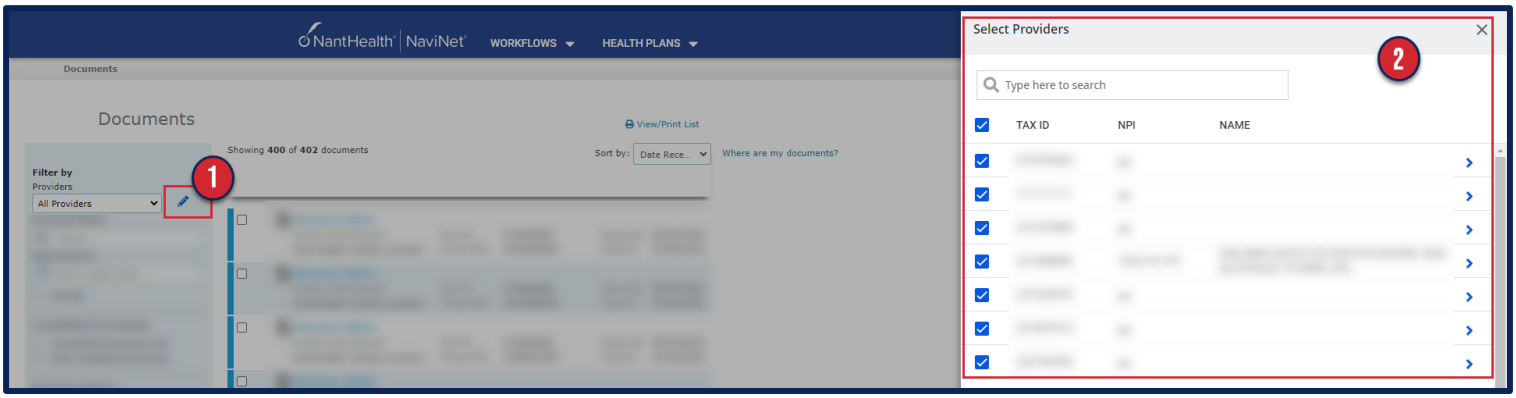
This field always has the option to view all providers. To have other options in this field, you must make manual provider selections or define a default list of providers. Once you do so, additional options appear in the Providers drop-down list.

The possible options in the drop-down list include the following:

- **All Providers –** View documents associated with all providers in your office.
- **Default –** View documents associated with the providers that you have saved as default.
- **Manually selected –** View documents associated with the provider selections that you have applied during the current visit to the Practice or Patient Clinical Documents screens.

To open the Provider Filter panel to review and select providers:

1. Click the pencil icon next to the Providers field
2. The Select Providers view of the panel appears



Provider Filter Panel

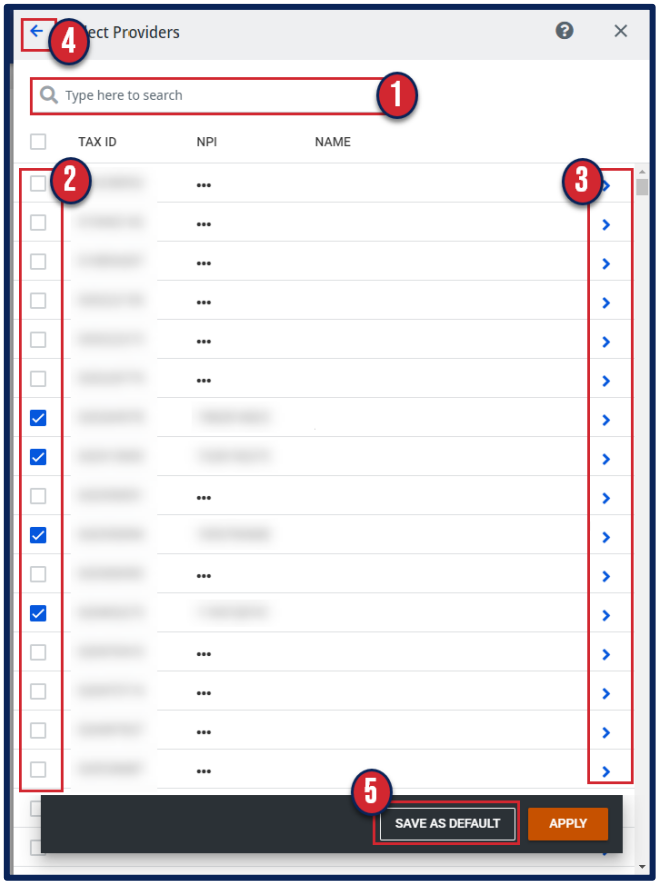
The Provider Filter panel allows you to search for providers, review provider details, make selections, and apply/save your selections.

The Provider Filter panel can show the following details for each record:

- Provider Name (Clinician or Billing Entity)
- NPI
- Tax ID
- Address
- Provider Group ID
- Provider ID
- Providers view (View all Providers for a specific Tax ID, sorted by health plan)
- Provider Details view

You can take any of the following actions in this view:

1. Type in the search box to find a specific provider or Tax ID.
2. Make selections, as needed.
3. Click a Provider to view Provider Details, including Group ID, health plan, and address
4. Return to the previous view by clicking the arrow in the top left of the panel.
5. Save as default or apply your selections



