curative

Provider Manual

Your practical guide to working with Curative—from credentialing through claims.

2026 EDITION | FOR CURATIVE NETWORK PROVIDERS

IN THIS MANUAL

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GETTING STARTED

Section 1 | How to Contact Us

Welcome to Curative

Welcome to Curative, a health plan designed to provide full cost-transparency and eliminate financial barriers to care. We offer a model with no copays, no deductibles, and no out-of-pocket costs for in-network care and preferred prescriptions, including many generic, brand-name, and specialty medications. The catch? Members complete a Baseline Visit in the first 120 days to keep the $0 benefit. That Baseline is a chance for a member to meet with a Care Navigator to understand how to make the most of plan benefits, including connecting to providers like you, and a visit with a Curative Clinician to get a jumpstart on a health roadmap.

This structure is designed not only to support our members' health but to simplify the operational and financial experience for our provider partners. By partnering with Curative, you benefit from:

Simplified Billing & Zero Patient Collections: When members have zero cost-sharing for in-network care, you bill Curative and only Curative. This eliminates the patient collections workflow and removes the risk of bad debt.

An Engaged Patient Population: Anchored by the Baseline Visit in the first 120 days, our members are activated early to establish care, identify health needs, and consistently follow through on preventive and specialty care without cost barriers holding them back.

Reduced Administrative Burden and Dedicated Support: We actively minimize practice friction—9 in 10 medical services require no prior authorization at all, and we have support teams available through providers services to assist your front desk and billing staff.

Using This Manual

This Provider Manual serves as your practical, everyday playbook for working with Curative. Inside, you will find the policies, guidelines, and step-by-step workflows for claims submission, prior authorizations, credentialing, and referral management.

Following these protocols helps keep our day-to-day operations running smoothly and ensures your payments arrive on time.

We look forward to a successful partnership.

> **Need help or have a question?** We're here to make health insurance coverage easy. Please reference the key points of contacts for each department. The Provider Reference Guide may be accessed here: https://curative.com/provider-resources. Scroll to General Resources to access this guide.

GETTING STARTED

Section 2 | Our Products

Provider Manual Updates

Curative may periodically update this Provider Manual. We will provide written notice of material changes to any policy or procedure in this Manual as specified in your Provider Agreement with us. We encourage you to contact a Curative Representative for any needed clarification on any information.

Regulatory Requirements

Curative complies with all applicable Federal and Regulatory requirements.

Our Plan

In-Network and Out-of-Network benefits apply to eligible employees and their dependents and services are limited to the allowable amount as determined by Curative. All In-Network providers have agreed to accept the Curative allowable amount. For Out-of-Network providers, any charges over the allowable amount for services are the member's responsibility, in addition to the deductible and coinsurance. Any dormancy markets where a wrap network currently applies may be switched over to Curative direct networks with a notice of 30 days to providers and website updates. Following that notice, only Curative agreements will be enforced, and Curative would no longer provide Members with access to the Cigna PPO network.

WHAT THE BASELINE VISIT UNLOCKS

If the member completes their Baseline Visit within 120 days of their effective date in the Curative Plan, most copays, deductibles and coinsurances will be waived. In-Network providers will receive the Curative allowable amount, as defined by the contract. Maximum visits and limitations will continue to apply.

The Baseline Visit is an appointment with a Curative Clinician for the Clinical Assessment related to the member's current health status to help them optimize their health care. The Assessment will also include an Evaluation of Preventive recommendations indicated by United States Preventive Services Task Force (USPSTF) and whether immunizations are up to date. The member will be assigned and meet with their Care Navigator for an orientation on the plan benefits, how to access In-Network providers and address any current physician or pharmacy needs.

GETTING STARTED

Section 3 | Member Identification Card

Sample ID Card (Florida, Georgia, Texas)

Baseline Visit Completed	Baseline Visit Incomplete
All new Curative members will receive a Baseline Complete insurance ID card. Effective 1/1/23, the member will have 120 days from the plan start date to complete the Baseline Visit to be eligible for the full benefits of in-network costs including a $0 deductible and $0 copays.	Effective 1/1/23, if the Curative member does not complete the Baseline Visit in 120 days from the plan start date, a Baseline Incomplete insurance ID card will be sent to the member. The member will be responsible for a $5,000 deductible and respective copay costs.

Sample ID Card (Outside Florida, Georgia, Texas)

Baseline Visit Completed	Baseline Visit Incomplete
All new Curative members will receive a Baseline Complete insurance ID card. Effective 1/1/23, the member will have 120 days from the plan start date to complete the Baseline Visit to be eligible for the full benefits of in-network costs including a $0 deductible and $0 copays.	Effective 1/1/23, if the Curative member does not complete the Baseline Visit in 120 days from the plan start date, a Baseline Incomplete insurance ID card will be sent to the member. The member will be responsible for a $5,000 deductible and respective copay costs.

Eligibility Verification

All participating providers are responsible for verifying a member's eligibility at each and every visit. Providers can verify member eligibility through one of the methods below:

Navigate to Curative: curative.com/eligibility — real-time eligibility lookup for Curative members.

OR

- Use your clearinghouse or provider portal (e.g. Availity, Optum, TriZetto)
- Enter the Member ID, Last name, DOB
- Click 'See Coverage'
- You'll see the member's coverage dates, basic copays and deductible information

Please note for both methods:

- Last name and member ID must match the ID card exactly.
- Birth date must be accurate.

