

Annual Training for Network Providers

Sept 16, 2026

Welcome!



There is **no sound** until the webinar begins.



Webinar **will be recorded**. Participation in the webinar is agreement to recording.



All participants phones have been **muted** except for the presenter.



Any unanswered questions today, will be addresses **following the presentation**.



Please use the chat for any technical issues.

Training Requirement

- The Pennsylvania Department of Human Services (DHS) requires Managed Care Organizations (MCOs) to ensure their providers attend at least one MCO-sponsored training during the course of the year. *By attending this session, you fulfill that requirement.*
- Additional training is required for providers who provide service to Medicare members.
 - Medicare Providers' FDR Requirements | Jefferson Health Plans
 - [Delegated Vendor Information](#)

Agenda - Annual Training for Network Providers

Topics Covered

- New and Trending
- Member Eligibility, Benefits, and Billing Reminders
- Provider Data Changes
- Prior Authorization
- Complaints, Grievances and Appeals
- Clinical Programs
- Benefits and Services
- Cultural and Linguistic Requirements and Services
- Tools and Resources

What's New

- Changes in Medical Assistance (MA) Eligibility Programs
- New and Updated Webpages
- Annual Training Reminders
- CMS Medicare GLP-1 Bridge
- Prior Authorization Lookup Tool
- Redesigned Care Gap Report
- Diabetes Prevention Program
- Community Health Workers
- New Fraud, Waste and Abuse Reporting Hotlink

Who We Are



Jefferson Health Plans is a not-for-profit Pennsylvania-licensed Managed Care Organization (MCO) providing comprehensive healthcare coverage in Pennsylvania and New Jersey.

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Our focus is on improving health outcomes through a wide range of initiatives that support member compliance and help to eliminate barriers to care.

Thank you for being part of our provider network and helping us to **improve the health outcomes of our members.**

High Quality and Affordable Health Plans



[Jefferson Health
Plans Medicare
Advantage](#)

[Jefferson Health
Plans Individual
and Family Plans](#)
(Commercial ACA product)

[Jefferson Health
Plans Everwell](#)

[Jefferson Health
Plans CHIP](#)

Click on any of the links to learn more about our plans.

What's New?

- Changes in Medical Assistance (MA) Eligibility Programs
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Changes in Medical Assistance (MA) Eligibility Programs

- Effective **January 1, 2027**, a new federal law will change Medical Assistance eligibility requirements. Some Medicaid recipients will have to meet work requirements AND renew their coverage every six months instead of every 12 months. This change creates new rules and additional reporting requirements that could cause people who would usually qualify for Medicaid to lose coverage if they do not report properly and on time.

What Your Office Can Do To Prevent Your Patients From Losing Their Medical Coverage:

- Ensure your patients with Medical Assistance are aware of the upcoming requirements starting in 2027:
- Educate them about exemptions to these rules so they understand what they must do to show they are exempt from work requirements.
- Share information about ways to meet the work requirements.
- Help patients receive important updates from PA DHS by advising them to confirm their address is current.
- Remind patients to look for PA DHS mailings beginning in Sept. Encourage patients to return all requested information on time.



Changes in Medical Assistance (MA) Eligibility Programs



Provider Assistance

- To assist providers, we have added a new data element to our PCP member roster to identify the renewal date for each assigned Medicaid member.
- To access your member roster, sign in to our provider portal at:
[JeffersonHealthPlans.com/ProviderPortal](https://www.jeffersonhealthplans.com/providerportal).
- From the Office Management dropdown, select “Document Manager” and search keyword “member roster” in the Name search field.

Resources:

- See how this change impacts noncitizen eligibility:
<https://www.pa.gov/agencies/dhs/resources/snap/noncitizen-eligibility>
- Access PA DHS’ Pre-Implementation Toolkit Resources for PA DHS messaging and flyers to post in your office and share with your patients:
<https://www.pa.gov/agencies/dhs/resources/medicaid/medicaid-toolkit#resources>
 - New and updated materials will be added as they become available, so please check the Medicaid Changes Communications Toolkit regularly.