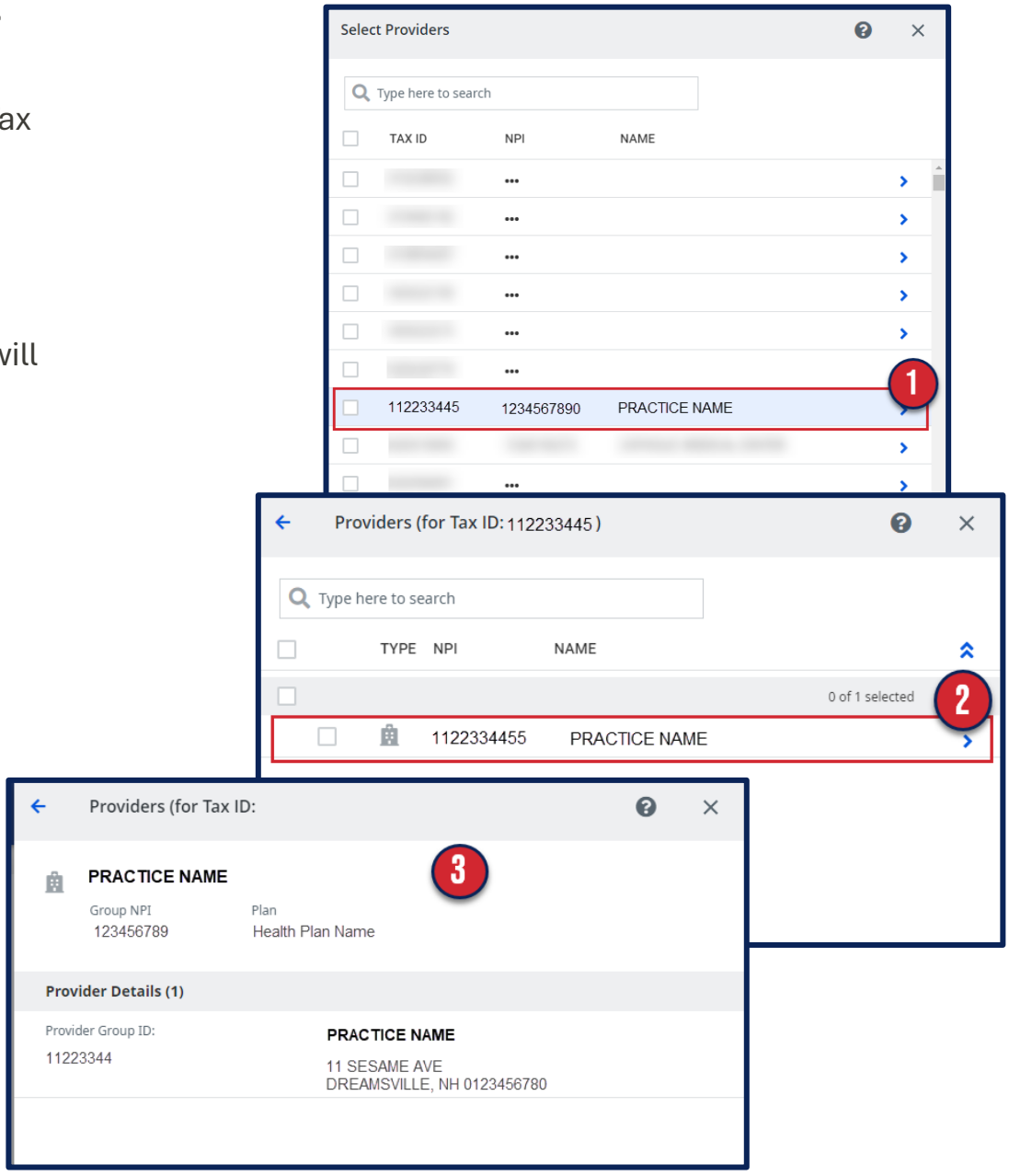
Provider Details View

The Provider View provides more details about the provider (or entities) associated with a particular Tax ID.

- Billing entities and Clinicians are sorted by health plan.
- You cannot make selections from this view.

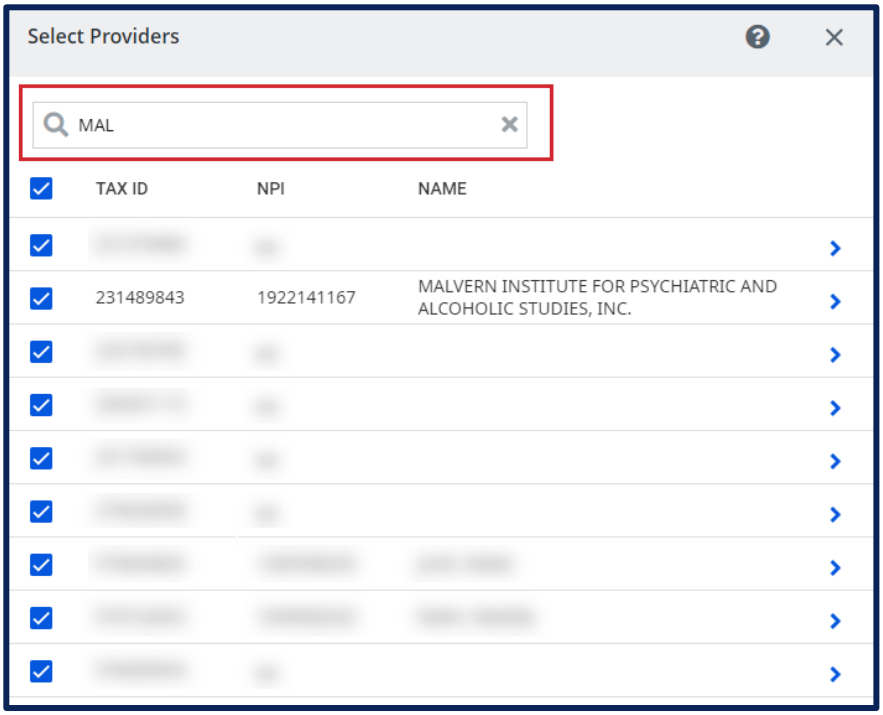
To access the Provider Details View:

1. Select a provider (Tax ID) from the Select Providers screen
2. Select Provider or Practice
3. The Provider View will display



Search for Providers to Select

Type at least three characters in the search box to search for an individual provider. The list of providers begins to sort.



Search requirements and included fields are as follows:

- The search includes sub-strings and is not case-sensitive.
- If you enter multiple words, an "or" search is performed.
- The search includes Tax ID, NPI, Group NPI, Provider Name, Address, and Health Plan Name.

Default Providers

You can save a list of providers to use to filter the list of documents by default every time you visit the Patient or Practice Document dashboard.

