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A newsletter for Highmark Blue Cross Blue Shield providers in western Pennsylvania

Issue 4, April 2024

Clinical Services is phasing out fax prior authorization submissions. Providers are required to use the Availity® portal to electronically submit authorization requests, attach documentation, respond to inquiries, and check status. To view Highmark's current prior authorization list, go here.

We have training resources and guides available to walk you through the electronic authorization process.

How Electronic Authorization Requests Benefit Your Organization

Submitting authorization requests electronically benefits offices and facilities in these six important ways:

1. **Less Administrative Time –** Manual authorization requests take 11 minutes longer than electronic submissions.[1]
2. **More Cost Savings –** Submitting requests manually costs nearly three times as much as electronic requests — $10.26 vs. $3.64 per transaction.[2]
3. **Faster Turnaround Time –** Using Availity increases authorization turnaround time by 75% compared to alternative submission channels; some approvals are available immediately.[3]
4. **Higher Approval Rates –** Cases submitted via Availity see a 4% higher approval rate due to the submission of complete clinical information.[3] Higher approvals mean fewer denials, saving your team additional time.
5. **Real-Time Status Updates –** The status of prior authorization requests is always available in real time, eliminating the need for unnecessary phone calls.
6. **Easy Process for Sharing Clinical Information –** Providers can upload requests for additional clinical information quickly and easily through Availity and receive a faster response.

Not signed up for Availity? Visit www.availity.com and click on the **Get Started** link.

BONUS: 3 More Reasons for Using the Availity Portal

- Single source for Eligibility and Benefits, Claims, and Authorization data.
- Ability to easily submit prior authorization requests for all members including Out of Area.
- Convenient, multi-payer portal reduces complexity for providers.

Training Resources

Both Availity and Highmark's Provider Resource Center (PRC) offer valuable training resources for providers and their teams to make the adoption of the provider portal easy, understandable, and advantageous.

Training Courses

- Log into Availity.
- Select **Help & Training** tab on the homepage:
  - Click Get Trained from the drop-down menu to view recorded demos and webinars.

Registration Guides

- Availity Essentials Registration for Health Care Providers
- Availity Essentials Registration for Billing Services

Reference Guides

- Availity Essentials Reference Guide for Users
- Availity Essentials Reference Guide for Administrators

Highmark Resources

- Availity – Provider Portal Transition
- Availity – FAQs
- Procedures/Service Requiring Prior Authorization
    - **Guides**
        - Inpatient Authorization Submission (Both Urgent and Non-Urgent)
        - Outpatient Authorization Submission
    - **Videos**
        - Electronic Authorization Submission Process (Predictal via Availity)
        - Case Management Referral Process (Predictal via Availity)

References

1. 2022 CAQH INDEX® A Decade of Progress. p. 20.

2. 2020 CAQH INDEX® Closing the Gap: The Industry Continues to Improve, But Opportunities for Automation Remain. p. 6.

3. Based on Highmark Utilization Management data.

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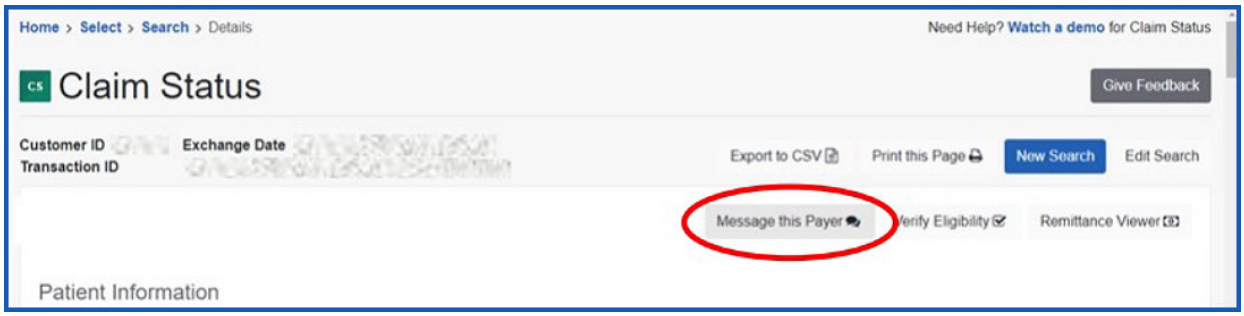
Access to Highmark's legacy provider portal, NaviNet®, ended on Friday, April 26. That means all Highmark-contracted providers should be using Availity® for their Highmark transactions, including:

- Eligibility and benefit searches
- Authorization submissions and status checks
- Claim status, submissions, and inquiries
- Validation of directory information for professional providers through Highmark's Provider Data Maintenance (PDM) application
- View value-based reporting

Claim Investigations in NaviNet

If you initiated a claim investigation in NaviNet, and it was still open as of April 19, Highmark will provide our response to you via postal mail. All new claim investigations must be submitted via the Availity portal. Locate the claim in **Claim Status**, and then click **Message this Payer** to send your inquiry.



Availity Training

You can access recorded training courses and materials in the Availity Learning Center. In addition, Availity has the following resources available for providers and their teams:

- Availity.com/Highmark
- Register and Get Started
- Sign-Up Tips for Primary Administrators

Highmark Resources

The Provider Resource Center (PRC) has a variety of resources regarding Availity and the transition to a new portal, as well as guides and videos for submitting authorization requests electronically via Highmark's Availity portal.

- Availity – Provider Portal Transition
- Availity – FAQs
- Procedures/Service Requiring Prior Authorization
    - **Guides**
        - Inpatient Authorization Submission (Both Urgent and Non-Urgent)
        - Outpatient Authorization Submission
    - **Videos**

- Electronic Authorization Submission Process (Predictal via Availity)
- Case Management Referral Process (Predictal via Availity)

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SHORT TAKES:

Fee Schedules, Respiratory Panels Reimbursement, and ASAM 4th Edition

Quarterly Fee Schedules

The standard professional quarterly fee schedules were published during the week of April 14, 2024. To view them on the Provider Resource Center (PRC), log into Availity®, go to **Payer Spaces**, and then select **Provider Resource Center** under **Applications**. Once you arrive at the PRC, choose **CLAIMS, PAYMENT & REIMBURSEMENT** from the left menu and click **Fee Schedule Information**.

Reimbursement Changes for Respiratory Panels that Test for 5 or More Pathogens

Highmark is committed to ensuring members receive appropriate care based on well-established, evidence-based clinical guidelines that result in better outcomes and lower costs. To promote medically necessary and cost-efficient patient care, Highmark is

reducing the reimbursement for respiratory pathogen panels that check for the presence of 5 or more pathogens, **effective July 1, 2024**.

Respiratory pathogen panels that test for fewer than 5 pathogens are effective for detecting three of the most common respiratory infections — COVID-19, respiratory syncytial virus (RSV), and influenza — while also being less expensive. For more information, click here.

ASAM 4th Edition to be Implemented on July 1

Effective July 1, 2024, Highmark will transition from American Society of Addiction Medicine (ASAM) 3rd Edition to ASAM 4th Edition. Highmark uses ASAM criteria to review authorization requests for substance abuse services.

To learn more about the ASAM 4th Edition, go here.

Quick Claims Functionality in Availity

Professional providers who use Availity Essentials™ for claim submission now have access to the Quick Claims functionality for Highmark members. Quick Claims allows providers to create templates that pre-populate certain fields when submitting a CMS-1500 claim. This will save time for providers who routinely submit claims for the same patient or same service each week or each month. For more information, see the recent **Special Bulletin**.

