

WellSense New Hampshire Medicaid

Orientation and General Overview

Updated 6/2/2023



Who Is WellSense

Agenda

- NH Medicaid and Coverage/Eligibility
- Working with WellSense
- Care Management
- Appeals
- Our Partners
- Fraud, Waste, And Abuse
- Provider Resources

More about WellSense

WellSense Health Plan is a non-profit Managed Care Organization founded by Boston Medical Center in 1997

WellSense Health Plan is our trade name across all products in New Hampshire and Massachusetts



Eligibility

One Program - One Fee Schedule - Two Products

- NH Standard
- Granite Advantage Health Care Plan

**NH Medicaid member eligibility is determined by NH DHHS.

Eligibility

- Online: Visit nheasy.nh.gov
- Phone: Medicaid Service Center at 888-901-4999
- Paper Application: DHHS district office or dhhs.nh.gov



Four steps to enrolling and keeping Medicaid coverage



Check member Eligibility

All eligible NH Medicaid recipients can be verified via the MMIS lookup tool. MMIS Portal will identify which of the three Manage Care Organizations (MCO) the member is enrolled in.

Before providing services; verify eligibility:

WellSense Tools to **check member eligibility online or by phone:**

1. Secure provider portal Health Trio at wellsense.org
2. Provider Service Center at 877-957-1300, option 3
3. IVR (interactive voice recognition) system
4. New Hampshire MMIS Health Enterprise Portal 6

Member ID Card

Sample WellSense member ID card:



Member Name

Member ID: NH0123456 00
Medicaid ID: 1098654321

DOB: 00/00/0000

New Hampshire Medicaid

Members wellsense.org

Member Services: (877) 957-1300 | TTY: 711
Medical, mental health, pharmacy benefit questions
or to file an appeal/grievance

Find a doctor: visit wellsense.org/find-a-provider

Transportation: (844) 909-7433

Vision: (800) 877-7195

Nurse advice (24/7): (866) 763-4829

Providers & Billing Offices

Provider Services (Referrals, PAs, Eligibility): (877) 957-1300 option 3

Behavioral Health Services: (855) 834-5655

Pharmacies: Express Scripts (877) 882-4187 **BIN:** 003858 **PCN:** MA
RxGRP: WLSNS

Working With WellSense

New Member Outreach

Members receive a welcome call within the first month of enrollment from our in-house member services team to ensure the following:

- Verify Primary Care Provider or assist in selection of PCP*
- Review benefits
- Verify spoken/written language
- Offer to complete a Health Risk Assessment
- Inform member of care management programs
- TDD/TTY and language options reviewed

*Members are required to have a PCP, if they do not elect one they will be assigned one



Hospitals, Facilities and Physicians in our Network

WellSense is dedicated to providing coverage to New Hampshire Medicaid members. WellSense offers an extensive, statewide network of acute care hospitals, primary care providers, specialists, and ancillary providers. Our network covers all of New Hampshire along with the bordering states of Maine, Massachusetts and Vermont.

- Statewide primary care physician and specialty coverage
- Statewide behavioral health coverage
- Federally Qualified Health Centers
- Rural Health Clinics

Statewide ancillary network: lab, imaging, PT, OT, ST, home health.

Prior Authorization

Prior Authorization is required for

- outpatient medical/surgical services
- home health services
- inpatient admission

Notification is required for

- Emergency services pending inpatient admission
- Observation
- Urgent care services



Prior Authorization (cont.)

- The Prior Authorization Matrix reference guide identifies services that require authorization/notification or you can consult the look up tool by service code. Look Up Tool: <https://www.wellsense.org/providers/prior-authorization>
- Specialist office visits do NOT require referrals for in network providers
- Authorization requests and notifications may be submitted online using HealthTrio. Authorization decisions are communicated to providers via online or by telephone/letter.
- Members receive a letter for all denials which include member appeal rights, including the right of a provider to file a member appeal on behalf of a member.
- For denials, requesting providers may seek a telephonic peer-to-peer review with a Medical Director

Care Management

Care Management Referrals

Providers may refer members to Care Management

Monday through Friday: 8:30 a.m. – 5:00 p.m.