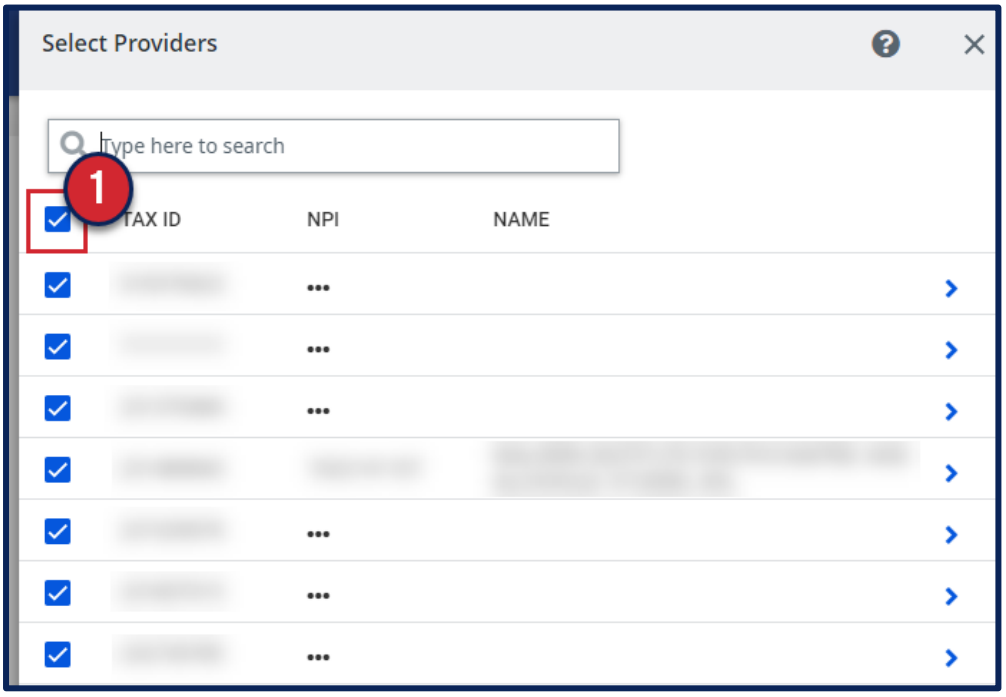
You can select:

1. All providers
2. All providers for a particular Tax ID
3. Individual providers

You can also make selections from the Select Providers and Provider views of the Provider Filter panel.

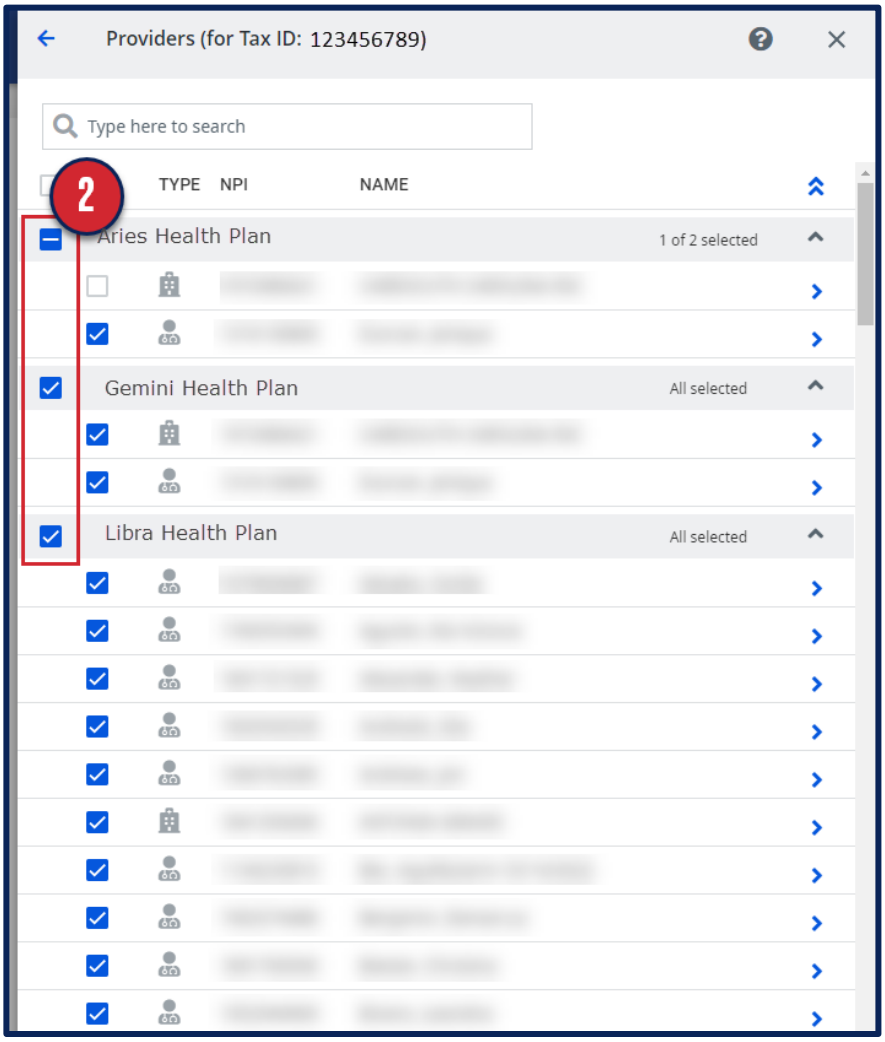
Default Providers: All Providers

1. On the Select Providers view, select the Select All checkbox to select all providers associated with your office
    - When new providers or health plans are added to your office in the future, they are automatically included in your default filter results.
    - The "Select All" checkbox is not checked if you choose individual Tax IDs.
    - If you perform a search, the "Select All" check box will only select the visible Tax IDs and providers. If you save these as default, any time a new provider is added to your office or to the selected health plan, it will NOT be included in your default filter results.