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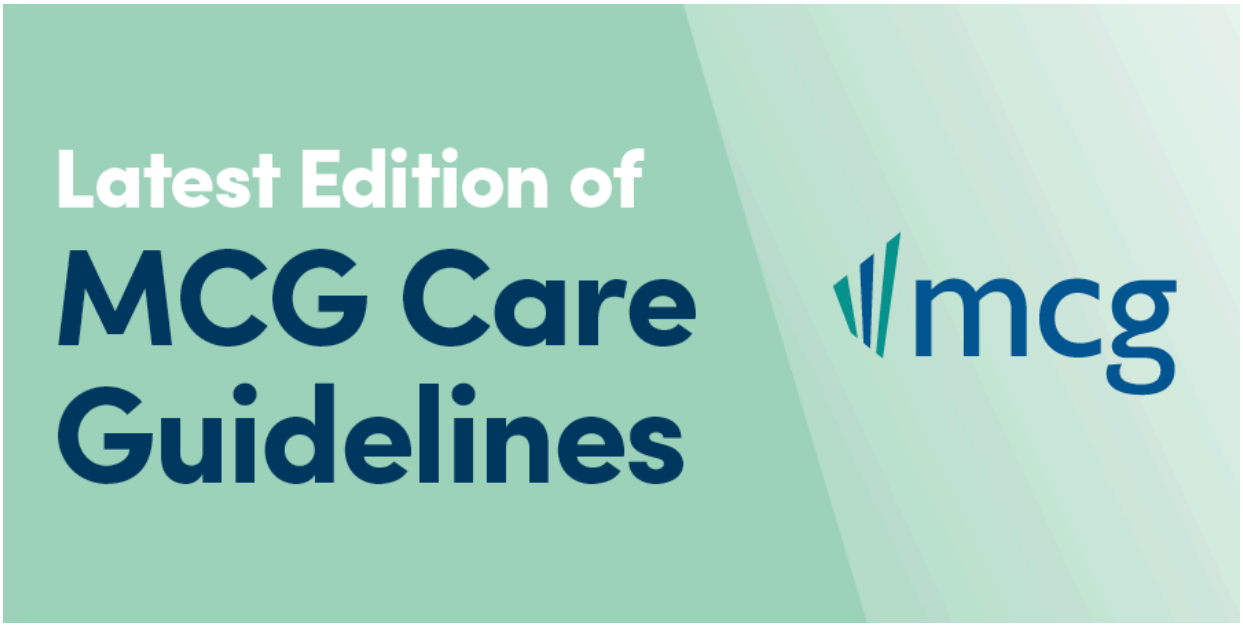

The 28th edition of MCG's Care Guidelines will be available on Aug. 1, 2024.

After that date, you will be able to submit authorization requests using the 28th edition for any new requests. Any authorization requests with a start of care date **prior** to Aug. 1, 2024, will be reviewed using the 27th edition.

We began incorporating clinical guidelines from MCG Health into our criteria of clinical support decisions in February 2023. This change has allowed us to enhance visibility to utilization management criteria while simplifying the authorization process for providers.

Please continue to use the Predictal application in Availity® to submit authorization requests with clinical information included.

Providers can view a summary of changes for the 28th edition from their MCG site.

Questions

Contact Highmark **Clinical Services** or the **Provider Service Center** with any questions. Phone numbers for each region may be found in the Quick Reference Guide.

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Most members with Medicare Part D coverage are eligible to receive up to a **100-day supply for generic medications** on Tier 1 and Tier 2 of Highmark's formularies. When appropriate, providers are encouraged to write prescriptions for this higher day supply.

Some examples of Tier 1 or Tier 2 drugs eligible for a 100-day supply include Lisinopril, Metformin, and Atorvastatin. This change went into effect on **Jan. 1, 2024**.

Writing prescriptions for a 100-day supply will save your Medicare patients money and promote better adherence.

If you are unsure whether the member has this benefit, or what tier the medication is, see our Tip Sheet, which is accessible from the left menu on the Provider Resource Center (PRC) under **PHARMACY PROGRAM/FORMULARIES** and then click **Medicare Formularies**.

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Many individuals with mental health concerns often delay care or find it difficult to schedule a visit with a mental health provider, according to statistics from the 2022 National Survey on Drug Use and Health.