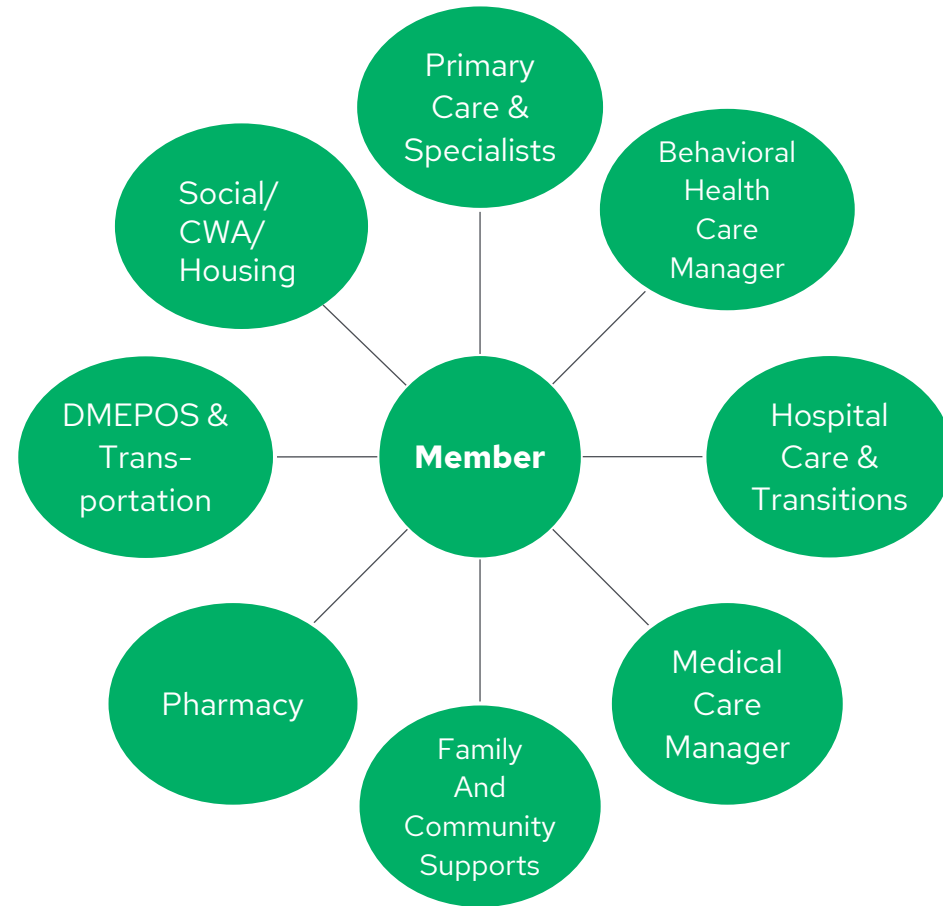
Phone: 855-833-8119

Email: NHCare.Management@Wellsense.org



Care Management Care Model

Our collaborative approach assesses the Member's overall health status, facilitates coverage for medically necessary services, works with social and community-based services, and advocates for the Member as they navigate the healthcare system



Care Management

With a focus on Members with high risk/high needs, WellSense's Care Management program integrates physical, social, and behavioral health supports services. WellSense Care Management collaborates with local community-based agencies, Area Agencies, Community Mental Health Centers, Local Care Management entities, and all our Providers. This collaborative approach assesses the Member's overall health status, facilitating coverage for medically necessary services, social and community-based services, and advocating for the Member as he or she navigates the healthcare system

Our interdisciplinary team of Registered Nurses, Social Workers, BH clinicians, Community Wellness Advocates, Housing Coordinator, and Care Navigators work closely with our Pharmacy, Utilization Management, and Vendors (nonemergency transportation, durable medical equipment, etc.) to ensure support services are wrapped around the member as needed.

Our Goal is always for Members to maintain optimum health and achieve wellness and self-management in their community setting.