Diabetes Prevention Program (DPP)

Help eligible patients with prediabetes lower their risk of type 2 diabetes



What is the DPP?

An evidence-based, year-long lifestyle change program focused on:

- Healthier eating
- Increased physical activity
- Sustainable weight loss

Flexible delivery

On-site • Virtual • On-demand online



Who is eligible?

Patients with prediabetes who meet program-specific criteria.

Review eligibility criteria:

[Medicaid eligibility](#)

[Medicare eligibility](#)



How providers can help

- **Identify** eligible patients with prediabetes
- **Discuss** the benefits of DPP participation
- **Refer** patients to a DPP provider

Provider portal: Access your prediabetic patient list

Jefferson Health Plans member support

Resources to help Medicaid and Medicare members succeed



[No-cost fitness benefit](#)

Medicaid fitness and Medicare SilverSneakers



[Wellness & fitness classes](#)

Free community and virtual programming



[Self-paced online learning](#)

Healthy eating, nutrition and wellness topics

[Find DPP providers](#)

Select the buttons and resource titles to open links.

New and Updated Webpages



[Smoking Cessation Resources](#) - Updated page with Counseling Resources, Tobacco Cessation Medications, Behavioral Health Resources and more



[Contact Us Page](#) - Update and more comprehensive list of Jefferson Health Plans Resources. Our quick reference guide still contains information for our vendors, online resources and samples of our member ID cards.



[Training and Education](#) - Redesigned page with ADA compliance attestation, DSNP MOC online v training, Annual Provider Trainings, and the Access and Availability Survey all in one location

Tools and Resources

Website Resources

[Prior Authorizations](#) - View online formularies PA guidelines and request forms

[Tools and Resources](#) - Provider Manual, Directory, Formularies, Policy Bulletin Library, Form & Supply Requests, Training & Education

[Clinical Resources](#) - Preventative and clinical care guidelines, developmental screening information, and telehealth resources.

[Quick Reference Guide](#)

The [Provider Portal](#)

Eligibility & Benefits - Verify patient coverage instantly.

Claims Management - View claims status and submit claims reconsideration requests with ease.

Authorization Requests - Submit and check prior authorizations in real time.

Annual Requirement Reminders

These annual requirements keep your practice in good standing with Jefferson Health Plans.
For your convenience, these requirements can now be accessed on our [Training and Education](#) page.

Requirement 1



ADA Survey

ADA Site Visit Attestation Form

All providers must complete a one-time attestation that their location meets the requirements as outlined in the Americans with Disabilities Act.

Requirement 2



DSNP MOC

DSNP Model of Care Training

Centers for Medicare & Medicaid Services (CMS) requires annual MOC training for all providers who serve DSNP members.

Requirement 3



Access & Availability Survey

Access & Availability Survey

This yearly requirement ensures providers are meeting the access, appointment, and telephone availability standards, as set by the Department of Human Services (DHS) and the Centers for Medicare & Medicaid Services (CMS).

Prior Authorization Lookup Tool



A new **Prior Authorization Lookup Tool** is now available on our website. This resource helps providers and staff quickly identify whether PA is required for select services before care is rendered.

Users can search by CPT or HCPCS code and view general PA information by line of business.

How to access the tool:

- Visit jeffersonhealthplans.com/prior-auth
- Use the lookup tool to search by CPT or HCPCS code.

Please note that the lookup tool is for general guidance only. Providers are responsible for verifying member eligibility, benefits, and detailed authorization requirements before rendering services, as requirements may vary by plan, place of service, provider status, diagnosis, benefit coverage, and other criteria.

If you have questions or need assistance, please contact the **Jefferson Health Plans Utilization Management** department at 1-866-500-4571.

Redesigned Care Gap Report



A redesigned **Care Gap Report** is now available to all primary care practices through our Provider Portal. This new, comprehensive report is intended to be a worklist. Offices can use it to easily see who needs to be called for appointments.

