Provider Quick Reference for Commonwealth Coordinated Care Plus (CCC Plus)

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

For more details about this program –
Visit the website at:
http://www.dmas.virginia.gov/#/cccplus
Or e-mail at: CCCPlus@dmas.virginia.gov

Important: Information contained in this guide is subject to change without notice

Updated March 2020 (Does not include COVID-19 flexibilities)

COMMONWEALTH COORDINATED CARE PLUS
PROVIDER QUICK REFERENCE GUIDE

Table of Contents

Glossary of Terms

Carved-Out Services: Specific services are paid through Medicaid fee-for-service for CCC Plus program enrolled individuals; these specific services for managed care enrolled individuals are being "carved-out" from the other services offered by a MCO and will remain fee-for-service.

Clean Claim: A claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim without errors originating in the Contractor's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

Coinsurance – The portion of a Medicaid member's Medicare, Medicaid, or other insurance, allowed charges for which the member is responsible.

Co-payment: Some Medicaid members must pay a small amount for certain services. Most of the co-payments (also referred to as copays) are $1.00 to $3.00; inpatient hospital is $100.00 per admission. CCC Plus members are not charged co-payments for services rendered, other than the member's patient pay towards long-term services and supports (if they have one). See Patient Pay.

Dual Eligible: Individuals who are enrolled in Medicare (Part A or B) and full Medicaid.

Excluded Populations: Individuals are not CCC Plus program eligible. The coverage for these individuals will continue through fee-for-service or through another DMAS managed care program.

Long Term Services and Supports (LTSS): Long-term services and supports (LTSS) are a variety of services and supports that help older individuals and individuals with disabilities meet their daily needs for assistance and improve the quality of their lives. Examples include assistance with bathing, dressing, and other basic activities of daily life and self-care. LTSS are provided over a long period, usually in homes and communities, but also in nursing facilities.

Managed Care Organization (MCO): MCOs are health care plans contracted with DMAS to provide services and coordinate health care services through a network of providers for their members.

Medically Complex: Having a behavioral or medical condition and functional impairment, meaning the complex condition makes it difficult to handle daily activities on their own.

National Committee for Quality Assurance (NCQA): The National Committee for Quality Assurance (NCQA) is an independent accreditation organization that evaluates the quality and service provided by health plans, including managed care organizations (MCOs), accountable care organizations (ACOs), managed behavioral health organizations (MBHOs), etc.

Patient Pay: Members with a certain amount of income may have to contribute toward the cost of their long-term services and supports. *Patient Pay* is determined by the local Department of Social Services.

Person-Centered: Person-centered healthcare establishes a partnership among practitioners, members, and their families (when appropriate) to ensure that decisions respect a person's wants, needs, and

preferences. Person-centered healthcare services encompass qualities of compassion, empathy, and responsiveness to the needs, values, and expressed preferences of the individual.

Commonwealth Coordinated Care Plus Overview

What is CCC Plus?

Commonwealth Coordinated Care Plus (CCC Plus) is a statewide Medicaid managed care program that serves over 246,000 individuals with complex health care needs, through a person-centered integrated delivery model including medical, behavioral health and long-term services and supports. This person-centered program includes care coordination and focuses on improving quality, access and efficiency. The General Assembly directed DMAS to transition individuals from the Fee-For-Service delivery model into the Managed Care Model to achieve high quality care and budget predictability.

CCC Plus Eligible Individuals in Existing (2018) Covered Groups

- Individuals aged 65 and older
- Adults and children with disabilities
- Individuals living in Nursing Facilities (NFs)
- Individuals enrolled in the Commonwealth Coordinated Care Plus Waiver (formerly the Technology Assisted Waiver and Elderly or Disabled with Consumer Direction Waiver)
- Individuals enrolled in one of the three waivers currently serving those with Developmental Disabilities (DD). CCC Plus will cover the individual's non-waiver services only, including primary, acute, pharmacy, behavioral health, and non-LTSS transportation services.
- In January 2018, individuals enrolled in Commonwealth Coordinated Care and Medallion 3 Aged, Blind and Disabled (ABD) transitioned to CCC Plus.

