Provider Partners Health Plans

Provider Partners Advantage Plan
Quick Reference Guide

Customer Service

For prior authorization:

Fax: (844) 593-6221
Phone: (855) 969-5907

For Claims and Eligibility:
(855) 969-5907

800-405-9681 | TTY 711
Hours of Operation:

October 1 – March 31
8 AM – 8 PM Daily

April 1 – September 30
8 AM – 8 PM M–F

pphealthplan.com

Claims Submission

Illinois Payor ID: #31401
Indiana Payor ID: #31407
Missouri Payor ID: #31404
North Carolina Payor ID: #31406
Pennsylvania Payor ID: #31400
Texas Payor ID: #31405

Paper:
Provider Partners Claims
PO Box 21063
Eagan, MN 55121

Appeals and Grievances Department:
PO Box 21063
Eagan, MN 55121
Fax: 888-918-2989

Pharmacy Benefit Inquiry and Authorization

Pharmacy Claims

Optum Rx
PO Box 650287
Dallas, TX 75265
Phone: (844) 368-8732
Fax: (844) 403-1028

For prescription drug benefit questions or coverage determinations (drug authorizations) please call OptumRx at (844) 368-8732. Assistance is available 7 days a week, 24 hours a day.

Provider Partners expedites claim payments through VPay Payment Portal – Optum Financial, a secure and convenient platform for managing payments.

Your first payment will be issued via Mastercard Virtual Card (VCard) and sent by fax or USPS. Simply enter the 10-digit card number into your merchant terminal to receive payment.
If you accept VCard payments, standard processing fees from your acquiring bank apply.

If you prefer a different payment method:

- Before your first payment: You may contact Provider Partners at providerrelations@providerpartnershealthplan.com or call 1-855-969-5907 to request payment by EFT/ACH or paper check and provide your banking information.
- After your first payment: You may contact VPay Optum at support@vpayusa.com or 1-844-343-3689 to change your payment preference.

Provider Partners and its payment partners comply with HIPAA EFT standards (45 CFR §162.1602) and ensure secure, timely transactions.
Claims are processed in accordance with Medicare billing rules, fee schedules, CMS transmittals, and Provider Partners' Terms and Conditions of Payment. Providers may not bill members for amounts covered by Provider Partners or state Medicaid.

PRIOR AUTHORIZATION

Notification of planned admissions should be submitted 10 days prior to the planned admission date. Unplanned admissions should be reported to Provider Partners within 24 hours. Weekend and holiday admissions should be reported by 5 pm next business day.

SERVICES REQUIRING PRIOR AUTHORIZATION

- Inpatient hospitalization, including acute, psychiatric, and partial hospitalization
- Skilled Nursing Facility (Transfer to SNF bed)
- Reconstructive/Potentially Cosmetic Procedures
- Transplant Services
- Durable Medical Equipment greater than $750 billed charges per month
- Prosthetics/Medical Supplies greater than $750 billed charges per month
- Hyperbaric Oxygen Therapy
- Intensive Cardiac Rehab
- Pulmonary Rehab Services
- Specialized Pain Management Services
- Home Health
- Outpatient Hospital Services
- Outpatient Diagnostic Procedures & Tests*
- Ambulatory Surgical Centers
- Substance Abuse Programs and Treatment, including Opioid Treatment Programs
- Skin Substitutes
- Part B drugs with billed charges in excess of $1,500 for course of treatment
- Occupational, Physical, and Speech therapy
- Medicare-Covered Dental Services
- Most services provided by a non-participating Provider require authorization. For questions regarding which services require authorization, please contact Provider Services at 855-969-5907

** A limited number of outpatient diagnostic procedures and tests, including, but not limited to, genetic testing and revascularization.*

Visit pphealthplan.com for a full list of prior authorization requirements referenced in the Evidence of Coverage, along with the provider manual, billing tips, and reimbursement information.