You will continue to receive the existing **Medicaid HEDIS Report** and the **Stars Performance Report**. These reports provide general overall performance at a glance.

These reporting changes will assist our primary care practices more effectively identify care opportunities, improve quality outcomes, and support population health management efforts.

Additional Information

For a comprehensive overview of our new Care Gap Report, you can visit our webinars page at jeffersonhealthplans.com/webinars. You will find a video recording of our recent webinar, **Getting the Most Out of Your Care Gap Report**, as well as a pdf of the slide deck for your reference.

Community Health Workers (CHW)

- Effective January 1, 2026, Jefferson Health Plans EverWell covers up to three (3) visits for CHW services per year that are recommended and billed for by a licensed practitioner of the healing arts enrolled in the Medical Assistance program.
- For your convenience we have created a [CHW Billing Requirement and FAQ](#) with more information.
- Also visit our [Policy Bulletin Library](#) for our Community Health Worker Services claim payment policy (RB.051.A).

CMS Medicare GLP-1 Bridge Demonstration Program

Effective July 1, 2026 the CMS Medicare GLP-1 Bridge Demonstration Program provides eligible Medicare beneficiaries with access to select GLP-1 medications for weight loss and weight maintenance at a reduced cost.

For the most current program information, eligibility requirements, and provider guidance, please visit the CMS Medicare GLP-1 Bridge Program webpage:

<https://www.cms.gov/medicare/coverage/prescription-drug-coverage/medicare-glp-1-bridge/information-providers>.

For your convenience, a Medicare GLP-1 Bridge Program FAQ is available on our Prior Authorization webpage at jeffersonhealthplans.com/prior-auth.

Potential Fraud, Waste or Abuse Reporting Resources



There is a new hotline link for reporting cases of suspected Fraud, Waste, or Abuse:

<https://secure.ethicspoint.com/domain/media/en/gui/1003032/index.html>

Hotline Information

If you wish to report Medicare, Medicaid, CHIP, or any other potential Fraud, Waste or Abuse, or other suspicious activity, please call:

- Our Special Investigations Unit (SIU) Hotline at (1-866-477-4848)

Member Eligibility, Benefits, and Billing Reminders

Check Eligibility Before Each Visit/Service

Providers may verify member eligibility by:



Logging on to our [Provider Portal](#)



Calling the **Provider Services Helpline** (1-888-991-9023)

- Use the automated system 24/7 to enter the patient's member ID, or the name and DOB.



Accessing the **Pennsylvania State Eligibility Verification System** (EVS) at 1-800-766-5387

- Providers must use the DHS Pennsylvania Access card to access the Department's EVS and verify the member's eligibility.

Coordination of Benefits

- **Jefferson Health Plans EverWell** is the payor of last resort; therefore, is secondary payor to all other forms of health insurance coverage (e.g., Medicare). Except for preventive pediatric care, if other coverage is available, the primary plan must be billed before we will consider any charges.
- After all other primary and/or secondary coverage has been exhausted; providers should forward a secondary claim and a copy of the Explanation of Payment (EOP) from the other payor to Jefferson Health Plans.
 - For more information, visit: [Provider Manual Chapter 12: Provider Billing & Reimbursement](#)

Review Member Benefits for Coverage and Prior Auth Requirements

We offer comprehensive overviews of all member benefits

Provider Manual	
Jefferson Health Plans EverWell	• Chapter 4
Jefferson Health Plans CHIP	• Chapter 6

Website Resources	
Jefferson Health Plans Medicare	• Medicare Plan Details
Jefferson Health Plans Individual and Family Plans	• Individual and Family Plans Details

If a Member has Primary Insurance, Remember...