CCC Plus Eligible Individuals through Medicaid Expansion (2019)

- Individuals aged 19-64, not Medicare eligible
- Individuals that meet the income requirement of up to 138% Federal Poverty Level
- Medically complex

CCC Plus Excluded Individuals

Some individuals are excluded from CCC Plus. The coverage for these individuals will continue through fee-for-service or through another DMAS managed care program. The full list of exclusions is in section 3.1.2 of the CCC Plus contract. A sample of the exclusion criteria is listed below:

- Individuals enrolled in another Medicaid managed care program (e.g., Medallion and FAMIS managed care, or Program of All-Inclusive Care for the Elderly - PACE).
- Individuals who are in limited coverage groups (Family Planning, or Qualified Medicaid Beneficiary only).
- Individuals who participate in the Health Insurance Premium Payment Program.

- Individuals enrolled in a hospice program at the time of enrollment. However, if an individual enters a hospice program while enrolled in the CCC Plus program, the individual will remain enrolled in CCC Plus.
- Individuals who are institutionalized in state and in private Intermediate Care Facility/Intellectual Disability and state Intermediate Care Facility /Mental Health facilities. Individuals who reside at Piedmont, Catawba, and Hancock state facilities operated by the Department of Behavioral Health and Developmental Services (DBHDS).
- Individuals who reside in nursing facilities operated by the Veterans Administration.
- Individuals who reside in The Virginia Home nursing home.
- Individuals who reside in local government owned Nursing Facilities: Bedford County Nursing Home, Birmingham Green, Dogwood Village of Orange County Health and Rehabilitation, Lake Taylor Transitional Care Hospital, Lucy Corr Nursing Home.

CCC Plus Carved-out Services

Some services are paid through Medicaid fee-for-service for CCC Plus program enrolled individuals. These specific services are "carved-out" of the CCC Plus managed care contract and include the following:

- **Dental services (Smiles for Children)**
- **School Health Services** – includes nursing and personal care services, physical and occupational therapies, and speech-language pathology offered to enrolled Medicaid children receiving special education/IEP services in the school setting.
- **Developmental Disability (DD) Waiver Services –** Carve out includes DD Waiver services and related transportation, case management, support coordination services, including when the DD waiver services are covered through EPSDT.
- **Long Term Services and Supports Screening (formerly Preadmission Screening)** – Screenings conducted by hospital screeners or community based screening teams using the UAI (Uniform Assessment Instrument) to assess and determine the level of care the individual requires (such as nursing facility, home and community based waivers, PACE, or assisted living facility).

Participating MCO Health Plans

DMAS has contracted with six (6) Managed Care Organizations (MCOs) health plans that will cover all regions of the state. MCOs must be accredited through the National Committee for Quality Assurance (NCQA). Providers must meet MCO credentialing standards (consistent with NCQA guidelines) and state and federal Medicaid requirements.

The six contracted MCOs are:

Aetna Better Health	https://www.aetnabetterhealth.com/virginia
Anthem HealthKeepers Plus	https://mss.anthem.com/va/Pages/aboutus.aspx
Magellan Complete Care of VA	http://www.mccofva.com/
Optima Health Community Care	https://www.optimahealth.com/plans/community-care/
United Healthcare Community Plan	https://www.uhccommunityplan.com/va/medicaid/ccc-plus.html
Virginia Premier Health Plan	https://www.virginiapremier.com/medicaid/

Each of the health plans hosts web based training modules for providers. These trainings cover a variety of topics including service authorizations, claims, and care coordination.

Continuity of Care

MCOs have to pay a member's existing Medicaid providers for up to the duration of the continuity of care period of 30 days or the length of the existing service authorization, whichever is sooner. The health plan will extend this time frame as necessary to ensure continuity of care pending the provider's contracting with the health plan or the Member's safe and effective transition to a contracted provider.

Members in a Nursing Facility (NF) at the time of enrollment will not be required to move even if the NF does not participate. The MCO will pay the NF as an out of network provider. However, the Nursing Facility will need to join a network in order to receive new individuals in the CCC Plus program.

Coverage Out of Network

In most cases, individuals will be required to use in network providers. MCOs must go out of network to provide a service that they are unable to provide in network.