For adults aged 18 and older diagnosed with a mental health disorder (roughly 15 million), only 67% received treatment. For those 12 years and older with substance use disorder, which is nearly 49 million individuals, the numbers are far grimmer, with less than 5% receiving treatment.

Some of your Highmark patients may face barriers to receiving mental health care due to a variety of reasons, including long wait times for appointments, transportation or geographic limitations, personal and work schedule conflicts, or discomfort with in-office appointments.

A Solution for Members

During Mental Health Awareness Month, which runs throughout May, Highmark is highlighting a high-quality mental and behavioral health care solution called **Highmark Mental Well-Being powered by Spring Health**.

It's available for most members with fully insured commercial, Affordable Care Act (ACA), Medicare Advantage, and Administrative Services Only (ASO) plans. The program offers expanded and timely access through customized interventions for eligible Highmark members (and their covered dependents ages 6+) from low-acuity wellness needs to high-acuity conditions.

Virtual and In-Person Care

Highmark Mental Well-Being powered by Spring Health features virtual and in-person (where available) appointments and a designated Care Navigator who will work to ensure our members get the right care at the right time, reducing improper emergency department (ED) utilization.

The program provides access to an expanded network of behavioral health providers who deliver evidence- and measurement-based care. Each member receives a customized care plan based on a digital assessment. Appointments for therapy and medication management are typically available within three business days. Members will also have access to a 24/7 crisis line. You can refer your eligible Highmark patients to **Mental Well-Being** using the form here. Members can also enroll in the program through their Highmark member portal.

Please note: If your patients have been seen in the ED for mental illness and/or substance use, follow-up is essential to make sure that they are receiving appropriate care.

Resources

Additional information about Highmark Mental Well-Being powered by Spring Health can be found on the Provider Resource Center by clicking **EDUCATION/MANUALS > Clinical Support Programs > Behavioral Health**.

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Quality Program Information for 2024

Highmark's Quality Program has been designed to improve the quality, safety, and equity of the clinical care and services providers render to our members. To do this, we continually review aspects of the program that affect the quality of the member care experience, including member satisfaction, and look for ways to make improvements.

Highmark works closely with the physician community in our efforts to address both the quality of the clinical care and service our members receive, as well as plan management for the services provided by Highmark (i.e., authorizations, claims handling, appeals, etc.).

We also use member satisfaction surveys and other tools to elicit feedback on how we're doing. These results are used to guide our future quality improvement activities and programs, supporting such areas as:

- **The Clinical Care and Service Received by Our Members**
- **The Provider Network**
- **Member Safety and Health Equity**

To learn more about the Quality Program, including information on program objectives, please visit the Provider Resource Center (PRC).

Once on the PRC, select ***Highmark Provider Manual*** from the gray navigation bar at the top. See **Chapter 5: Unit 6: Care & Quality Management** > *Quality Management*.

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Medical Review Committee Members Needed

Highmark is seeking members to serve on its Medical Review Committee for the upcoming two-year term of 2025–2026.

Highmark's Medical Review Committee resolves disputes between health service providers and Highmark, which may involve utilization and quality of care issues, as well as alleged violations of participating provider agreements and appeals regarding network terminations. The Committee also considers and reviews appeals for practitioners who have been denied privileges for providing imaging services.

The Committee is currently comprised of four doctors of medicine, one doctor of osteopathy, one doctor of chiropractic, one physical therapist, and two consumer representatives. The Medical Review Committee Selection Committee appoints the members to a two-year term. Members may be re-appointed.

Responsibilities

The Medical Review Committee generally meets four times a year via a Zoom video conference call. Members receive an honorarium from Highmark for meeting participation.

Considerable preparation time for the meetings may be required. Members are expected to attend all meetings and be prepared to participate in each case discussion.

Committee Member Requirements and How to Apply

All potential candidates must be a Pennsylvania licensed health care provider with one or more professional provider contracts with Highmark.