UTILIZATION MANAGEMENT

Section 4 | Prior Authorization and Notification

Curative Utilization Management (UM) includes the following services:

- Prior Authorization of certain services is required.
- Notification only of certain services is required.
- Concurrent review of members in hospitals, SNF, and LTAC.

Access to the services requiring the above listed levels of authorization, notification and/or concurrent review may be accessed at https://curative.com/provider-resources. To initiate an authorization request or notification, we encourage providers and facilities to use the electronic portal available at: https://curative.com/pa/med. Any retroactive requests will only be reviewed in accordance with Curative's Retrospective Authorization Policy for PPO/EPO Commercial Plans.

> **Questions about a member's care?** Any time you have Clinical Care Management questions and/or concerns regarding a Curative member, we encourage you to call us at 855-414-1083. The Clinical Care Management department maintains a toll-free fax line 24 hours daily. The fax number is 877-942-4448.

Prior Authorization Process

1 Review Criteria Source

Prior authorization requests are reviewed utilizing decision guidelines based on reasonable evidence. Curative uses internal guidelines based on published medical evidence to perform prior authorization.

2 Contact Information

Providers may submit prior authorization requests via the electronic portal at https://curative.com/pa/med, telephone, fax, or HIPAA secure encrypted email from the provider's office. The guidelines are applied and the services are authorized by the UM reviewer or referred to the Medical Director or Physician Reviewer for further review.

3 Peer Review

As required by state law, in any instances where the medical necessity or appropriateness of the requested service is questioned, the Medical Director or Peer Reviewer will make every reasonable effort to contact the requesting provider in order to afford him/her the opportunity to discuss the plan of treatment and the clinical basis for the decision, prior to a final determination.

4 Adverse Determination

Any Adverse Determinations will follow established policies prior to final determination and communications of the Adverse Determination to the member and providers.

5 Prior Authorization Numbers

Curative will provide prior authorization numbers that fully comply with the format for federal and state requirements and currently utilizes ANSI ASC X12 837 claim form format.

UTILIZATION MANAGEMENT

Timeframes for Provider Prior Authorization Requests and Notifications

The following timeframes are required of the ordering provider for prior authorization and notification. If a provider fails to follow these established prior authorization and notification requirements, the prior authorization request may be reclassified as a retrospective review. Retrospective reviews are not covered and will result in an administrative denial, unless the provider can demonstrate that the service was provided in an urgent / emergency circumstance, or that incorrect benefits information was supplied by the patient. Please note that the member cannot be held responsible for the provider's failure to notify Curative in accordance with the notification requirements.

Service Type	Timeframe
Elective admissions	Prior Authorization required three (3) business days prior to the scheduled admission date
Outpatient services that require prior authorization	Prior Authorization requests three (3) business days prior to the outpatient service date
Non-Elective (emergent) inpatient admissions	Notification within one (1) business day of admission
Newborn admissions	Notification within thirty (30) days
Inpatient admissions, facility transfers, or changes in level of care	Notification within one (1) business day
Organ transplant initial evaluation	Prior Authorization requested at least thirty (30) days prior to the initial evaluation for organ transplant services
Clinical trials services	Clinical Trials are not covered.

Notification

Prior Authorization for medical necessity of services does not guarantee the network level of benefits. Even if approved by Curative, non-network providers paid at the Curative allowable amount may balance bill for charges in excess of this amount. The member is responsible for these charges, which can be significant.

Certain services, such as emergency admissions or maternity admissions, only require notification to Curative. Prior Authorization and Notification Requirements may be accessed at https://curative.com/provider-resources.

Concurrent Review

Curative performs concurrent review and discharge planning on inpatient admissions and observations, consistent with health plan benefits. Curative will work closely with the attending physician and hospital discharge planners to coordinate the use of home health care and other health care alternatives, which may decrease a hospital's length of stay.

UTILIZATION MANAGEMENT

Care Navigation & Clinical Care Navigation

Care Navigation (CN)

Curative's Care Navigation (CN) team serves as the central coordination hub for members and providers, providing assistance with non-urgent care coordination, navigation support, and status updates. Care Navigators respond via email and text, typically within 4 hours, sometimes sooner.

They help with Prior Authorization submissions, escalations, status updates, and process questions, or connect members and providers with the Clinical Care Management team for unique and complex situations.

Disease & High-Acuity Clinical Management

For members facing severe clinical barriers or complex medical needs, Clinical Care Navigation (CCN) operates as an expert clinical extension. Staffed by licensed Registered Nurses (RNs), CCN provides high-touch clinical intervention, complex disease management, and specialized care coordination.

CCN is available for qualifying members with complex, high-risk conditions or severe clinical crises (e.g., uncontrolled Diabetes, advanced Heart Failure, active Oncology/Transplant workups, or complex multi-morbidity care plans) to support care plan compliance and empower members.

Complex Care & Discharge Support

CCN RNs work closely with attending physicians, specialists, and home health providers to assist members and their families with complex clinical transitions. For multi-service, complex outpatient setups—such as concurrent home health, specialized wound care, or outpatient IV antibiotic infusions—CCN helps bridge gaps in post-acute care plans.

Note: Standard inpatient discharge authorizations and routine facility concurrent reviews continue to be managed through standard Utilization Management pathways.

Management of Members With Special Circumstances

Some members may require services that fall outside of the ordinary scope of Clinical Care Navigation. Under these special circumstances, Curative may identify special needs, including but not limited to individuals with a disability, acute condition, or life-threatening illness.

The team will gather the facts of the case and forward them to the Medical Director, who will develop a plan of action to assist the member with special circumstances.