- [Jefferson Health Plans EverWell](#) is the payor of last resort; therefore, is secondary payor to all other forms of health insurance coverage (e.g., Medicare). Except for preventive pediatric care, if other coverage is available, the primary plan must be billed before we will consider any charges.
- After all other primary and/or secondary coverage has been exhausted; providers should forward a secondary claim and a copy of the Explanation of Payment (EOP) from the other payor.
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Remember Medicare Beneficiary Billing Guidelines

The Qualified Medicare Beneficiary (QMB) eligibility group is a Medicaid eligibility group through which states pay Medicare premiums and cost-sharing for certain low-income Medicare beneficiaries.

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All Medicare providers and suppliers, including pharmacies, are prohibited by Federal law from billing Medicare beneficiaries in the (QMB Plus or QMB only) eligibility group for Medicare Part A or Part B cost-sharing.

This includes **Medicare Part A and Part B** deductibles, coinsurance, and copayments.

Medicare Beneficiary Information - Identifying QMBs

- To ensure compliance, Jefferson Health Plans Medicare Advantage providers and suppliers should:
 - Implement processes to ensure compliance with QMB billing prohibitions.
 - Make sure their office staff and vendors are using systems to identify the QMB status of Medicare beneficiaries

To assist in this process, CMS provides several ways for plans to identify the QMB status of their enrollees, including:

- Medicare Advantage Medicaid Status Data File
- Monthly Membership Detail Data Report (MMR)
- MARx User Interface (MARx UI)

- For a full explanation of how to identify QMBs, please visit [The CMS MedLearn Matters article](#)

Balance Billing Dual Eligible Members: Medicare/Medicaid



Fully Dual Eligible beneficiaries are not directly responsible for their appropriate cost share amounts. These charges are payable by Medicaid (the CHC plan).



Medicaid (CHC) will remain the payer of last resort.



Providers may not balance-bill participants when Medicaid, Medicare, or another form of TPL does not cover the entire billed amount for a service delivered.



Please note that Jefferson Health Plans Medicare Advantage DSNP members are dual eligible.

Medicare Beneficiary Information - Community HealthChoices

Community HealthChoices (CHC) plan beneficiaries are 21 or older and have both Medicare and Medicaid or receive long-term support through Medicaid. There are three CHC plans:

- PA Health & Wellness (Centene)
- AmeriHealth Caritas (Keystone First CHC/AmeriHealth Caritas Pennsylvania CHC)
- UPMC

Keep in Mind:

- Our members eligible for CHC were notified by the state that they must enroll with a CHC plan.
- Pennsylvania auto-enrolled members into one of the three plans if they did not choose a plan.
- Medicare is the **primary** payor and drives the care. Medicaid benefits are accessed after Medicare benefits have been exhausted.
- As a participating provider, you can provide services to Jefferson Health Plans Medicare Advantage members and submit claims, even if they are enrolled in a CHC (Medicaid) plan.
- Our Care Coordinator can assist you with coordinating services between Medicare and Medicaid.

Medicare Beneficiary Information - Community HealthChoices

Resources

- [CHC Fact Sheet](#)
- [Adult Benefit Package](#)
- [Long-Term Services and Supports Benefits Guide](#)
- [Coordination With Medicare](#)
- [Populations Served By CHC](#)
- [Eligibility Verification System \(EVS\)](#)



Submit Encounter Data



Participating providers must provide encounter data for professional services on properly completed CMS-1500 forms or electronic submission in an ASC X12N 837P format for each encounter.



For professional claims, providers who are registered as home health providers, hospice providers, certified nutritionists, DME, X-ray clinics, and renal dialysis providers must include the referring provider on their claim submissions. The data can be submitted in the referring provider loop (2310A) or the ordering provider loop (2420E), whichever is appropriate to your claim situation.

Reporting Provider Data Changes

Quarterly Provider Data Validation

Provider data validation forms are mailed to all non-delegated provider practices quarterly. It's imperative that these forms are reviewed and returned as soon as possible

Benefits:

- Provides members with accurate provider information.
- Allows for timely and accurate claims payments.