If you are interested in being considered for membership by the Medical Review Committee Selection Committee, please send a copy of your current resume or curriculum vitae, by **Aug. 2, 2024**, to:

Earl Bock
Secretary, Medical Review Committee
Financial Investigations and Provider Review
Highmark Inc.
1800 Center Street, Mailstop FIPR
Camp Hill, PA 17011

Or

Earl.Bock@Highmark.com

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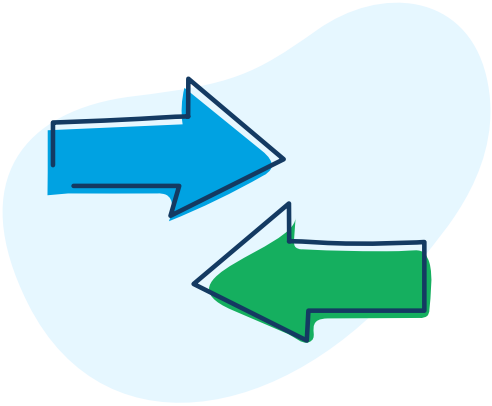
New and Updated Reimbursement Policies



Highmark regularly issues new or updated reimbursement policies. Keep an eye on this newsletter and the Provider Resource Center (PRC) homepage for announcements regarding upcoming policy changes. As specific policy changes go into effect, the updated policies can be found on the Reimbursement Policy page of the PRC.

Below is a list of recent and upcoming updates to reimbursement policies (RPs):

RECENTLY UPDATED

April 1, 2024

RP-034 Prolonged Detention or Critical Care
Code 93598 will be added to the "Prolonged Detention or Critical Care" section of this policy.

April 15, 2024

MRP-007 Modifiers CO and CQ
The reimbursement rate percentage was changed from 85% to 88%.

April 22, 2024

RP-057 Evaluation & Management Services
Medicare Advantage was made applicable to this policy, and a Medicare Advantage section was added to clarify direction that Centers for Medicare & Medicaid Services (CMS) guidelines are followed for Evaluation and Management services.

April 29, 2024

RP-009 Modifiers 25, 59, XE, XP, XS, XU, and FT
This policy was reviewed as part of our standard review process. No changes in direction were made.

RP-012 Rigid Immobilization
This policy was reviewed as part of our standard review process. No changes in direction were made.

RP-013 Electrocardiogram and Medical Imaging Interpretation
This policy was reviewed as part of our standard review process. No changes in direction were made.

RP-041 Services Not Separately Reimbursed
Code 76140 will be added and will no longer be a separately reimbursed service.

UPCOMING

May 1, 2024

RP-026 Portable Radiography and ECG Services – Modifiers UN, UP, UQ, UR, US
Direction for "U" modifier reductions reported with code R0075 will be made applicable for Commercial.

June 1, 2024

RP-068 Mid-Level Practitioners and Advanced Practice Providers
This policy will be updated to include the new licensed associate marriage and family therapist (LAMFT) and licensed associate professional counselor (LAPC) specialties. It will also be restructured for clarity purposes.

June 24, 2024

NEW: RP-077 Intraoperative Neurophysiological Monitoring

Highmark has created RP-077 to provide direction on reimbursement for Intraoperative Neurophysiological Monitoring (IONM) services. *(NOTE: This policy will be available on the PRC on the effective date of June 24, 2024.)*

August 8, 2024

RP-053 Gene and Cellular Therapy

This policy will be updated with new drugs and therapies, as well as cross-references to medical policies. The name of RP-053 will change from "Gene and Cellular Therapy" to "Advanced Therapies (Gene Therapy and Cellular Immunotherapy)."