Priority Populations

Health Needs	Social Determinants of Health
<p>Chronic Conditions</p> <ul style="list-style-type: none">• Diabetes• Asthma• COPD• CHF <p>Pregnancy</p> <p>High Risk Infants (NAS)</p> <p>HIV/AIDS</p> <p>Substance Use Disorder</p> <p>Behavioral Health</p> <p>High Utilizer of ED or inpatient stay</p> <p>Polypharmacy</p>	<p>Medicaid Waivers</p> <ul style="list-style-type: none">• DCYF• Choices for Independence• Developmental Delay and Acquired Brain Disorder <p>Homelessness</p> <p>Food Insecurity</p> <p>Transition of Care</p> <p>Recent incarceration</p> <p>Refugee Status</p>

Care Management Programs

All Members referred to Care Management are comprehensively assessed and an individualized care plan (ICP) is developed.

Members in Care Management are supported by our Care Navigators and team to ensure they are getting the most out of their WellSense benefits and member extras.

Care Management Programs:

Chronic Condition Management Program

- Health Care Education
- Provides education materials, tools, resources to promote wellness and prevention education materials
- Addresses members with specific medical, behavioral, and social needs
- Involves coordination of care, services, available benefits, community resources, and supports either in-person locally or by phone

Care Management Programs (cont.)

Transitions of Care Program

- Members who have an inpatient hospitalization
- Members who are discharged from one clinical setting to another
- Assist with discharge planning when a Member is in a facility
- Are struggling with multiple admissions/readmissions
- Goal is to help the Member remain in the least restrictive setting possible, avoiding unnecessary use of the ED and/or inpatient settings

Maternal Child Health

- High risk pregnancy and high risk newborns
- Mothers with SDoH needs
 - Substance Use Disorder
 - Homelessness or housing instability

Care Management Program (cont.)

Complex Care Management Program

- Intensive care management for Members with significant and overlapping needs across medical, behavioral, and social conditions
- Involves coordination of care, services, available benefits, community resources, and supports either in-person locally or by phone
- Referrals to Complex Care Management may include Priority Populations and Members who:
 - Show evidence of having certain functional impairments
 - Have an illness or event that has caused a change or decline in ability to self-manage

Social Care Management Program

- Emphasis is on psychosocial and socioeconomic support. Triages and assesses all referrals and inquiries and provides effective advocacy and resources.
- Members primary needs are those that are SDoH related
- Homelessness
 - Maintains working relationships with key New Hampshire homeless and housing service agencies, housing authorities, landlords, and community and housing stakeholders

Care Management Program (cont.)

Behavioral Health Care Management Program

Carelon and WellSense work together to enroll members with behavioral health needs into Care Management

- Educates member on diagnoses, treatments, therapy process, co-morbidities and risk factors
- Provides information for crisis and peer services
- Members with unmet BH needs will get support connecting to providers
- Members currently working with BH providers will receive Care Coordination and support around any co-morbidities (medical or social)

Claims and Appeals

Member & Provider

Claims Submission

To expedite payments, we recommend submitting claims electronically.

Electronic Claims:

- WellSense Payor IR: 13337
- Submit an 837 transaction

Submit through Direct Submission (WellSense Payor ID is 0515)

- Examples: XACTIMED, Emdeon/Web MD, McKesson, SSI

HealthTrio – WellSense Secure Provider Portal

Paper Claim Submissions

WellSense Health Plan
Claims Department
PO Box 55049
Boston, MA 02205-5049

Claims and Provider Administrative Appeals

WellSense Health Plan is the “Payer of last resort”

- Claims must be *received* by WellSense within 120 calendar days from the date of service
- Coordination of Benefits and Other Party Liability rules apply

Provider Administrative Appeals

- Provider administrative appeals include requests for reviews of denied claims (including but not limited to untimely claims filing, level of compensation/reimbursement, no prior authorization/inpatient notification, member eligibility issues, clinical editing, COB denials) credentialing/re-credentialing denials, program integrity issues.
- Provider administrative appeals must be *received* within 30 calendar days from the date of the claim denial.

DHHS State Fair Hearing for Provider Administrative Appeals

A State Fair Hearing through the New Hampshire DHHS is an independent review by DHHS of a Plan internal appeal adverse action.