When you receive your **Provider Data Validation Form** from Press Ganey, be sure to respond as directed.

Provider Demographic Changes

Providers are recredentialed within 36 months or less. If there are changes before this time, please notify the Network Management department immediately in writing when any of the following occurs:



- | | | |
|------------------------------------|--------------------------------------|--|
| • Site relocation | • Full practice terms | • Site location terminations |
| • Telephone number change | • Change in hours of operation | • Provider practice name change |
| • Additions/deletions of providers | • Change in patient age restrictions | • Change in payee information (W-9 required) |
- All professional provider data changes must be emailed to datavalidation@jeffersonhealthplans.com

Reminder to Revalidate Medical Assistance Enrollment



MA Revalidation:
The Pennsylvania Department of Human Services (DHS) requires all providers to maintain active enrollment, which includes ensuring **all service locations are actively registered.**



PROMISE System Check:
Providers should regularly review PROMISe to confirm demographic details, service locations, revalidation dates, and ensure their **Medical Assistance ID (MAID)** is active.



Enrollment (revalidation) applications located at:
http://www.dhs.pa.gov/provider/promise/enrollmentinformation/S_001994

Failure to enroll/revalidate **all registered service locations** with DHS will result in non-payment of claims for services rendered at the unenrolled location(s)

Prior Authorization

Prior Authorization (PA) Overview

- Prior Authorization requests should be submitted through the designated provider portal.
- [Prior Authorization Management Tools](#) are available to determine the appropriate submission type.
- **Drug specific PA** forms are available on our [Prior Authorization](#) webpage.
- **Non-Participating Facility Transfers:** For elective admissions or transfers, call:
Inpatient Services at 1-866-500-4571.
- **Disenrollment Planning:** Providers may be contacted for discharge/ transition planning for disenrolled members. We may remain responsible for up to 6 months post-disenrollment unless the member selects another plan.

Viewing an Authorization

If you have submitted an authorization request that you are now unable to locate, please follow the timeframes below before checking on its status:

- **Urgent Requests:** Wait 24 to 48 hours before checking status.
- **Standard Requests:** Wait 7 days before checking status.

Requesting Provider Reminder

When submitting a Prior Authorization - please keep in mind

- **Requesting Provider** = Physician rendering the service
- **Servicing/Facility Provider** = Location where services are provided

*Incorrect requesting provider submissions can potentially cause delays

Pharmacy

- There are specific medications on the formulary that require prior authorization.
- Drug specific prior authorization forms are available to help expedite the process with specific clinical criteria on our [Prior Authorization](#) webpage.



The [Recipient Restriction Program](#) is a Pennsylvania Department of Human Services initiative that identifies Medical Assistance members who excessively or improperly use Medicaid services. These members may be restricted to a certain physician and/or pharmacy.

To request a prior authorization, or for more information on the Recipient Restriction Program, contact our [Pharmacy department](#) at [1-866-841-7659](tel:1-866-841-7659), Monday through Friday, 8 a.m. to 6 p.m.

Requests can also be faxed to 1-866-240-3712.

In the event of an immediate need after business hours, please call [Member Relations](#) at: [1-800-553-0784](tel:1-800-553-0784). The call will be evaluated and routed to a clinical pharmacist on-call 24/7.

Complaints, Grievances, and Appeals

Complaints, Grievances and Appeals

When we deny, decrease, or approve a service or item different than the service or item requested because it is not medically necessary, a written grievance may be filed by the member, member's legal representative, healthcare provider or other member's representative (with the appropriate written consent of the member) to request a reconsideration.

In some cases, a member can ask DHS to hold a hearing because they disagree with our decision. A member must exhaust our Complaint or Grievance Process before requesting a Fair Hearing.

For more information, visit:

- [Jefferson Health Plans EverWell Member Handbook](#)
- [Provider Manual Chapter 13: Complaints, Grievances, and Appeals](#)
- eLearning: [Complaints, Grievances and Medical Necessity Reviews: Learn The Process](#)

Clinical Programs

Clinical Programs

Our clinical programs:

- Our team of licensed and non-licensed staff supports provider treatment plans by helping members reach their health goals, reducing social and behavioral barriers to care, and addressing needs across the life continuum.