Members have a 30-day continuity of care period, where nonparticipating providers can bill the plan out of network during a member's first 30 days of enrollment with the MCO. Following the initial 30 days of enrollment, nonparticipating providers may also contact the member's plan to request a Single Case Agreement to bill for necessary follow-up visit(s); i.e., until the member transitions to a new MCO or until the member can be transitioned to a provider that participates with the member's assigned MCO. Members have the ability to change from one MCO to another within their first 90 days of managed care enrollment through the DMAS enrollment broker, Maximus. Most requests for new plan assignments will be processed within 30 days.

Person Centered Care

The CCC Plus model of care is explained in detail in the CCC Plus contract section 5.0. Health plans will contact CCC Plus members to conduct the MCO Member Health Screening. This screening verifies that members are medically complex and collects information about food, housing and other social determinants of health. Health plans also conduct a health risk assessment with members to inform the member's individualized care plan. Health plans assign a Care Coordinator to each member. The Care Coordinator will work with the member, their family members, if appropriate, their providers and

anyone else involved in their care to help them get the services and supports that they need. The Care Coordinator also leads Interdisciplinary Care Team meetings. The Care Coordinator can assist providers in getting authorizations and resolving member issues. To connect to a Care Coordinator, please use the phone numbers below.

Aetna Better Health of VA	1-855-652-8249
Anthem HealthKeepers Plus	1-855-323-4687
Magellan Complete Care of VA	1-800-424-4524
Optima Health Community Care	1-866-546-7924
UnitedHealthcare	1-877-843-4366
Virginia Premier Elite Plus	1-877-719-7358

For members on a waiver, health plans conduct annual level of care reviews. While members have the option to refuse Care Coordination and the Health Risk Assessment, members must complete annual level of care reviews to remain eligible for a waiver.

Service Authorization

During the continuity of care period, existing service authorizations will continue to be honored by the MCO through the end of the Service Authorization (SA) or 30 days, whichever comes first. MCOs must cover services within at least equal amount, duration, and scope as available through the Medicaid fee-for-service program. MCOs do not have to adhere to the DMAS established criteria. MCOs can choose to require an authorization for services even if DMAS does not require it.

Information for LTSS providers, by provider type (i.e., Nursing Facility, Personal Care, CMHRS, etc.) detailing how to submit service authorizations are found here:
http://www.dmas.virginia.gov/#/cccplusproviders

Member Appeals

Members have the right to appeal an adverse benefit determination. The first level of appeal is to the health plan. This process has to be exhausted prior to requesting a second level appeal. The second level of appeal is to the Department of Medical Assistance Services (DMAS) and is called a State Fair Hearing. Appeal Request forms and more information are available at:
http://www.dmas.virginia.gov/#/appealsresources

Provider Appeals

The first level of a provider appeal is a reconsideration with the health plan. For services that have been rendered, providers have the right to appeal adverse actions. If a provider has rendered services to a member enrolled with the health plan in a Medicaid program and has either been denied authorization or reimbursement for the services or has received reduced authorization or reimbursement, that provider

can request a reconsideration of the denied or reduced authorization or reimbursement. Before appealing to DMAS, providers must first exhaust the Contractor's reconsideration process. Providers in the health plans' network may not appeal the health plan's enrollment or terminations decisions to DMAS.

A provider appeal is a request for a neutral party to review the action taken by the Department of Medical Assistance Services (DMAS) or one of its contractors that impacts either your reimbursement for services you have rendered to a Medicaid recipient or your enrollment as a Medicaid participating provider. It is a two-step process that begins with an informal appeal. If you disagree with the decision issued, the second step is to file a formal appeal. More information is available at:
http://www.dmas.virginia.gov/#/appealsresources