- A Plan participating provider may be eligible for a State Fair Hearing Appeal only after they have exhausted the Plan's Internal Provider Administrative Appeals process.
- The State Fair Hearing Appeal must be filed within 30 calendar days of the date on the Plan's Internal Provider Appeal adverse action notice.
- The provider must be present for the DHHS Hearing.
- Representatives from the Plan also participate in the Hearing.

Member Appeals and Grievances

WellSense Health Plan strives to promptly resolve member appeals and grievances.

Difference Between Member Appeals and Provider Appeals

- **Provider Administrative Appeals** = a formal process for providers to request reviews of their claims pertaining to the areas mentioned on the previous slide.
- **Member Appeals** = a formal process for members or their Authorized Representatives, which includes providers, for reviews of denied services that have **not yet occurred***. When a prior authorization or inpatient stay is denied in advance of the member receiving the services, a Plan denial letter is issued to the member and requesting/servicing provider(s) and includes Member Appeal rights.

*The member appeals process also includes benefit reviews for excluded services/member reimbursements pertaining to out of pocket member liability. These are typically filed by members themselves.

Member Appeals and Grievances (cont.)

Member Appeals

WellSense has an efficient process in place to resolve member appeals. A member or authorized representative, which includes a provider acting on behalf of a member, may request three types of member appeals. Member internal appeals must be received by WellSense within 60 calendar days of the date of the notice of an adverse action.

- 1. Standard Internal Appeal** = resolved within 30 calendar days, unless extended. A signed Authorized Representative Form is required from the member for a provider or any other Authorized Representative to file the appeal on the member's behalf. The appeal is dismissed if this form is not received by the 30th calendar day.
- 2. Expedited Internal Appeal** = resolved within 72 hours unless extended. For the Plan's records, a provider must formally assert that a member's health and/or life is in serious jeopardy awaiting the Standard Internal Appeal timeframe. If this is the case, a signed Authorized Representative Form from the member is not required for a provider to file the appeal on the member's behalf.
- 3. External DHHS State Fair Hearing** = may be utilized only after the internal appeals process has been exhausted. These appeals must be filed within 120 calendar days of the date of the Plan's internal appeal denial letter.

Member Appeals and Grievances (cont.)

Information on the Member Appeals process is included in all initial denial letters sent to members and requesting/servicing providers and is located after the denial or partial approval rationale. The detailed information in the letter from the Plan includes but is not limited to:

- timeframes for filing member appeals
- methods and contact information for filing member appeals
- timeframes for processing of member appeals
- rights of the member throughout the appeal
- information on Authorized Representatives
- an informative member appeals insert
- an Authorized Representative Form

It is essential that providers/office staff review the denial or partial approval letter in its entirety to ensure any Member Appeals for prospective services are sent to the appropriate department at the Plan. This will allow the Plan to process the member appeal as quickly as possible for the member.

Member Appeals and Grievances (cont.)

Provider Tips for effective and efficient Member Appeals process:

1. Review the initial denial/partial approval rationale. The rationale for the decision will inform the provider which part(s) of the clinical criteria a member did not meet to qualify for coverage of the service/supply/medication/inpatient stay.
2. If clinical information/documentation exists to prove the member meets the clinical coverage criteria but was not sent initially, be sure to include that information with the member appeal request.
3. Include a written narrative supporting your member appeal on the member's behalf, including documentation of new/additional information being sent, reason(s) the member should be covered for the service/supply/medication/inpatient stay and any other information pertinent to the request.

*This will reduce the number of follow-up phone calls required, based upon provider availability, and allow for faster processing of the member appeal.

DHHS State Fair Hearing for Member Appeals

A State Fair Hearing through the New Hampshire DHHS is an independent review by DHHS of a Plan internal appeal adverse action.

- A member may be eligible for a State Fair Hearing Appeal only after they have exhausted the Plan's Internal Member Appeals process.
- The State Fair Hearing Appeal must be filed within 120 calendar days of the date on the Plan's Internal Member Appeal adverse action notice.
- The member or their Authorized Representative, including providers filing on behalf of members, must be present for the DHHS Hearing.
- Representatives from the Plan also participate in the Hearing.

Member Appeals and Grievances (cont.)