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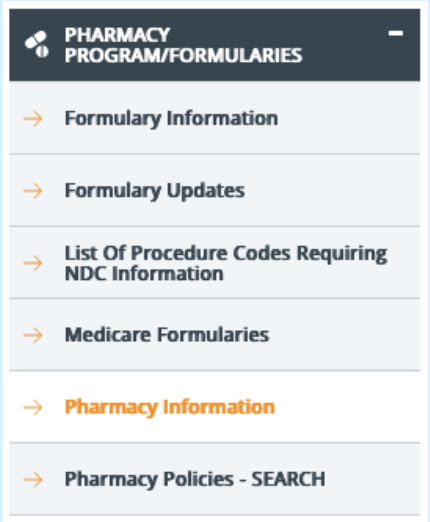
Quarterly Formulary Updates

View the January 2024 updates to Highmark's prescription drug formularies and related pharmaceutical management procedures at the Formulary Updates page on the **Provider Resource Center (PRC)**. From the left menu, select **PHARMACY PROGRAM/FORMULARIES** and then **Formulary Updates**.

Pharmaceutical Management Procedures

To learn more about how to use these procedures, go to the **PHARMACY PROGRAM/FORMULARIES** section on the PRC. Click on **Pharmacy Information** from the sidebar and then **Pharmaceutical Management** from the list on the right.



This section includes information on:

- Exception requests
- The process for generic substitutions
- Explanations of limits/quotas, therapeutic interchange, and step-therapy protocols

Federal Employee Program (FEP) Drug Formularies and Pharmaceutical Management Procedures

The FEP specific drug formularies are available online. Providers also may obtain formulary information by calling **866-763-3608** and following the prompts for *Pharmacy*.

To learn more about the FEP exception request processes for non-formulary drugs, click here.

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Directory Information – Here's How to Attest

When Highmark members are looking for a primary care physician (PCP) or specialist, they expect that our online provider directory presents information that is accurate and current.

That's why it is essential to ensure that your practice information on file with Highmark remains up to date.

Please be aware that providers who don't validate their data quarterly may be removed from the directory and their status within Highmark's networks may be impacted.

Reviewing Data Is Vital for You

The Centers for Medicare and Medicaid Services (CMS) requires Highmark to reach out to you every quarter and ask you to validate your provider directory information. We use this information to populate our online provider directory and to help ensure correct claims processing.

Your thorough review of your directory information confirms:

- **Each practitioner's name** is correct and matches the name on his/her medical license.
- **Each practitioner's National Provider Identifier (NPI) is correct.**

- **The practice name is correct** and matches the name used when you answer the phone.
- **All specialties are correctly listed** and are currently being practiced.
- **Practitioners listed at a location** currently see members and schedule appointments at that office on a regular basis.
    - All practitioners listed must be affiliated with the group. Practitioners who cover, read test results, or are hospitalists should not be listed in the provider directory.
- **The practitioner is accepting new patients** — or not accepting new patients — at the location.
- **The practitioner's address**, suite number (if any), and phone number are correct.

Professional Providers – Use the PDM Tool

Professional providers are now required to validate their Highmark Provider Directory information within the Provider Data Maintenance (PDM) tool every 90 days.

To access PDM, sign in to Availity®, choose the state you practice in, click **Payer Spaces** from the task bar, and then select the Highmark plan you participate in. Once you arrive at the **Payer Spaces** page, scroll down, and select **Provider Data Maintenance** under **Applications**.

Facility, Ancillary, and Medicaid Providers – Use Atlas

The attestation process through Atlas is quick and easy. Just follow these steps...

1. **Go to hub.primeatlas.com.**
2. **Log in.**
3. **Review your information.**
4. **If no changes, confirm.**
5. **If there are changes, update your information.**

If you haven't attested your provider directory information this quarter, you will receive a letter from Atlas to review your provider information. Some providers may also receive emails from Highmark about validating their directory information through the Atlas website. To ensure delivery of emails from Highmark, please add the following email address, resourcecenter@highmark.com, to your address book.

During the attestation process, always double-check your current email address(es) to ensure that you can receive electronic communications from Highmark without delay.

If you need additional information regarding the attestation process, Atlas' step-by-step guide is available on the Provider Resource Center.