Billing

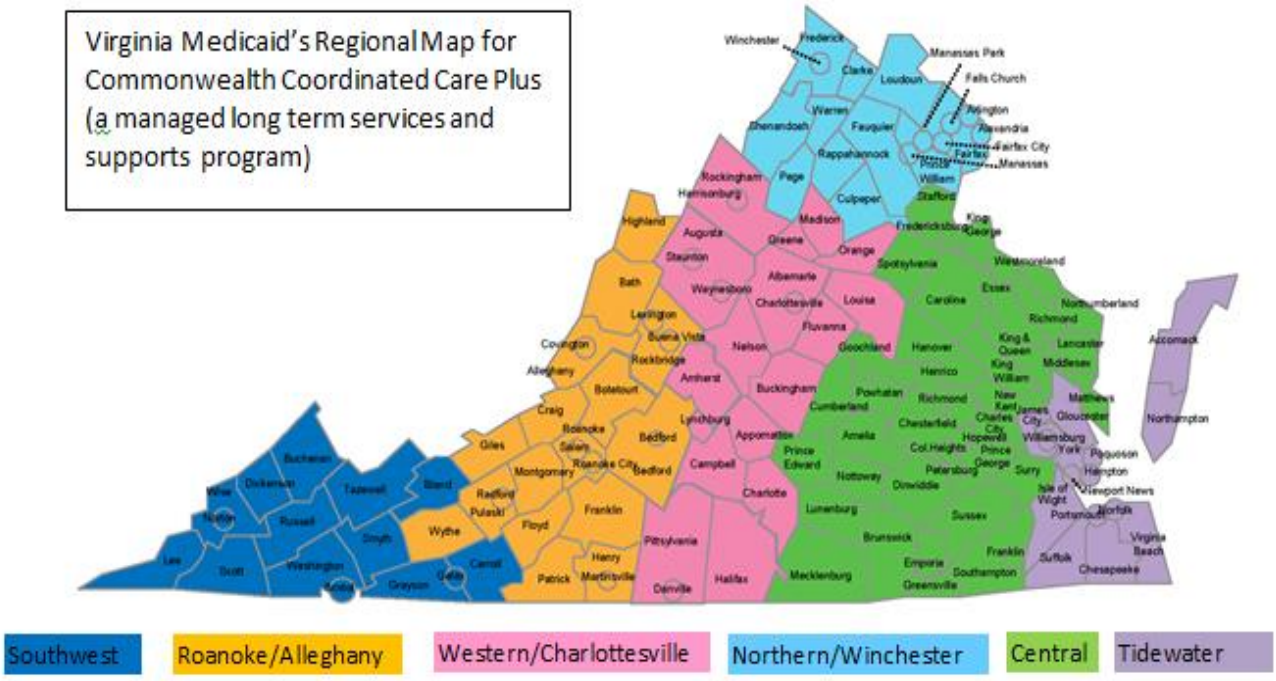
MCOs will pay providers at least the Medicaid rate for Nursing Facilities, waivers, behavioral health and early intervention services. All MCOs have multiple methods of claim submission. "Clean claims" for LTSS Medicaid-covered services will be paid within 14 days. Billing methods are detailed in the charts described above. Please see the MCO Directory by Region for contact information for the health plans under the information section of the CCC Plus Provider/Stakeholder page:
http://www.dmas.virginia.gov/#/cccplusproviders

Providers should reach out to the health plan to resolve any authorization or billing issues. If you cannot resolve an issue with the health plan, please email cccplus@dmas.virginia.gov for assistance.

Coordination of Benefits with Medicare and Other Insurance

In accordance with the CCC Plus Contract, Section 12.4.11 and 12.4.12, the CCC Plus health plans are required to coordinate benefits with Medicare and other insurance carriers for services covered under the CCC Plus contract. In addition, the contract specifies in Sections 11.6 and 11.7 that the member is not subject to cost sharing and the member is not held financially liable for Medicaid covered services including coinsurance, copayments, deductibles, financial penalties, or any other amount other than any Patient Pay established by Department of Social Services (DSS) towards Long Term Support Services (LTSS). Attachment 15 Clarification of Coordination of Benefits with Medicare and Other Insurance Medicaid Memorandum July 13, 2018 and Attachment 16 MCO Coordination of Benefits Resource Chart in the CCC Plus contract provide additional information.