Member Grievances

Process where members or their Authorized Representative, including providers on a member's behalf, express dissatisfaction about the services they receive from the Plan and/or providers. Types of grievances include but are not limited to:

- Plan processes
- Plan staff
- Provider and/or provider staff attitude/service
- Quality of care
- Quality of practitioner office site
- Billing/financial issues
- Access and availability

Member Appeals and Grievances (cont.)

Providers may assist members or their Authorized Representatives in bringing forth grievances. Grievances may be filed with the Plan verbally through the Plan's Member and Provider Services department, via fax to the Member Appeals and Grievances department to 617-897-0805 or in writing to:

Member Appeals & Grievances Department
529 Main Street, Suite 500
Charlestown, MA 02129

If a member or their Authorized Representative files a grievance against a facility, provider and/or provider staff member, providers are expected to work with Plan staff by reviewing the expression of dissatisfaction and responding timely to the Plan's requests for administrative and/or clinical information. The applicable information is crucial to the Plan's timely review and response to the member.

Partnerships and Strategic Relations

Partnerships and Strategic Relations

WellSense collaborates with vendors to build our New Hampshire network of behavioral health care, pharmacy, radiology, durable medical equipment, non-emergent medical transportation, and vision care providers.

- Carelon Behavioral Health formally Beacon Health Strategies
- Express Scripts (pharmacy)
- Cornerstone Health Solutions (Specialty Pharmacy Program)
- eviCore (high-end radiology)
- Northwood Inc. (DME)
- WellSense non- emergency medical transportation vendor
- Vison Service Plan (VSP) (vision services)

Behavioral Health - Carelon

Providers interested in participating in the Carelon Behavioral Health network should follow these steps:

- Request participation through their website at:
 - <https://www.carelonbehavioralhealth.com/providers/join-our-network> and
 - Complete a Letter of Interest (LOI)
 - Credentialing Application/Provider Service Agreements

**There is a 45 day turnaround for all complete submissions

Carelon Online Resources

Provider Manual – provides a variety of information including, performance measures and standards
Notifications and FAQ's

eServices provides clinical, administrative, claims transactions and access to:

- Submit claims and authorization requests
- Verify member eligibility
- Confirm authorization status
- Check claim status
- View claims performance information
- Access to forms, bulletins and mailings
- View or print frequently asked questions (FAQs)
- Toolkit to assist PCP in the diagnosis and treatment of mental health and substance use disorders



Carelon Behavioral Health Provider Reference Guide

WELLSENSE CONTACT LIST	
Main Phone Number (claims, web, benefits/eligibility, authorizations, credentialing/contracting)	<u>855-834-5655</u> <u>Monday-Friday, 8 a.m.-6 p.m. ET</u>
National Provider Services Line	<u>800-397-1630</u> <u>Monday-Friday, 8 a.m.-8 p.m. ET</u>
TTY Number	<u>711</u>
Website	<u>https://www.carelon.com/</u>
Provider Portal	<u>https://providerportal.carelonbehavioralhealth.com/index.html#/login</u>
EDI Helpdesk	<u>888-247-9311</u> <u>Monday-Friday, 8 a.m.-6 p.m. ET</u>
EDI Helpdesk Email	<u>e-supportservices@Carelon.com</u>
EDI Operations (technical questions about electronic transactions)	<u>EDI.Operations@Carelon.com</u>
Provider Relations Department Email	<u>BH_Provider.Relations@Carelon.com</u> <u>Indicate NH in addition to name, NPI, Tax ID, and inquiry details</u>
Appeals, Complaints, and Grievances	<u>844-231-7949 or email Woburn.appeals@Carelon.com</u> <u>Include detailed description, records, and claims as applicable</u>

WellSense Pharmacy Benefit



WellSense Health Plan is contracted with Express Scripts

Please visit wellsense.org for great information on:

- Formulary
- Pharmacy benefits
- Prior authorization requirements and process

Specialty Pharmacy Program



The Specialty Pharmacy Program requires that certain drugs be supplied by a specialty pharmacy. These drugs include injectable, intravenous and oral drugs that are often used to treat chronic conditions, like Hepatitis or Crohn's disease. Storing and dispensing these drugs generally requires special expertise and facilities. In addition, specialty pharmacies have extensive training and detailed knowledge to provide personalized support to members and providers.