Default Providers: All Providers for particular Tax ID

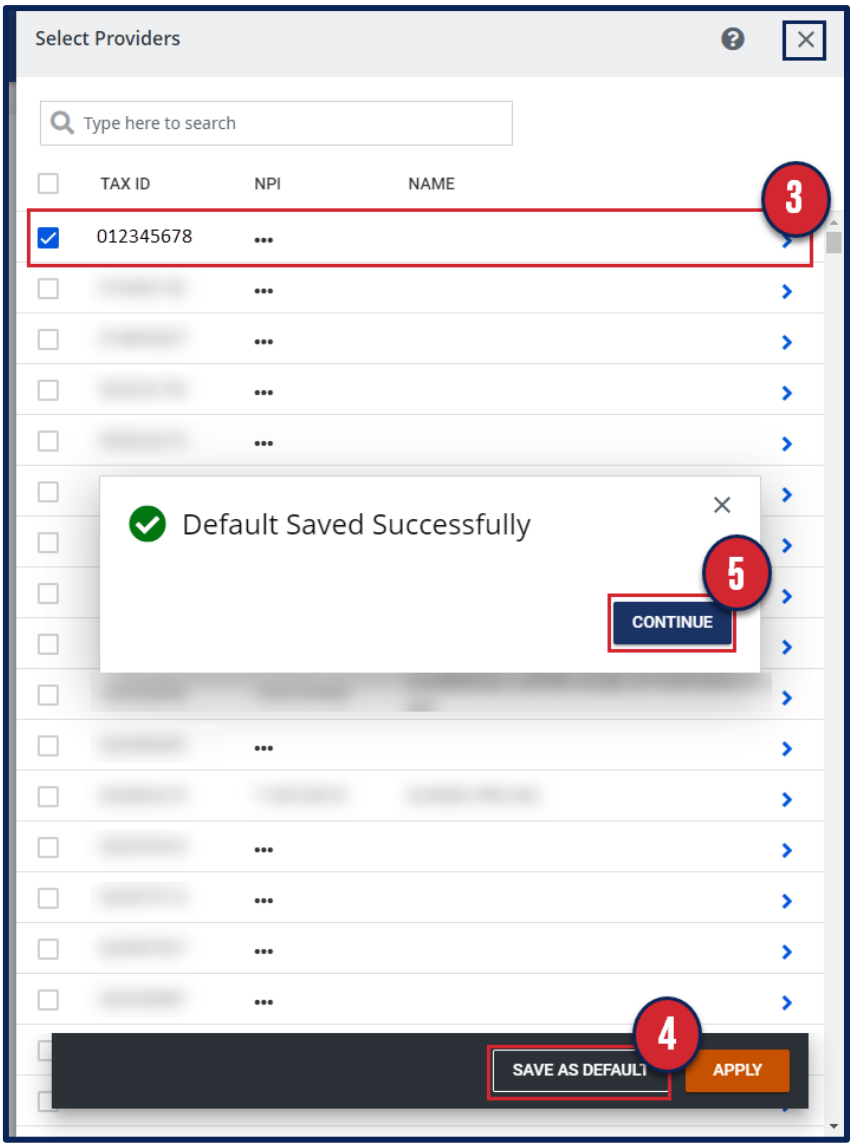
2. On the Providers view, click the Select All checkbox for the required health plan to select all providers associated with a Tax ID for that health plan.
    - When a new provider is associated with the health plan for the selected Tax ID in the future, it is automatically included in your default filter results. In the following example, the Select All checkbox for Gemini and Libra health plans is selected.



Note: The Select All checkbox displays a dash (-) if only individual providers associated with a Tax ID are selected on the Provider view (as shown in the Aries Health Plan Select All checkbox in the screenshot).

Default Providers: Individual Providers

3. On the Select Providers view, select the check box next to the provider. If necessary, use the search box to find a particular provider.
    - This selection will include all details associated with that provider (for example, multiple locations or health plan associations).
4. Once you have made your selections, click Save As Default
    - Click Apply to close the panel and apply your selections. They are retained until you navigate away from the Practice or Patient Documents screen
    - You can close the panel without saving or applying your selections by clicking the X button at the top-right of the panel.
5. A pop-up will display, click Continue



Note: If you selected too many items, a pop-up window will appear with a message indicating that changes cannot be saved because you selected too many providers. Click Cancel, reduce the number of selections you made, and try again.

Select and Save Providers (for one-time use)

During your current session, you can view documents for specific providers by selecting:

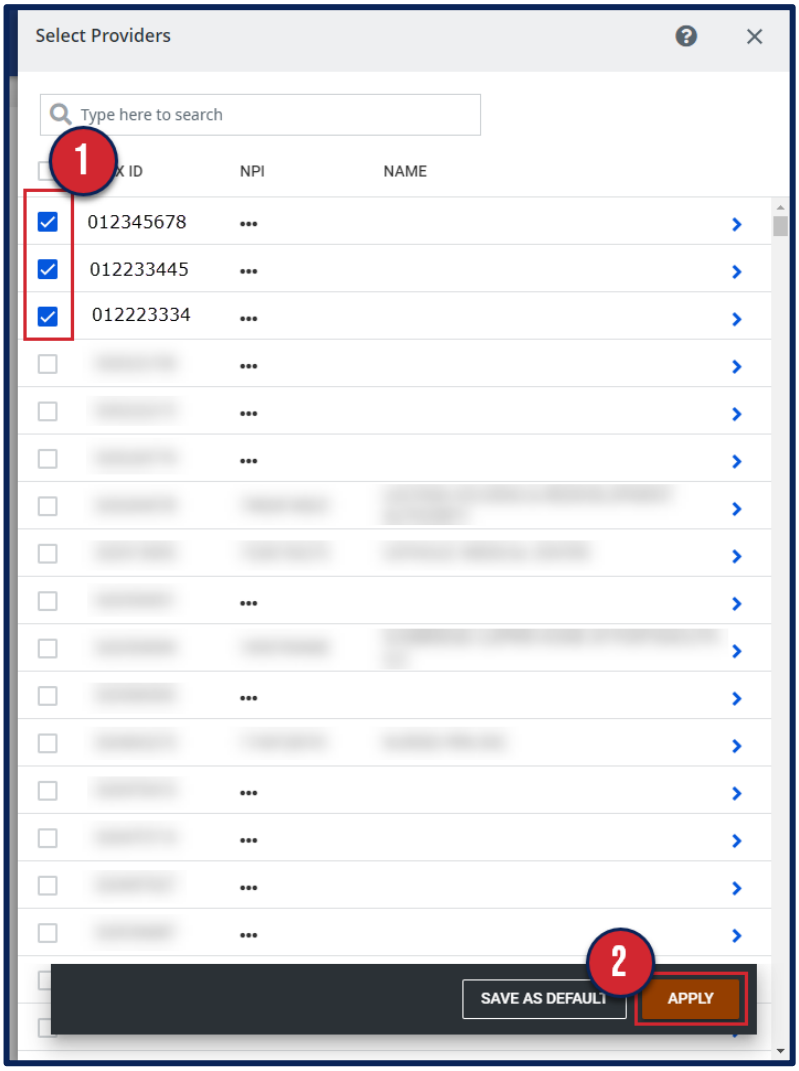
- All providers
- All providers for a particular Tax ID
- Individual Providers

These selections are not retained for future visits to the Practice or Patient Clinical Documents screens.