Critical components for all programs:

- **Collaboration** with member, family/caregiver, health care providers and community agencies, as appropriate
- **Member-centric** whole-person focus
- **Voluntary** with the ability to opt out at any time by calling Member Relations or discussing with a Care Coordinator
- **Variety of Communications**: Telephonic, face to face, email, social media, in the community and in provider offices
- **Use of PA Navigate** to identify Health Related Social Needs (HRSN) resources

Health Related Social Needs (HRSN)

Health Related Social Needs are the conditions in the environment where people are born, grow, work, live and age.

HRSN includes factors such as:



Food insecurity



Economic Stability



Housing stability



Transportation Needs



Childcare needs



Exposure to Violence



Utility Needs



Education Needs

You may use PA Navigate to identify Health Related Social Needs (HRSN) resources.

For more information, please visit our website at: [Quality and Population Health](#)

Enhanced Member Services Unit (EMSU): Jefferson Health Plans EverWell and CHIP

Baby Partners

- Care coordination for prenatal and postpartum members
- Connection to local resources, such as food, diapers, car seats

(833)-705-3751

Clinical Connections:

- Provides discharge screenings, health risk assessment follow-up and disease education for members who are not associated with other Health Plan programs.

Pediatrics

- Care coordination for complex children who have identified special needs or require shift care
- Connection to supplemental benefits, programs, and community resources

Adults

- Connection to supplemental benefits, programs, and community resources

Care Coordination: Jefferson Health Plans Medicare Advantage and Individual and Family Plans

The Care Coordination team works with members and their providers to address barriers and connect needed resources.

Care Coordination supports members with:

- Accessing and coordinating care
- Finding community resources for Health-Related Social Needs (HRSN)
- Receiving education related to their condition.

For DNSP Members

A **Health Risk Assessment (HRA)** is completed which identifies the below needs or barriers.

Medical	Functional	Cognitive
Psychosocial	Mental Health	Health-related social needs of barriers

- Complete a **Clinical Programs Referral Form** to refer any member for services. Found at: [Form and Supply Requests](#)
- Send completed forms to ClinicalConnectons@jeffersonhealthplans.com or Fax: 215-845-4181
- For additional assistance please call the **Clinical Programs Provider Referral Line**: 215-845-4797

Benefits & Services

Mental Health and Substance Abuse Treatment

- Under HealthChoices, all Jefferson Health Plans EverWell members, regardless of the health plan/MCO to which they belong, can receive mental health and substance abuse treatment through their behavioral health managed care organization (BH-MCO).
- PCPs who identify a member in need of behavioral health services should direct them to their county's BH-MCO, who will conduct an intake assessment and refer the member to the appropriate level of care.
- Each HealthChoices consumer is assigned a BH-MCO based on their county of residence.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

EPSDT standards are comprised of routine care, screenings, services and treatment that allow Medicaid members under 21 to receive recommended services set forth by the American Academy of Pediatrics' Guidelines.

If a provider performs a screening and suspects developmental delay, and the child is not receiving services, refer the child (not over 5 years of age) through the [CONNECT Helpline](tel:1-800-692-7288) (1-800- 692-7288) for appropriate eligibility determination for Early Intervention Program services.

- For the latest guidelines, visit our website at: [EPSDT / Bright Futures](#)
- Call our Pediatric Care Coordination team at 1-866-500-4571

Childhood and Adolescent Immunizations

[Immunization Schedules](#) are now available and effective immediately

Lead Screening Requirements

Children under the age of 2 should have a minimum of 2 lead screenings. For more information, visit: [Lead Screening](#)

Bright Futures (CHIP)

The **Bright Futures/American Academy of Pediatrics (AAP)** developed a set of comprehensive health guidelines for well-childcare, known as the “periodicity schedule.”