UTILIZATION MANAGEMENT

Section 5 | Adverse Determinations of Prior Authorizations

Questions about an adverse determination or appeal? If you have questions and/or require clarification regarding an adverse determination and/or the appeal process, please do not hesitate to contact Curative's Provider Services Department at Provider Services 855-414-1083.

Adverse Determination

An Adverse Determination is an instance where Curative is questioning the medical necessity or appropriateness or the experimental or investigational nature of health care services.

All Curative Prior Authorization requests will be reviewed for medical necessity. Requests for services may be denied for the following reasons:

- Not medically indicated (Adverse Determination).
- Services are considered experimental or investigative (Adverse Determination).
- Services can be safely provided in an alternative setting or level of care (Adverse Determination).
- Services rendered were not determined to meet the definition of emergency care (Adverse Determination).

Adverse Determinations may only be issued by the **Medical Director** or **Physician Reviewer**. The Medical Director will make every reasonable effort to discuss the case with the requesting physician prior to issuing an Adverse Determination.

Administrative Denials may be issued by the Clinical Care Coordinators which relate to cases, such as an employee is not eligible, or benefits are not a covered service.

Notification of Determinations

Provider Notification: The requesting provider shall be notified via phone call or electronic transmission within **three (3) calendar days** of the determination. For Adverse Determinations, a written notification will also be provided no later than the third (3rd) working day after the date of the request. If related to an acquired brain injury, provider notification will be via phone call.

Such communications will include the following:

- **Clear and Concise Statement:** A statement of the specific medical or contractual reasons for the resolution shall be sent to the requesting provider and include a request for further information or action.
- **Appeal Rights:** Information regarding the appeal process and the right to appeal the decision, including instructions on how to file a complaint to Curative.
- **Member Notification:** Members will be notified of the denial of services via the United States Postal Service. Notification will include a description of the procedure for filing a complaint and for filing an appeal. It will include a notice to the member of the member's right to appeal an adverse determination to an IRO and of the procedures to obtain that review, including a copy of the form prescribed by the Texas Department Insurance.

UTILIZATION MANAGEMENT

Adverse Determination Notification Timelines

Curative will use the following timelines to notify providers and members:

Hospitalization

If a member is hospitalized at the time of the adverse determination, Curative will notify the Provider of record: **Within twenty-four (24) hours** by phone or electronic transmission. Will follow with a letter within **three (3) working days** to notify the member and the provider of record of this determination.

The letter shall state that benefits will be terminated at a stated date and time after notification. The notification letter will also inform you as to the right of appeal and the process to follow.

Medical (No Hospitalization)

If the member is not hospitalized at the time of the adverse determination, Curative will notify the member and the provider of the record within **three (3) calendar days** in writing.

Post Stabilization

If the adverse determination is related to denying post stabilization care subsequent to emergency treatment as requested by a treating physician or other health care provider, Curative shall provide the notice to the treating physician or other health care provider **no later than one (1) hour** after the time of the request.

This will be followed by a letter within **three (3) working days** to all parties.

Retrospective Review

If an adverse determination is related to a retrospective review, Curative will notify the provider of record and the member within a reasonable period, but **not later than thirty (30) days** after the date on which the claim was received.

UTILIZATION MANAGEMENT

Adverse Determinations Appeal

Overview & Process Requirements

A member, a person acting on behalf of the member, or the member's provider may appeal an adverse determination of a prior authorization request orally or in writing. All appeals of an adverse determination will be processed within set time frames and must fulfill the requirements as follows:

- All appeals must be submitted to Curative orally or in writing.
- The appealing party will be allowed a minimum of 180 days after the date of issuance of written notification of an adverse determination to file an appeal.
- In a life-threatening condition, the member is entitled to an expedited appeal or an immediate appeal to an IRO and is not required to comply with internal reviews.
- Curative may not require exhaustion of internal appeals prior to external review if:
    - Curative fails to meet its internal appeal process timelines, or
    - The claimant with an urgent care situation files an external review before exhausting Curative's internal appeal process.
- Within 5 working days from receipt of the appeal, Curative will send an acknowledgment letter to the member, representative, and provider.
- Appeal decisions will be made by a physician who has not previously reviewed the case.
- Once a determination is made, written notice will be sent to all relevant parties as soon as practicable, but no later than 30 calendar days after receipt.
- If an appeal is denied, a provider can request a specialty review in writing within 10 working days, to be completed by a specialist within 15 working days.
- After review, a letter explaining the resolution of the appeal will be sent to the member, representative, and provider.

Directory & Contacts

APPEAL SUBMISSION

If you disagree with a prior authorization (PA) denial, you may submit an appeal on behalf of your member. An appeal must be submitted within 180 days of the PA denial.

Please include a copy of the original denial, a claim form, and supporting documentation.

MAILING ADDRESS

Curative Health Plan
Attn: Appeals Coordinator
PO Box 1786
Austin TX 78767

DECISION TIMELINES

Curative will consider the appeal request and issue a written decision within 30 days of receipt. Your appeal will be reviewed by a claims representative not involved with the initial decision.

UTILIZATION MANAGEMENT

Adverse Determinations: Expedited & Specialty Appeals

Curative provides structured pathways for expedited appeals of emergency care denials, care for life-threatening conditions, and/or continued stays for hospitalized members.