Cornerstone Health Solutions:

- Phone: 844-319-7588
- Fax: 781-805-8221
- Mail: 41 Teed Dr., Randolph, MA 02368



Outpatient High-End Radiology

- Services
 - CT scans
 - MRI/MRA
 - PET scans
 - Nuclear Cardiology
 - Genetic Testing
 - Musculoskeletal and Rehabilitation Radiology
-
- Authorization requests can be made via phone, fax or web
 - website: evicore.com
 - Phone: 888-693-3211
 - Fax: 888-693-3210



Durable Medical Equipment – Northwood, Inc.

Administrator of a national network of home care providers with over 5,800 retail centers throughout the US

- Manages our DME, prosthetics & orthotics, and medical supplies network
- Prior authorization is required for all DMEPOS dispensed and billed items by a DMEPOS supplier and oral enteral dispensed to any provider
- Dedicated provider line: 866-802-6471
- website: northwoodinc.com



VSP manages the vision benefits offered to WellSense Health Plan members, including routine and non-routine eye care, as well as, vision hardware

- Phone: 800-877-7195
- website: vsp.com

Non-emergent Transportation

- Members are required to call to obtain authorization for these services unless these services are requested as part of a discharge plan or facility transfer.
- To request transportation for a medical visit on behalf of a member, call **844-909-RIDE** (844-909-7433) at least 48 hours before the appointment. Have the member's WellSense Health Plan Member ID number, phone number and address, and appointment information available when you call. Our Customer Service Representative will ask you simple questions to help you arrange a ride for the member.
- To ensure that the member's transportation vehicle is appropriately equipped, please fill out the Level of Need Form and submit according to the instructions.
- To learn more about the transportation benefit, please see our transportation webpage.

Provider Responsibilities

Provider Changes/Credentialing

Demographic Changes must be reported to the Plan using our Change Form available on our website at www.wellsense.org

Adding new providers? Please send the following documents,

- HCAS Enrollment Form (including NH Medicaid ID)
- WellSense Health Plan Provider Data Form
- W-9

Submit completed documents to:
NHProvider.Enrollment@wellsense.org

Cultural Competency

The Plan encourages and expects providers to:

- Be aware of cultural differences and the potential impact of those cultural differences
- Acquire cultural knowledge and skills to understand the needs of the populations they serve – visit our website for additional information
www.wellsense.org/providers/resources/training/cultural-competency
- Ask questions relevant to how the family and culture values might influence the patient's health care perceptions and needs
- Listen to the patient's opinion in considering treatment options
- Assist members (such as those with disabilities) in maximizing both their involvement in their care as well as their independence and functioning
- Let us know if your providers receive this training which will be published in our provider directory

Primary Care Provider Responsibilities

- PCPs must provide comprehensive primary care services to members
- Track and follow-up on missed health screening appointments, including Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program
- Schedule timely appointments in accordance with Access to Care standards
- Refer and assist with scheduling follow-up care with other providers

Early, Periodic, Screening, Diagnosis & Treatment program (EPSDT)

EPSDT ensures that individuals under age 21 receive comprehensive and preventive health services

- Early:** Assessing and identifying problems early
- Periodic:** Checking children's health at periodic, age-appropriate intervals
- Screening:** Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems
- Diagnostics:** Performing diagnostic tests to follow up when a risk is identified
- Treatment:** Control, correct or reduce health problems found

WellSense Health Plan has adopted the evidence-based "Bright Futures" Guidelines. Bright Futures Guidelines are endorsed by the American Academy of Pediatrics and have been used as a standard of care for nearly a decade. For more information and to view the periodicity schedule, visit wellsense.org

If you have any questions, please email Provider Engagement at: nhproviderinfo@wellsense.org