You can make selections from the Select Providers and Provider views of the Provider Filter panel.

1. Select the providers
2. Click Apply to close the panel and apply your selections.

Your selections are retained until you navigate away from the Practice or Patient Documents screen.

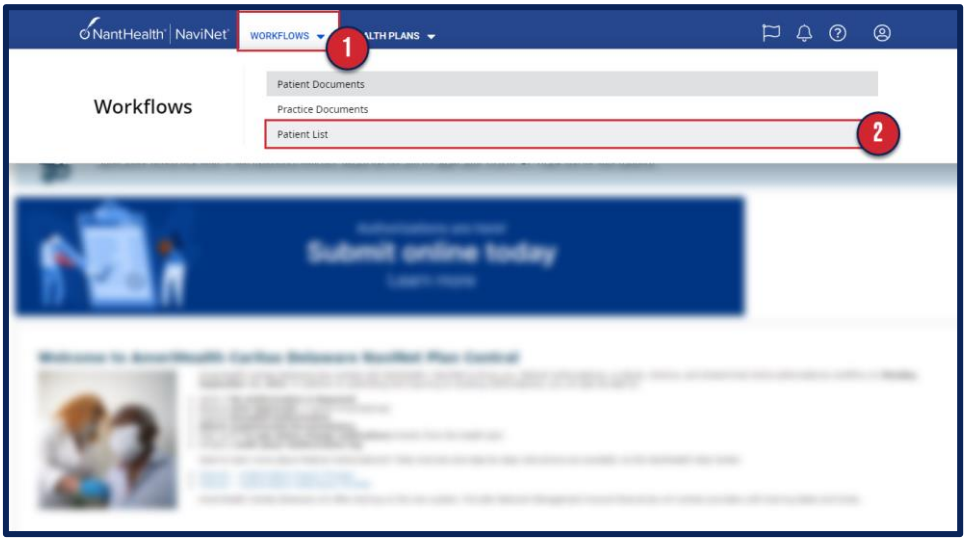


Note: If you selected too many items, a pop-up window will appear with a message indicating that changes cannot be saved because you selected too many providers. Click Cancel, reduce the number of selections you made, and try again.

WORKFLOWS MENU CONT'D.

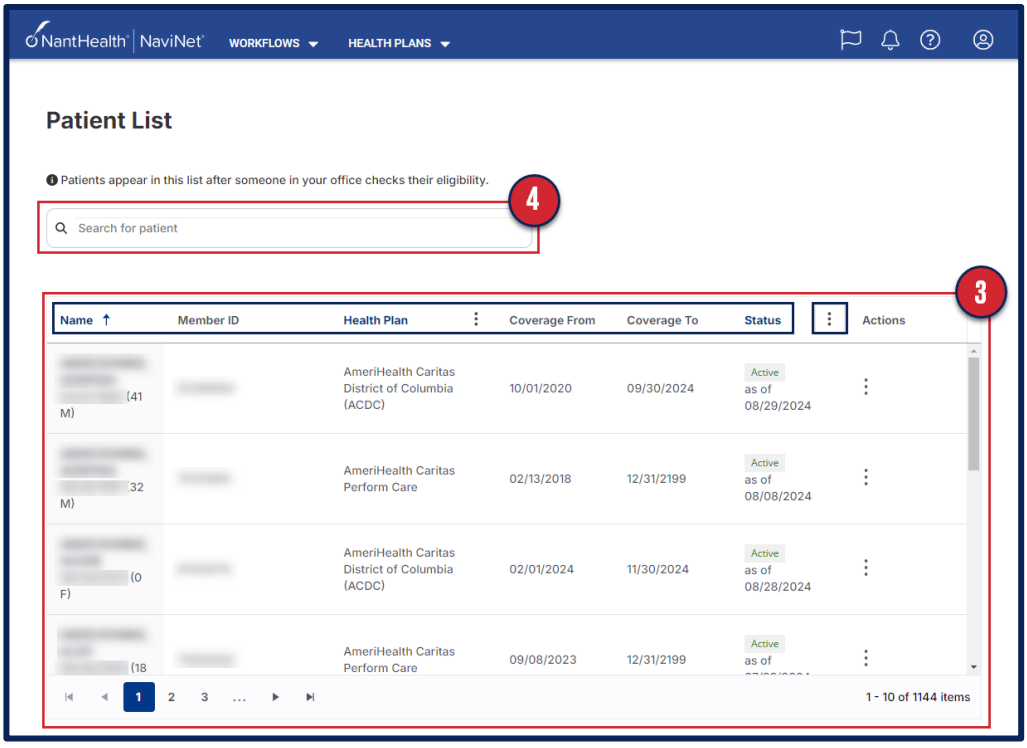
Patient List

You can view your patients in one place and quickly check their eligibility details or claim status. Patients automatically appear in the list after the eligibility is checked.