Expedited Appeal Process Requirements

- **Independent Specialist Review:** Expedited appeals are reviewed by a specialist of the same or similar specialty who has not previously reviewed the case. The reviewer may interview the member, an authorized representative, or the provider to reach a decision.
- **Rapid Decision Timeline:** Decisions are completed based on clinical urgency and no later than **one (1) working day** from the receipt of all necessary information. Notification is immediately provided by phone, followed by a formal letter within **three (3) working days**.
- **Written Documentation:** All official correspondence with the appealing parties will be delivered in writing and formally signed by the Medical Director or an authorized designee.
- **Life-Threatening Exceptions:** If a member faces a life-threatening condition, they are entitled to an immediate appeal to an Independent Review Organization (IRO) without being required to exhaust internal appeal procedures.

Specialty Review Appeals for Adverse Determinations

A provider of record may request that a specific type of specialist review an adverse determination. To initiate this request, the provider must submit a written appeal containing a good cause explanation detailing why a specialized evaluation is necessary.

SUPPORT

Section 6 | Member Complaints and Complaint Appeals

Member Complaints

If you or your member are dissatisfied with any aspect of the operation of Curative, including but not limited to dissatisfaction with plan administration, you may file a complaint.

When Curative is notified of a complaint, orally or in writing, we will send an acknowledgment letter no later than the **5th business day** after receipt. If received orally, we will enclose a Complaint Form which must be returned to us for prompt resolution. We will investigate and send a resolution letter within **30 calendar days**.

A complaint expressing dissatisfaction with an adverse determination constitutes an appeal and will be processed according to Section 5: Adverse Determinations. Urgent complaints regarding ongoing emergencies or hospitalization stay denials will be resolved within **1 business day** of receipt, concluded in accordance with medical immediacy.

Member Complaint Appeals Process

A provider may file an appeal of a complaint resolution, for themselves or on behalf of our member. Curative provides an appeal process for a provider who is not satisfied with the resolution. Complaint appeals must be submitted in writing.

Upon receipt of the written Complaint Appeal request, Curative will send an Appeal Acknowledgment Letter to the member, provider, or designee no later than the **5th business day** after the date received, and issue Curative's Final Decision of the Appeal Resolution within **30 calendar days**.

Directory & Contacts

PROVIDER COMPLAINTS

Submit orally to Curative Provider Services at **855-414-1083**, or in writing to:

Curative Health Plan
ATTN: Provider Complaints
P.O. Box 1786
Austin, Texas 78767

COMPLAINT APPEALS

Must be submitted in writing to:
Email: providers@curative.com

or by USPS Mail
Curative Health Plan
ATTN: Provider Complaint Appeals

P.O. Box 1786
Austin, Texas 78767

PROVIDER SERVICES

For general questions and clarifications:

Phone: **855-414-1083**
P.O. Box 1786
Austin, TX 78767

CLAIMS & PAYMENT

Section 7 | Claims Processing and Payment

We work hard to ensure that your claims are processed timely and accurately. To be paid promptly for the services you provide, please follow these best practice procedures:

Filing deadlines:

- Claims must be submitted within 95 days from the date of service or date of discharge, unless otherwise specified in your Provider Agreement.
- Coordination of Benefits (COB): When Curative is the secondary payor, providers must submit claims within 95 days from the date of the primary carrier's Explanation of Payment (EOP).

Eligibility and Benefits Verification

Curative Website

- Navigate to curative.com/eligibility
- Enter the Member ID, Last Name, and DOB
- Click **'See Coverage'**
- View coverage dates, basic copays, and deductibles

OR

Clearinghouse Verification

- **Use your clearinghouse or provider portal (e.g. Availity, Optum, TriZetto):**
- Real-time eligibility lookup for Curative members
- View covered services, copays, coinsurance, and deductibles
- Check plan-specific coverage & benefit limitations

Reimbursement & Allowable Amount

Curative reimburses covered services at the lesser of (a) the provider's billed charges, or (b) the contracted rate or fee schedule amount applicable under your Provider Agreement. The lower of these two amounts is the Allowable Amount. Where your Agreement establishes a different reimbursement methodology, the terms of your Agreement control.

Billed charges operate as a payment ceiling. As a matter of standard practice, Curative does not pay more than the amount billed on a claim, even where the contracted rate for that service is higher. Providers should bill their usual and customary charges for each service rendered.

The Allowable Amount represents payment in full. Curative's payment plus any applicable member cost share will not exceed the Allowable Amount, and participating providers may not bill the member for the difference. Allowable Amounts remain subject to Curative's Payment Policies.

When applicable, providers must obtain prior authorization or notify Curative for planned procedures (refer to **Section 4.0 – Utilization Management**). **Important:** To ensure prompt processing, all claims must be submitted completely, accurately, and in compliance with Curative's billing requirements.

Claim Preparation Requirements

Use the HIPAA-compliant 837 electronic format or the appropriate paper form (**CMS-1500** for professional, **UB-04** for institutional). Include all required data elements:

- Member ID (as shown on the Curative ID card)
- Rendering/servicing provider NPI
- Billing/pay-to provider NPI and Tax ID (TIN)
- ICD-10 diagnosis & CPT/HCPCS procedure codes
- Dates of service and billed amount
- Place of service code
- Servicing location address in Box 32 of CMS-1500 (or UB-04 field)
- "Pay-To" address must be accurate in Box 33
- NDC code, quantity, and dosage for claims with drugs
- Ensure Assignment of Benefits is marked "Yes" or "No"
- Interim billings for extended inpatient/long-term services
- All claims must be legible, complete, and contain all service lines
- Claims must be submitted within 95 days of service or discharge

CLAIMS & PAYMENT

Electronic Claims Management

Curative supports claims management, eligibility verification, and remittance tracking through any accepted clearinghouse or portal you use. Providers can submit, correct, and monitor claims in real time, ensuring accuracy and timely payment.