PCP Access and Availability

Service	Access Standard
Hours of Operations	Must be no less than hours offered to commercial enrollees
Office/Service Waiting Time	30 minutes or less
After-Hours Services	Provide one of the following: <ul style="list-style-type: none"> • 24-hour answering service with option to page the physician, or • Advice nurse with access to the PCP or on-call physician
Emergency and Psychiatric Services	Immediately upon entrance to delivery site, including network and out-of-network facilities 24 hours a day, 365 days a year
Primary Care Services	<ul style="list-style-type: none"> • Routine, non-symptomatic: 45 days • Non-urgent, symptomatic: 10 days • Urgent: 48 hours
Outpatient Specialty Services	<ul style="list-style-type: none"> • Routine, non-symptomatic: 45 days • Non-urgent, symptomatic: 10 days • Urgent: 48 hours
Other Healthcare Services	In accordance with New Hampshire Medicaid standards and guidelines at https://www.dhhs.nh.gov/programs-services/medicaid
Transitional Care (Primary, Specialty or approved Community Mental Health Provider)	Within two business days following discharge
Transitional Home Care	Within two calendar days following discharge.

Fraud, Waste, and Abuse

Fraud, Waste, and Abuse

You must report any provider, pharmacy or member who is suspected of committing fraud, waste or abuse. You do not have to give your name to report an incident.

You can report an incident by calling the Compliance Hotline at 888-411-4959.

Or in writing to:
WellSense Health Plan
Compliance Officer
Schrafft's City Center
529 Main Street, Suite 500
Charlestown, MA 02129



Fraud, Waste, and Abuse Definitions

FRAUD: Intentionally making, or attempting to make, a false claim, representation or promise in an effort to receive payment or property to which one is not entitled. It can also be a concealment or omission of a material fact.

WASTE: Poor or inefficient practices occurring without intent to deceive that result in the provision of unnecessary health care services and subsequent expenditures.

ABUSE: Any activity that unjustly allows the perpetrator to obtain money or health care services to which he or she is not entitled but for which there is not the intent to deceive that is necessary for fraud to have occurred.

Common Fraud, Waste, and Abuse Schemes/Situations to Avoid

- Billing for services not rendered
- Billing for a non-covered service as a covered service
- Billing for medically unnecessary services
- Misrepresenting dates of service, locations of service, and/or provider of service
- Billing services performed by one professional under another professional's provider ID
- Waiving of deductibles and/or co-payments
- Incorrect reporting of diagnoses, modifiers or procedures
- Overutilization of services
- False or unnecessary issuance of prescription drugs

Common Fraud, Waste, and Abuse Schemes/Situations to Avoid (cont.)

- Up coding services by billing for services at a higher complexity than services actually provided.
- Unbundling-billing for services included in a panel, global reimbursement, or capitation arrangement.
- Paying or receiving "Kickbacks" in Exchange for Referring Business
- Charging members out of pocket for covered services
- Cutting and pasting electronic medical records (cloning)
- Double billing for services
- Billing for a provider whose license has lapsed, is no longer in practice, is deceased, or is an ineligible Medicaid provider

Suspected Member Fraud That Should Be Reported

- Insurance card sharing
- Ineligible members (financial or geographical)
- Identity Theft (look for complaints of member's claiming they did not have a service with you, or that their ID was stolen; photo ID does not match individual seen in your office)
- Prescription fraud:
 - Allegations of forged prescriptions
 - Doctor shopping
 - Theft of prescription pads/paper

Provider Resources

Provider Resources

Our website – wellsense.org:

- Provider Manual, including a forms section
- Provider Directory
- Check member eligibility, claims status, remittance history
- Important reports through the provider portal
- Claim forms and guidelines
- Clinical & reimbursement policies
- Quick reference guides
- Benefit summaries
- News and updates
- And much more

Visit wellsense.org to register for your provider portal secure login.

Training Opportunities

Call your Provider Relations Consultant for:

- New Provider Orientation
- Requests for materials
- General Plan questions
- Participation status
- Requests to join the Plan
- Re-education
- Provider Portal training
- Review of policies & procedures

Important Websites

- WellSense Health Plan wellsense.org
- Carelon Behavioral Health plan.carelonbehavioralhealth.com
- Envision envisionrx.com
- Northwood northwoodinc.com
- VSP vsp.com
- DHHS dhhs.nh.gov/ombp/caremgmt
- NHEASY nheasy.nh.gov
- DHHS SUD/MAT Coding [DHHS SUD/MAT Coding Link](#)
- NH MMIS nhmmis.nh.gov

**Thank you for joining
the WellSense Network**