To access the Patient List:

1. Click Workflows from the top menu bar
2. Select Patient List
3. The Patient List appears. You can see the patient's coverage status, which is based on the most recent eligibility check
4. Find the patient
   - Type criteria in the search box at the top to narrow the list
   - Click a column header to sort by that column
   - Click the Filter icon ( ) in the Health F or Status column to filter the list by a specific health plan or coverage status



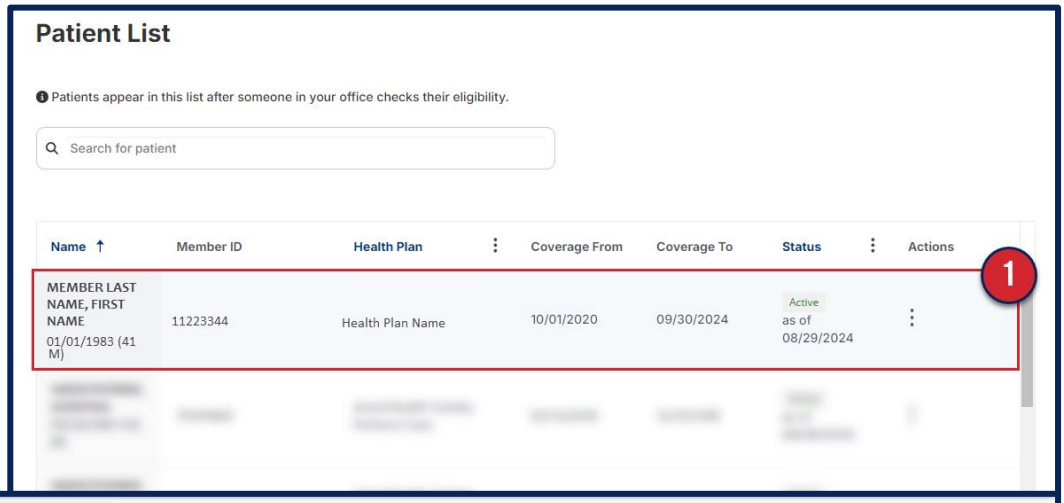
Patient List Actions

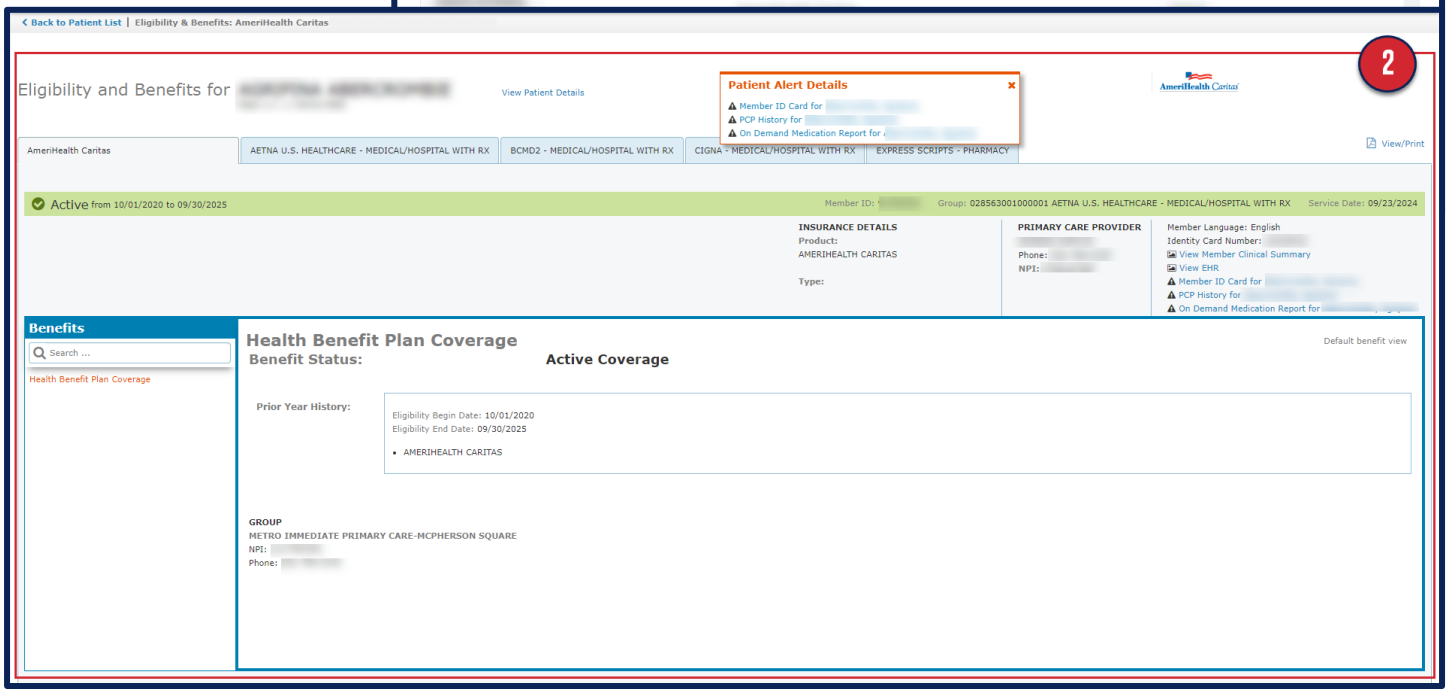
The following actions can be performed in the Patients List:

- View the patient's eligibility for today
- Update the eligibility search criteria
- Check the status of a claim (only available if the health plan supports it)
- Remove a patient from the list

To **view the patient's eligibility for today**:

1. Click the patient row
2. The Eligibility and Benefits screen will display

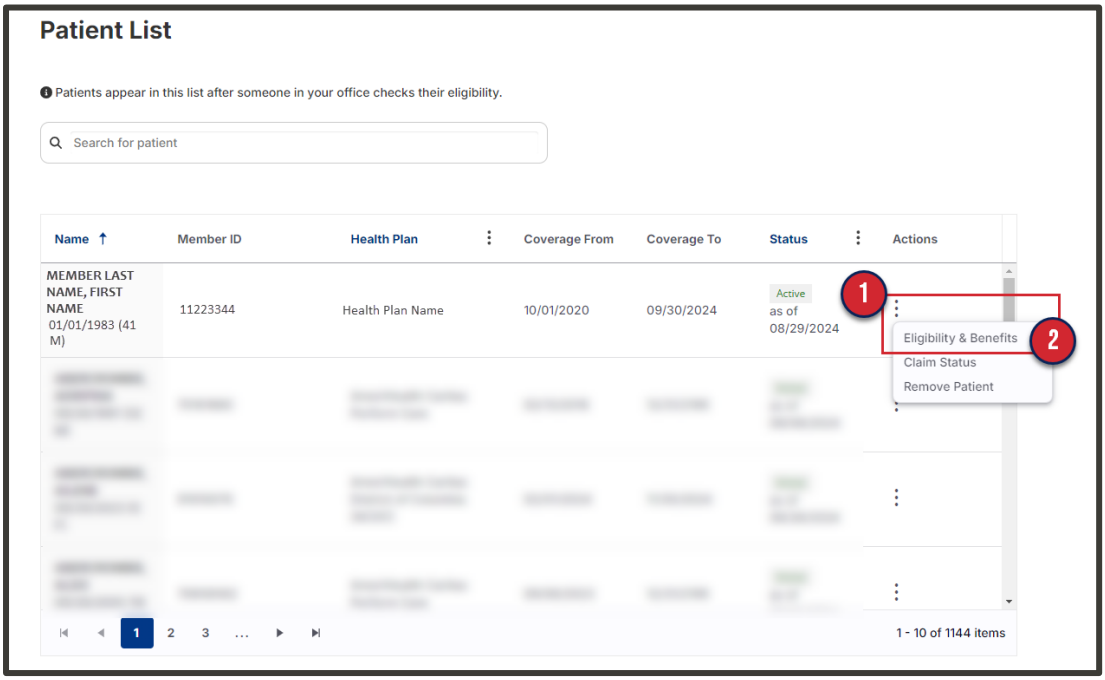


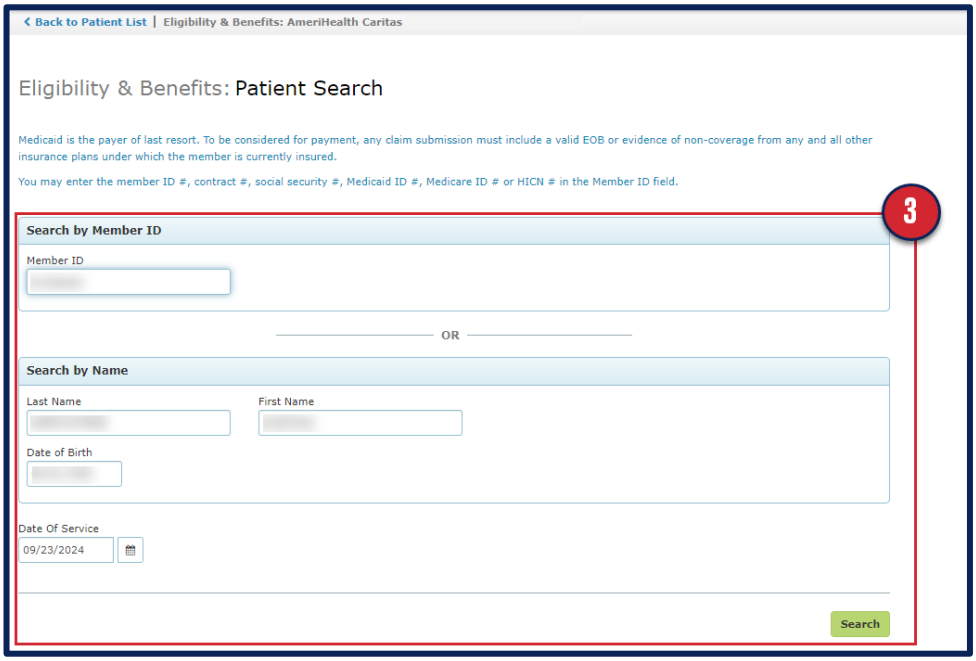


Patient List Actions Cont'd.

You can **update the eligibility search criteria** by:

1. Clicking the Actions menu (three vertical dots) on the right side of the patient row
2. Select Eligibility & Benefits
3. The Patient Search screen will display. Update the search criteria
    - You can use the current patient or search for a new one. You cannot change the health plan.