Claim Type	Supported Format	Form Reference
Professional	837P	CMS-1500
Institutional	837I	UB-04

Claim Status Inquiry

Use the claim status function of your clearinghouse or portal to verify claim receipt.

Search Options:

- Member ID or Last Name
- Claim Number, if known
- Date(s) of Service
- Rendering or Billing NPI

Results Include:

- Claim received date
- Current status
- Payment date & amount
- Rejection reason

Corrected & Re-submitted Claims

- Review rejection reasons in your clearinghouse or portal and correct before re-submission.
- Post-adjudication denials should use the Reconsideration/Appeal form.
- Do not mark a claim as “Corrected” when submitting an appeal.

Remittance & Payment Reconciliation

Use your clearinghouse or portal's remittance viewer to review ERA and EOP data.

- View and download ERAs and EOPs
- Search by Check/EFT Number, Claim, or Date
- Match ERA data to bank deposits for reconciliation

Error Resolution

Clearinghouses and portals provide a claim error report identifying missing/invalid data. Correct these errors prior to re-submission to prevent delays.

Electronic Claims Submission

Providers are strongly encouraged to submit electronic claims.

Requirements:

- Use the HIPAA-compliant 837P/837I format.
- Curative accepts electronic claims through vendors including Optum, Availity, or TriZetto

PORTAL & WEBSITE

Clearinghouse options (non-exclusive examples):

optum.com

www.availity.com

trizettoprovider.com

Electronic Processing:
curative.com/electronic-claims-processing

Provider Support

Availity Client Services

For system setup and portal troubleshooting:

Phone:
1-800-282-4548

Hours:
Monday–Friday
7:00 a.m.–8:00 p.m. (ET)

Submission Checklist

- Ensure all provider data maps cleanly to the HIPAA 837 standard.
- Double check rendering and billing NPIs before routing.
- Regularly pull the Claim Errors report to identify workflow delays.
- For paper submissions, refer directly to coordinates on the member ID card.

Transplant Services and Third-Party Arrangements

Transplant Claims Evaluation

Transplant claims are evaluated according to the applicable third-party network or case-rate arrangement, the member's eligibility and benefits, the approved authorization, medical-necessity requirements, coding and billing rules, and any applicable provider agreement. The provider's Explanation of Payment or electronic remittance advice identifies the final disposition, payment, adjustments, and member responsibility.

Claim Reconsiderations & Appeals

A claim denied or adjusted because of claim processing, payment, coding, network pricing, or an authorization mismatch must be disputed through the claim reconsideration process. A denial of the underlying prior-authorization request follows the prior-authorization appeal process described above.

Claim reconsiderations must generally be submitted within **90 days** of the original Explanation of Payment or Provider Remittance Advice, unless the provider agreement specifies a different period.

A claim reconsideration is required before a payment-related claim appeal. If the provider remains dissatisfied with the reconsideration determination, a formal claim appeal may be submitted using the same form and channels, with the subject line **"Claim Appeal [Curative Claim Number]."**

Corrected Claims

Claims missing required documentation should generally be resubmitted as corrected claims rather than appealed. Corrected claims should use **frequency code 7**, reference the original claim number, and include the missing documentation.

Submission Channels

REQUIRED FORM

Submit the **Curative Claim Appeals and Reconsiderations Form**, the Explanation of Payment, and supporting documentation.

EMAIL (Most Efficient)

claims@curative.com
Subject: **"Claim Reconsideration [Curative Claim Number]"**

FAX

877-734-6537

MAIL

Curative Health Plan
Attn: Claim Reconsiderations
P.O. Box 1786
Austin, TX 78767

CLAIMS & PAYMENT

Electronic Submission & Payment Methods

Providers choosing electronic submission must use the HIPAA-compliant 837 format, CMS-1500, or UB-04. Curative utilizes TriZetto as an allowable clearinghouse. Submit an EFT Form at **curative.com/electronic-claims-processing**. Providers will need to work with their clearinghouse to establish ERA with Curative.

Clearinghouse	Payer ID	Contact Information
TriZetto www.trizettoprovider.com	CURTV (Professional Claims) CURTV (Institutional Claims)	Phone: 1-800-556-2231 physiciansupport@cognizant.com
Optum	CURTV (Professional Claims) CURTV (Institutional Claims)	customerconnect.optum.com/payerlist
Availity	CURTV (Professional Claims) CURTV (Institutional Claims)	Phone: 1-800-282-4548 www.availity.com

Paper Claims

Submit paper claims to the address on the member ID card:

Curative Health Plan

% Paper Claims

P.O. Box 1786

Austin, Texas 78767

Voided & Reissued Checks

If a check has not been received, please email Provider Services to verify the address and status.

- Curative will verify the current address and if the check was cashed.
- Checks may be reissued if mailed to a wrong address or outstanding for 45+ days.

Electronic Payments (EFT/ERA)

Curative offers secure, electronic claims payments and remittances for faster reconciliation.

Electronic Funds Transfer (EFT)

Safe, secure, and deposited directly into your bank account once claims are released. Avoid manual check deposits entirely.

Electronic Remittance Advice (ERA)

Receive claim details in HIPAA-mandated ASC X12 835 5010 A1 format to automate posting to your billing software.

Contact Provider Relations for setup assistance.