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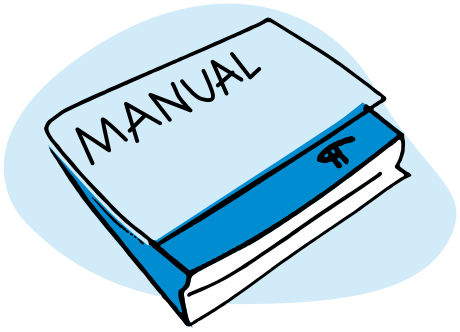
Staying Up to Date with the *Highmark Provider Manual*

Ensure you are regularly reviewing the *Highmark Provider Manual* for our most recent guidance on:



- Participation Rules
- Credentialing/Recredentialing Criteria and Procedures
- Medical Record Criteria
- Requirements for 24/7 Coverage

Some recent noteworthy changes occurred in the following chapters and units:

- **Chapter 2, Unit 6: The BlueCard Program**
- **Chapter 3, Unit 2: Professional Provider Credentialing**
- **Chapter 5, Unit 4: Behavioral Health**
- **Chapter 5, Unit 5: Denials, Adverse Benefit Determinations, Grievances, and Appeals**
- **Chapter 5, Unit 6: Quality Management**
- **Chapter 6, Unit 2: Electronic Claim Submission**

To see the full list of recent changes, visit the Highmark Provider Manual Changes page.

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About This Newsletter

Provider News is a valuable resource for health care providers who participate in our networks. Published monthly on the last Monday of the month*, *Provider News* conveys important product, policy, and administrative information, including billing, claims, and program updates.

The publication also features the latest news, information, tips, and reminders about our products and services, as well as relevant interviews, articles, and stories, for health care professionals who serve Highmark members.

Regular topics include:

- New and Updated Reimbursement Policies
- Authorization Updates
- Staying Up to Date with the *Highmark Provider Manual*

*When a holiday falls on the last Monday of the month, *Provider News* will be published on the preceding Friday.

Another Valuable Resource

For medical policy and claims administration updates, including coding guidelines and procedure code revisions, please refer to the ***Medical Policy Update Newsletter***.

You can access both *Provider News* and the Medical Policy Update Newsletter on the Provider Resource Center from the **NEWSLETTERS/NOTICES** link on the sidebar. Email subscriptions are available via the **eSubscribe** button on the PRC taskbar.

Comments/Suggestions Welcome

We want *Provider News* to meet your needs for timely, effective communication. If you have any suggestions, comments, or ideas for articles in future issues, please email the *Provider News* team at ResourceCenter@Highmark.com.

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Legal Information

Highmark Blue Cross Blue Shield is an independent licensee of the Blue Cross and Blue Shield Association. Highmark Blue Cross Blue Shield serves the 29 counties of western Pennsylvania. BlueCard, Blue Distinction, Blue Distinction Center, and the Federal Employee Program are registered marks and Blues On Call is a service mark of the Blue Cross and Blue Shield Association.

Highmark Senior Health Company and Highmark Coverage Advantage are service marks of Highmark Inc. Highmark Health is the parent company of Highmark Inc.

The Blue Cross Blue Shield Association is an association of independent, locally operated Blue Cross and Blue Shield companies.

Atlas Systems, Inc. is a separate and independent company that conducts physician outreach for Highmark.

NaviNet is a registered trademark of NaviNet, Inc., which is an independent company that provides a secure, web-based portal between providers and health care insurance companies.

Current Procedural Terminology (CPT) is a registered trademark of the American Medical Association. Healthcare Effectiveness Data and Information Set (HEDIS)® and Quality Compass® are registered trademarks of the National Committee for Quality Assurance (NCQA). Consumer Assessment of Healthcare Providers and Systems (CAHPS)® is a registered trademark of the Agency for Healthcare Research and Quality. CORE is a registered trademark of CAQH.

Note: This publication may contain certain administrative requirements, policies, procedures, or other similar requirements of Highmark (or changes thereto) which are binding upon Highmark and its contracted providers. Pursuant to their contract, Highmark and such providers must comply with any requirements included herein unless and until such item(s) are subsequently modified in whole or in part.