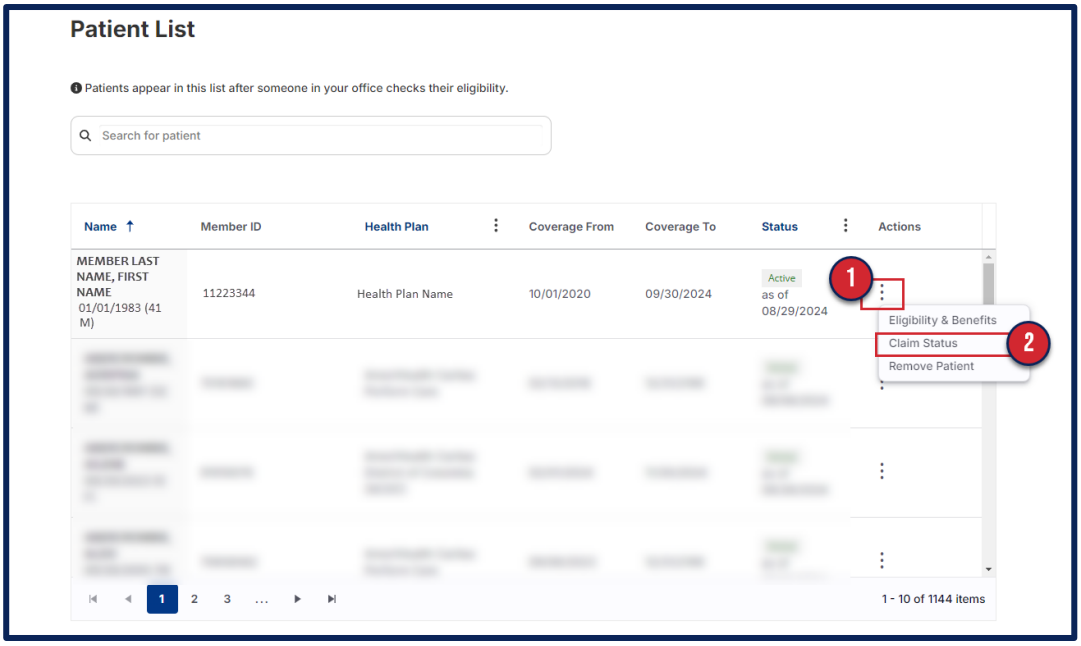


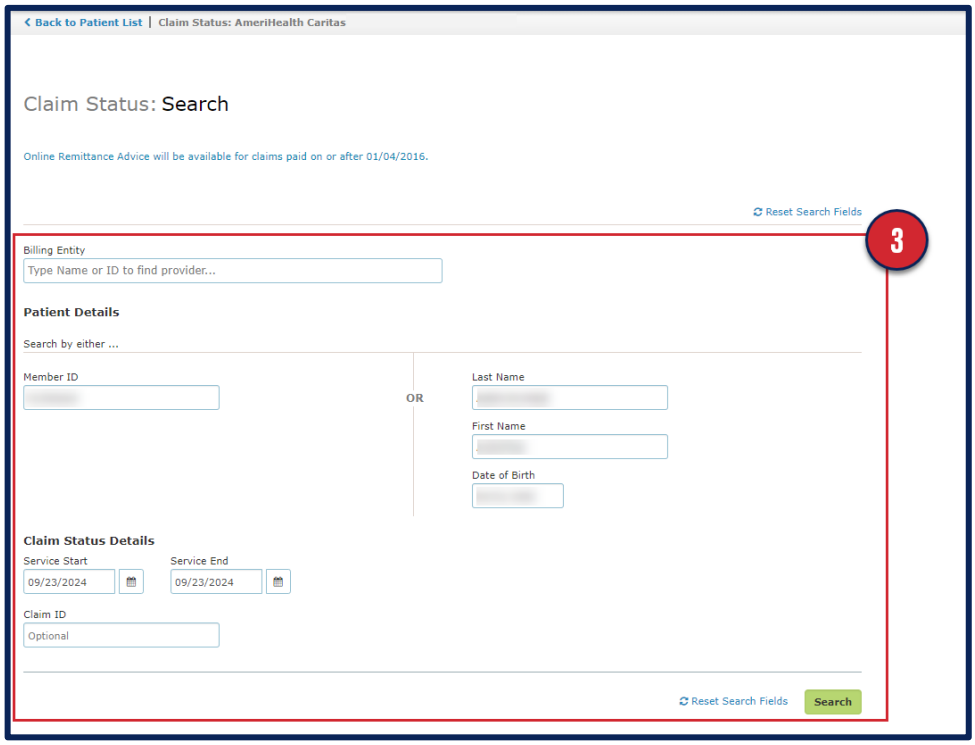


Patient List Actions Cont'd.

You can **check the status of a claim** by:

1. Clicking the Actions menu (three vertical dots) on the right side of the patient row
2. Select Claim Status
3. The Claim Status Search screen will display. Enter your search criteria
    - You can use the current patient or search for a new one. You cannot change the health plan.





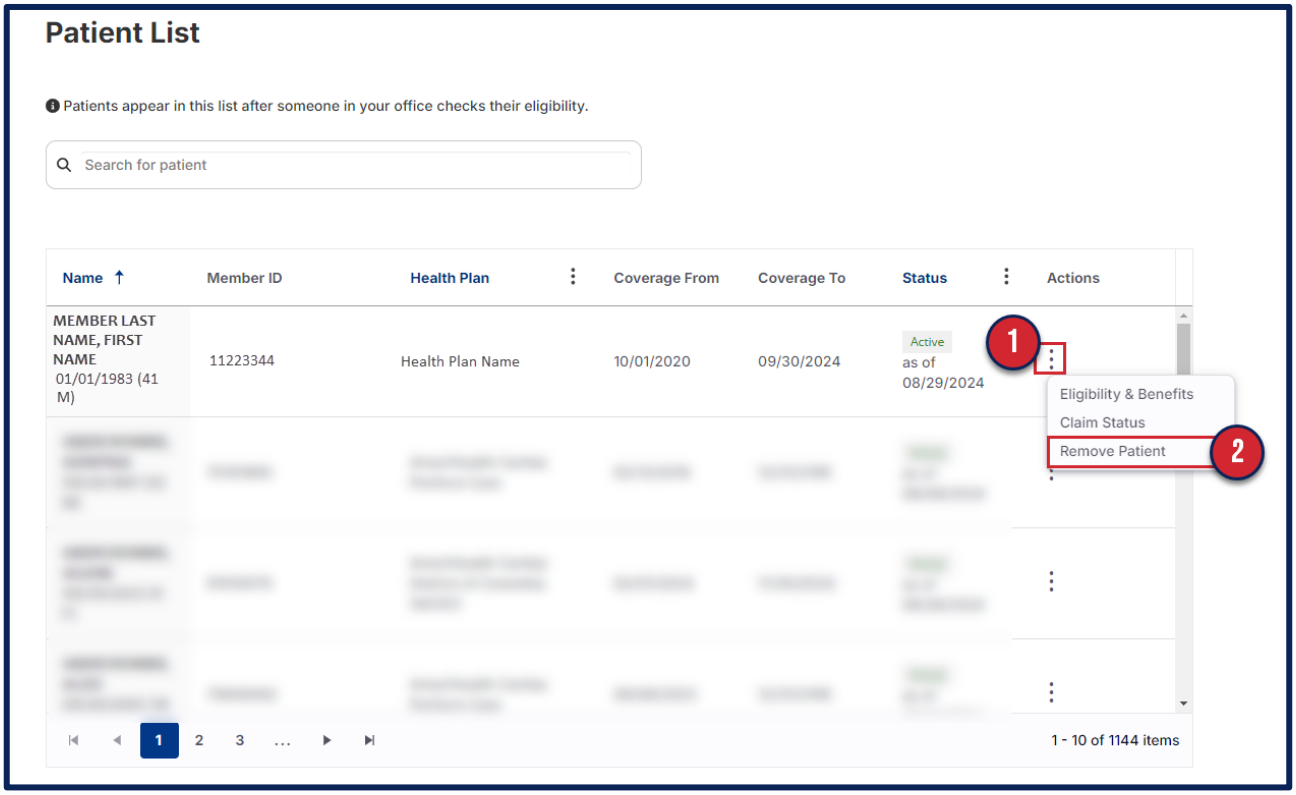
Patient List Actions Cont'd.

After a patient appears on this list, they stay there unless you remove them.

To remove a patient from the list:

1. Clicking the Actions menu (three vertical dots) on the right side of the patient row
2. Select Remove Patient

This action removes the patient from the list until someone in your office checks their eligibility again in NaviNet.



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