CLAIMS & PAYMENT

Correcting or Voiding Claims

95-DAY SUBMISSION WINDOW

Please submit corrected claims within 95 calendar days from the Explanation of Payment (EOP) issue date. Adjustments must clearly indicate they are corrected or voided and reference the original claim number (found on the EOP). Corrected claims received after 95 days will be denied.

Electronic Submissions

Professional Claims (837p)

- Enter Frequency code ***7*** for all corrections in Loop 2300 Segment CLM05-3.
- Enter the original claim number on the 2300 loop in the **REF*F8***.

Institutional Claims (837I)

- Enter Frequency code ***5*** for late charge(s) (only additional charges not in original claim).
- Submit with last character of Type of Bill as ***7*** to indicate Frequency Code *7* for corrections.
- Use Type of Bill as ***8*** to indicate Frequency Code *8* for voided or cancelled claims.

Paper Submissions

Submit corrected paper claims to:

Curative Health Plan
% Paper Claims
PO Box 1786
Austin, Texas 78767

Filing Guidelines

TIMELY FILING LIMIT

Providers cannot bill members for covered services submitted beyond the timely filing limit set forth in the agreement.

COMPLETE CLAIM POPULATION

All submitted claims must have all lines populated. Do not file only the line items needing correction, or they may be denied as duplicate.

Avoiding Duplicate Claims

Do not resubmit a claim if:

- **The claim is in process:** Resubmitting will not speed payment but will delay processing while the duplicate is researched. Use Availity to check claim status.
- **Payment is not yet posted:** Process all received reports and checks promptly to ensure correct posting.

- A claim that has not yet been paid. For electronic claims, the reports received by a provider's office will indicate if a claim is in process or if action is needed by the provider. If the claim is in process, resubmitting will not speed payment but will in fact delay payment as the duplicate is researched. Effectively using the reports generated and/or the Availity website for claim status will make filing additional claims unnecessary in most cases. The Availity website can also be used for claim status regarding paper submitted claims.
- Payment that has been received but not posted to show the claim is paid. It is important to process all reports and checks promptly once they reach the provider's office.

CLAIMS & PAYMENT

Overpayments

45-DAY REFUND WINDOW

We will inform you in writing of an overpaid claim within 180 days of the date of payment and you will have 45 calendar days (unless otherwise indicated in your Provider Agreement) from receipt of notice to refund the money back to us. If your payment is not received by that time, we may offset the overpayment against future claim payments, or in accordance with the terms of your Provider Agreement. For further details, please refer to your Curative Provider Agreement.

All overpayment refunds should be sent to the address below. In the case that you identified an overpayment and are refunding the amount, please provide sufficient documentation (Member ID, Date of Service, Claim Number, Overpayment Amount and Reason for Overpayment, if known) to enable us to research the overpayment.

Curative Health Plan
Attn: Refunds
PO Box 1786
Austin TX 78767

Payment Policy

Curative administers provider reimbursement in accordance with this Manual and the applicable Payment Policies available in the Provider Resources section of the Curative.com website. Curative may update its Payment Policies at any time by posting revised versions on the website. When required by applicable state law, Curative will provide advance notice of such updates to providers through the website.

Coordination of Benefits

Curative shall coordinate payment with the terms of a member's benefit plan and applicable state and federal laws. Providers shall bill primary insurers for items and services they provide to a member before they submit claims for the same items or services to Curative (when Curative is secondary). Any balance due after receipt of payment from the primary payer should be submitted to Curative. The claim must include information verifying the payment amount received from the primary. If Medicare is the primary payer, we will use the Medicare Allowed Amount.

Subrogation

Third-Party Injury & Subrogation

In the event a member is injured by a third party, Curative reserves the right to recover payments. Providers must cooperate in recovery efforts and refund payments up to the amount paid by the third party for the items or services involved.

Charging Members for Non-Covered Services

Billing Guidelines

Providers may bill members only if the service is not covered by Curative and the member is informed of this status before the service is provided.

Prior to delivering a service that will not be covered, the provider must inform the member and the member must agree to pay.

Three Reasons for Non-Coverage

1. It is excluded from Curative coverage.
2. It exceeds a benefit limit (e.g. occupational therapy visits) and prior authorization was not granted.
3. It is deemed experimental or not medically necessary, and a prior authorization was denied.

Curative Cash Card

Members can use the Curative Cash Card at in-network or approved providers to expand access while ensuring prompt, direct payment.

When it can be used:

- We don't yet have a direct contract with your practice or facility.
- A member nominated your practice and Curative wishes to connect.
- Your practice/facility has an agreement related to Cash Card use.

Provider Benefits:

- **Faster payment:** Reimbursement at time of service, not weeks later.
- **No patient collections:** Members pay $0.
- **Less admin burden:** Skip traditional claim & authorization delays.
- **New patient volume:** Access a growing member base.

Covered Care Examples:

- Primary care & office visits
- Urgent care
- Behavioral health
- Inpatient & outpatient hospital services

Important:

Labs and prescriptions are not typically covered with the Cash Card; members should use their Member ID for those services. Curative reserves the right, at its absolute discretion, to restrict Facility's access to payment via the Curative-issued cash card and to require Facility submit claims for Covered Services.

CLAIMS & PAYMENT

Section 8 | Provider Claim Reconsiderations, Appeals and Arbitration

STAGE 1

Claim Reconsideration

Must be submitted prior to filing a formal appeal. Providers have up to **90 days** from the original Explanation of Payment (EOP) or Electronic Remittance Advice (ERA) to submit.