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QUICK REFERENCE

HIGHMARK PROVIDER SERVICE CENTERS

Please use NaviNet® for all of your routine eligibility, benefit, and claim inquiries.
For non-routine inquiries that require analysis and/or research, contact Highmark's Provider Services.

What Is My Service Area?

PENNSYLVANIA:

- Western Region: Professional Providers **1-800-547-3627**; Facilities **1-800-242-0514**
  Hours of Availability: 8 a.m. to 5 p.m. EST, Monday through Friday
- Central & Northeastern Regions: Professional Providers **1-866-731-8080**; Facilities **1-866-803-3708**
  Hours of Availability: 8 a.m. to 5 p.m. EST, Monday through Friday
- Eastern Region **1-800-975-7290**
  Hours of Availability: 9 a.m. to 12 noon, 1 p.m. to 4:30 p.m. EST, Monday through Friday.
- Medicare Advantage:
  - Freedom Blue PPO: **1-866-588-6967**
  - Community Blue Medicare HMO: **1-888-234-5374**
  - Community Blue Medicare PPO: **1-866-588-6967**
  - Security Blue HMO (Western Region only): **1-866-517-8585**
- Behavioral Health:
  - Western & Northeastern Regions: **1-800-258-9808**
  - Central & Eastern Regions: **1-800-628-0816**

DELAWARE:

- Highmark Delaware Provider Services: **1-800-346-6262**
  Hours of Availability: 8:30 a.m. to 5 p.m. EST, Monday through Friday
- Behavioral Health: **1-800-421-4577**

WEST VIRGINIA:

- Highmark West Virginia Medical: **1-800-543-7822**
- Highmark Senior Solutions Medicare Advantage Freedom Blue PPO: **1-888-459-4020**
  Hours of Availability: 8 a.m. to 8 p.m. EST, Monday through Sunday
- Behavioral Health: **1-800-344-5245**

NEW YORK:

- Highmark Blue Cross Blue Shield of Western New York: **1-800-950-0051 or (716) 884-3461**
- Highmark Blue Shield of Northeastern New York: **1-800-444-4552 or (518) 220-5620**
  Hours of Availability: 8 a.m. to 8 p.m. EST, Monday through Sunday
- Behavioral Health: **1-844-946-6264**
  - Fax: Behavioral Health Outpatient: **1-822-581-1867;** Behavioral Health Inpatient **1-833-581-1866**

Please listen carefully to the available options to reach the appropriate area for your inquiry.

HIGHMARK CLINICAL SERVICES

NaviNet® is the preferred for authorization requests. Contact Clinical Services for inquiries that cannot be handled via NaviNet.® **Hours of Availability:** Monday-Friday 8:30 a.m.-7 p.m.; Saturday & Sunday 8:30 a.m.-4:30 p.m. for urgent issues.

PENNSYLVANIA:

- Western Region:
  - Medical Services: Professional Providers **1-800-547-3627**; Facilities **1-800-242-0514**
  - Behavioral Health: **1-800-258-9808**

- Central Region:
  - Medical Services: Professional Providers **1-866-731-8080**; Facilities **1-866-803-3708**
  - Behavioral Health: **1-800-628-0816**
- Northeastern Region: Medical Services **1-800-452-8507**; Behavioral Health **1-800-258-9808**
- Eastern Region: Call Independence Blue Cross at **1-800-862-3648**

DELAWARE:

- Medical Services **1-800-572-2872**; Behavioral Health **1-800-421-4577**

WEST VIRGINIA:

- Highmark West Virginia Products for Medical and Behavioral Health Services: **1-800-344-5245**
- Medicare Advantage Freedom Blue PPO: **1-800-269-6389**

NEW YORK:

- Medical Services: **1-844-946-6263**
  - Fax: Medical Outpatient **1-833-619-5745**; Medical Inpatient **1-833-581-1868**

Please see the *Highmark Provider Manual's* Chapter 1.2 for additional contact information.