It includes:

- **Prevention:** Scheduled immunizations; dentist visit at the first sign of a tooth and to establish a dental home at no later than 12 months of age; regular oral checkups (two each year), teeth cleanings, fluoride treatments and overall oral health.
- **Growth and development:** Tracking growth and development since their last visit; discussing milestones, social behaviors and learning with parents/guardians.
- **Identify concerns:** Well-child visits are an opportunity to speak with parents about a wide variety of issues, including developmental, behavioral, sleeping, eating and relationships with other family members.
- **Sick visits:** Determine if the condition, illness or injury that led to the sick visit impedes with the ability to complete a well-child visit and that the child is eligible for a well-child visit.

Cultural and Linguistic Requirements and Services

Cultural and Linguistic Requirements and Services

Cultural Competency is one of the main ingredients in closing the disparities gap in health care.



It requires a commitment from doctors and other caregivers to understand and be responsive to the different attitudes, values, verbal cues, and body language that people look for in a doctor's office by virtue of their heritage.



Members have the right to receive services provided in a culturally and linguistically appropriate including: LEP, limited reading, vision, hearing skills, and those with diverse cultural and ethnic backgrounds. All providers are required, by law, to provide translation and interpreter services including qualified sign language interpreters.

Cultural and Linguistic Requirements and Services

- As part of the credentialing process, providers self-report language spoken by either themselves or office staff for inclusion in our provider directory, helping members select a provider who meets their cultural, linguistic, and health care needs.
- For credentialed providers who need to update or add additional languages, please contact us at datavalidation@jeffersonhealthplans.com.

Resources Available to Members

Member needing translation or language services, including sign language and TTY services, can call our **Member Relations line at 1-800-553-0784 (TTY 1-877-454-8477)**.

We have an online interpreter service that provides over 140 languages and is available 24 hours a day, seven days a week.

There is no cost to members for this service.

Non-Discrimination Policy

We recognize the diversity of our members and offer services that are sensitive to these differences. Members enrolled in our plan(s) have the right to receive and expect courteous, quality care regardless of race, color, creed, sex, religion, age, national or ethnic origin, ancestry, marital status, sexual preference, gender identity and expression, genetic information, physical or mental illness, disability, veteran status, source of payment, visual or hearing limitations, or the ability to speak English.

The Provider's Role with LGBTQ+ Patients

- Treat all patients with dignity; respect their identities
- Break the cycle of discrimination that creates barriers for LGBTQ+ communities to access healthcare
- Adopt best practices that are inclusive of and welcoming to LGBTQ+ communities
- Provide complete, unbiased, person-centered care that results in risk reduction and expanded

Conclusion

Questions

Please use the chat for any questions.

For additional questions, please email: providereducation@jeffersonhealthplans.com

Please take a moment to complete the post-webinar survey. Your feedback is greatly appreciated.

Upcoming webinars

Register at:

jeffersonhealthplans.com/webinars

Appendix

Plan Resources

Providers Website	https://www.jeffersonhealthplans.com/home/providers/
Provider Manual	https://www.jeffersonhealthplans.com/home/providers/tools-and-resources/provider-manual/
Provider Portal	https://www.jeffersonhealthplans.com/home/providers/provider-portal/
Training & Education	https://www.jeffersonhealthplans.com/home/providers/training-and-education/
Provider Directories	https://www.jeffersonhealthplans.com/home/providers/tools-and-resources/provider-directory/
Formularies	https://www.jeffersonhealthplans.com/home/providers/tools-and-resources/formularies/
ECHO Health	http://www.echohealthinc.com/
Claims	https://www.jeffersonhealthplans.com/home/providers/eligibility-and-claims/
Contracting	Contracting@jeffersonhealthplans.com
Credentialing/ Recredentialing	https://www.jeffersonhealthplans.com/home/providers/credentialing-recredentialing/

Thank You for Attending