When is this appropriate?

Disputing processing errors, underpayment, timely filing denials, missing information, or coordination of benefits.

Medical Records Requirements

Not typically required unless the dispute involves a **code audit, code edit,** or **authorization-related denial**. Failure to provide required records will result in the original denial being upheld.

How to Request

Use Curative's Claim Reconsideration Form, available on our website at **curative.com/provider-resources**.

STAGE 2

Claim Appeals

If you disagree with the reconsideration outcome, you may file **one formal Claim Appeal** within **90 calendar days** of the determination date.

When is this appropriate?

Disputing clinical determinations (medical necessity, level of care, authorization denials) or when submitting new documentation.

Your submission must include:

- Copy of original EOP or ERA
- Detailed written explanation of the appeal reason
- Supporting documentation (medical records, correspondence)

How to Request

Use Curative's Appeal Form, available on our website at **curative.com/provider-resources**.

Claim Reconsiderations	Claim Appeals
Curative Health Plan Attn: Claim Reconsiderations PO Box 1786 Austin TX 78767	Curative Health Plan Attn: Claim Appeals PO Box 1786 Austin TX 78767

How to Submit Requests

Preferred Method by Email: providers@curative.com

Fax: 877-734-6537

Subject Line Format: Claim Reconsideration or Claim Appeal [Your Claim Number]

Submissions by mail are accepted but may result in longer processing times. Incomplete or untimely submissions may be returned without review.

CLAIMS & PAYMENT

Medical Records

When submitting medical records to support a claim, appeal, or clinical review, please include the following key details to ensure accurate routing and timely processing:

Submission Checklist

- **Member ID**
- **Claim number** (if applicable)
- **Date(s) of service**
- **Reason for submission**
  (e.g., medical necessity, coding, appeal)

Supporting Documentation

Attach all relevant correspondence—such as provider letters, requests from Curative, or formal review notices.

This ensures the submission is properly indexed and linked directly to the corresponding claim without processing delays.

IMPORTANT NOTICE

Curative does not process unsolicited medical records or clinical documentation that has not been specifically requested by Curative or submitted as part of a defined claim reconsideration or appeal process. Unsolicited medical records will not be reviewed and may be returned or securely discarded in accordance with Curative's privacy and data retention policies.

Arbitration

If either party remains dissatisfied after following the claims dispute resolution procedures in this section, an **arbitration proceeding** may be filed unless otherwise stated in your Agreement with Curative.

In the event that arbitration becomes necessary, such arbitration shall be initiated by providing **written notice** to the other party. The shared fees and costs of arbitration (fee of the independent arbitrator, etc.) will be **shared equally** between the parties or as indicated in the Provider Agreement.

Each party shall be responsible for the payment of that party's specific fees and costs (e.g. the party's own attorney's fees, the fees of the party-selected arbitrator) and any costs associated with conducting the non-binding mediation or arbitration that the party chooses to incur (e.g. expert witness fees, depositions).

CREDENTIALING & COMPLIANCE

Section 9 | Credentialing

Credentialing Overview & Support

Curative requires participating Providers to be initially credentialed and recredentialed every thirty-six (36) months throughout their tenure treating Curative members. This applies to contracted physicians, institutional providers, and other allied health practitioners.

Questions? Contact Curative's Credentialing Department: credentialing@curative.com, or write to Credentialing, P.O. Box 1786, Austin, TX 78767.

Credentialing Committee

Responsible for administering the Credentialing Plan on behalf of Curative. Operating as a peer review body, the Committee makes decisions to accept, retain, deny, or terminate a network contracted Provider. The number of voting members present constitutes a quorum.

Curative's Medical Director, or a designee, chairs the Credentialing Committee. All members of the committee are in-network, credentialed Curative Providers. The Chair may appoint additional providers to form broad-based knowledge for peer review. Other Provider specialists may be consulted as needed to complete review.

Non-Discrimination Policy

Curative will not discriminate against any applicant for participation in its network on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran, or marital status or any unlawful basis not specifically mentioned herein.

Scope of Credentialing

Curative credentialing and recredentialing includes, but is not limited to, the following providers:

- Medical Doctors (MD) & Doctors of Osteopathic Medicine (DO)
- Doctors of Podiatry (DPM) & Oral Surgeons (OMS)
- Psychiatrists, Doctoral/Master's psychologists, & Master's clinical social workers
- Speech, Occupational, and Physical Therapists (ST, OT, PT)
- Independently contracted Pathologists, Radiologists, & Telemedicine practitioners
- Institutional Providers: Hospitals, Skilled Nursing, Rehabilitation, Free Standing Surgery, Behavioral Health, Laboratories, and Radiology facilities

CREDENTIALING & COMPLIANCE

Practitioner Rights & Verification

Practitioner Rights & Corrections

Curative practitioners have the right to review information submitted to support their credentialing application (excluding peer-review protected references). They may correct erroneous information from another source by submitting a written request (including email) within sixty (60) calendar days to the Curative credentialing representative.

This written request is added to the credentialing file and verified by credentialing personnel. Under direction from the Medical Director (or designee), practitioners will be notified of receipt and acceptance of the correction within ten (10) calendar days.

Initial Credentialing Requirements

Curative requires each applicant to use the Council for Affordable Quality Healthcare's (CAQH) ProView for initial credentialing and recredentialing. This free online service allows applicants to fill out a single application that meets the needs of multiple organizations.

To initiate the process, providers must supply their National Practitioner Identification (NPI) number and their CAQH ProviderID. The CAQH attestation must not be older than sixty (60) days. Institutional providers must complete the Curative Institutional Provider Onboarding Form.

Primary Source Verification

Curative will verify regulatory authority, relevant training, experience, and competency. Primary Source Verification results are obtained for state licensure, education/training, board certification, NPI number, and hospital affiliations. Secondary sources verify DEA registration, work history, and liability coverage.

National Practitioner Data Bank (NPDB): The history of state and federal professional board sanctions and professional liability claims resulting in paid judgments is obtained directly from the NPDB.

Timeliness: All verifications must be current and verified within one hundred twenty (120) calendar days prior to the Credentialing Committee making its credentialing decision.

CREDENTIALING & COMPLIANCE

Recredentialing

Recredentialing Timeline & Requirements

Curative's network providers are required to recredential at least every thirty-six (36) months. Using the CAQH Provider ID, Curative automatically initiates a provider's recredentialing cycle no later than sixty (60) days prior to its expiration.

If recredentialing information is not received within thirty (30) days of the due date, a termination notice is sent. Providers terminated for failure to return documents may re-apply after 30 calendar days as a new applicant.

Texas Standardized Credentialing Application (TSCA)

All individual practitioners applying for recredentialing must complete the TSCA or provide an up-to-date CAQH number. The signed attestation (valid within 180 days prior to eligibility decision) acknowledges that omissions or nondisclosure may result in denial or termination. Institutional Providers will also be recredentialed every three years.

AREAS REVIEWED FOR SUBSTANTIAL OMISSIONS:

- Work history covering at least five (5) years
- Limitations in ability to perform essential job functions
- History of loss of license and felony convictions
- History of loss or limitation of privileges, sanctions, or disciplinary actions
- Current professional liability insurance coverage
- Lack of present illegal drug use and signed attestation of completeness

Delegated Credentialing

Curative may delegate authority to perform provider and institutional credentialing and recredentialing to contracted groups. Even when delegated, Curative retains ultimate responsibility for the credentialing and recredentialing of contracted providers, and reserves the right to decline or terminate providers credentialed or recredentialed by delegates.

CREDENTIALING & COMPLIANCE

Appeal of Credentialing or Recredentialing Determination

If the Credentialing Committee recommends acceptance with restrictions or the denial of an initial or recredentialing application, the provider shall be entitled to appeal the recommendation. An appeal will be heard by the Appeals Committee. If the applicant chooses to appeal, the applicant must request a hearing in writing and the request must be received by Curative within thirty (30) days of the date Curative gave notice of its decision to the applicant.

Provider Performance Monitoring

Curative monitors network providers to encourage the provision of safe, quality care to Curative members between providers credentialing cycles. Curative has an on-going monitoring process to determine providers' performance between periods of credentialing and recredentialing.

Provider Data Demographics

Federal provider directory regulations require Curative and providers to work together to maintain accurate provider directory lists. It is required by law for you and Curative to keep your information current and to confirm its accuracy every ninety (90) days. However, Curative may require confirmation upon request as well. We include provider data information in our directories to help members find care. Being in our directories allows new members to find out if you are accepting new members, where you are located and how to reach you. In addition, by making sure we have your current information, we can send you timely communications and reminders. Remember to notify us of your data changes in accordance with state, federal and contractual requirements and guidelines.

CREDENTIALING & COMPLIANCE

Section 10 | Confidentiality

> Curative Confidentiality / HIPAA Policy is based on the premise that adherence to the highest standards of ethical conduct is consistent with the goals and objectives of the organization. Consistent with this premise is the critical importance of maintaining confidentiality of the activities of the organization.

Information related to individual medical records of members, provider credentialing / Recredentialing files, contract terms / rate arrangements and other sensitive issues are managed with the utmost respect for the confidential nature by all board, committee members and staff and in full compliance with Health Information Portability and Accountability Act (HIPAA) and other privacy regulations.

All Provider information obtained and/or documentation created during the credentialing and recredentialing process is treated in a confidential manner. Curative complies with HIPAA guidelines regarding the release of credentials information to third parties. Curative employees and committee members attending credentialing committees sign confidentiality agreements and are responsible to maintain confidentiality of credentialing and Recredentialing activities.

CREDENTIALING & COMPLIANCE

Section 11 | Fraud, Waste, and Abuse (FWA)

Curative is committed to preventing, detecting, and correcting Fraud, Waste, and Abuse (FWA). Providers must comply with all applicable laws, contractual requirements, and accepted billing and coding standards, including CPT®, HCPCS, ICD-10, and NCCI guidelines.
Fraud is an intentional act to obtain improper payment. **Waste** is unnecessary utilization resulting in excess cost. **Abuse** is billing or service practices inconsistent with accepted standards that result in improper payment.

Providers are responsible for submitting accurate claims, maintaining supporting medical records, implementing controls to prevent FWA, and cooperating with audits, reviews, and investigations.

Identified overpayments may be recovered through refunds, claim adjustments, or offsets as permitted by law. Confirmed FWA may result in corrective action, recoupment, payment suspension, termination, and referral to regulatory or law enforcement authorities. Reports of suspected FWA made in good faith are protected from retaliation.

AUDIT RESPONSE REQUIREMENT

FWA Audit failure denials: You are required to submit, or provide access to, medical records upon our request. Failing to do so in a timely manner may result in an audit failure denial, creating an overpayment. Overpayments created as a result of a failure to provide access to requested medical records will be subject to recoupment in accordance with applicable state regulations.