Commonwealth Coordinated Care Plus Regions



CCC Plus operates statewide across 6 regions. A list of CCC Plus regions by locality is available at: http://www.dmas.virginia.gov/#/cccplusinformation

Member Enrollment for a CCC Plus Medicaid Health Plan

Choosing a Health Plan

Each member has a choice between six CCC Plus Medicaid Health Plans. Members receive an assignment letter that includes a brochure, and a comparison chart of all the health plans. The assignment letter informs members of their health plan and that they have 90 days to choose a different health plan. During the first ninety (90) calendar days of the member's CCC Plus program enrollment, the member can change health plans for any reason. To change their health plan, they must call the CCC Plus Helpline at 1-844-374-9159 or use the website at: https://cccplusva.com/. The member can also change their health plan once a year during open enrollment. They will receive a letter during open enrollment with more information.

How Members Can Verify Provider Enrollment

A trained helpline representative can look up the caller's doctors or other healthcare providers to ensure they are in the MCO network. They are also able to review each plan available in the caller's area. This information is also available on the https://cccplusva.com/.

How Providers Can Verify Member Enrollment

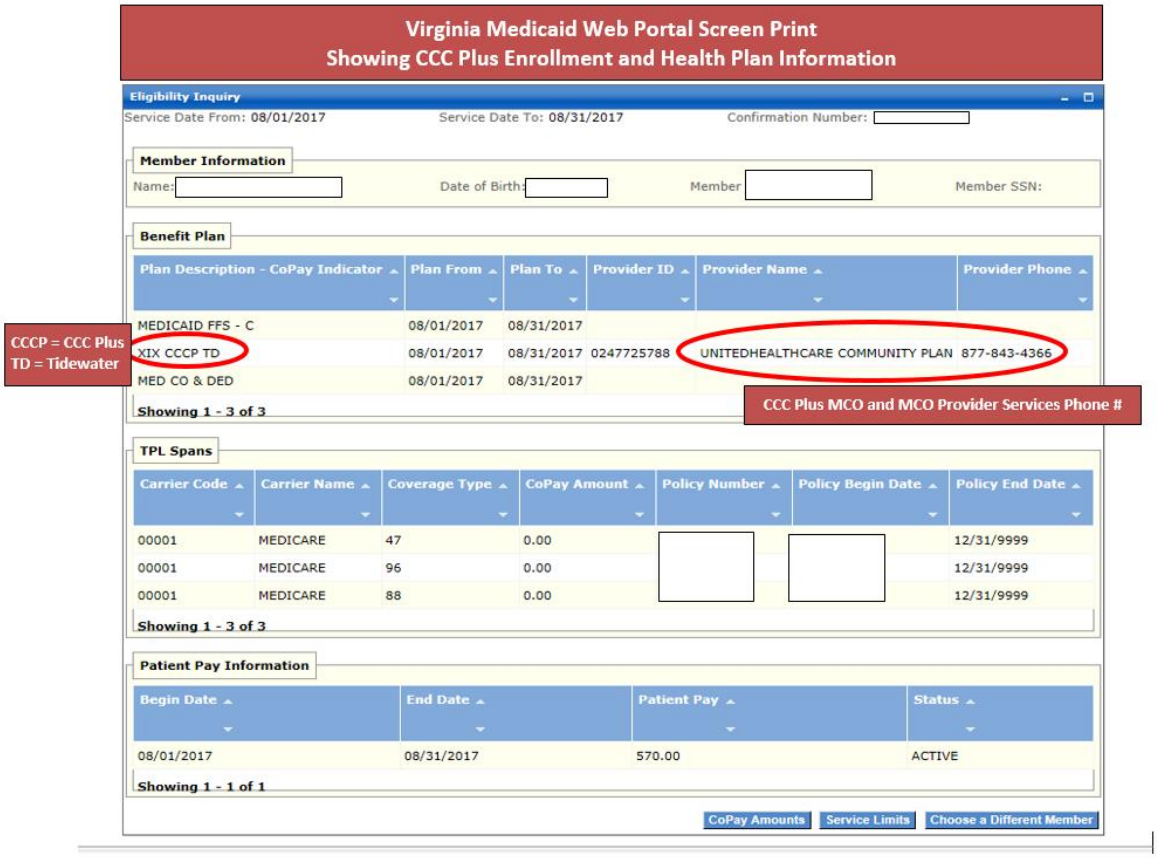
It is important for providers to verify a member's Medicaid eligibility at each point of service. Verification of a member's participation in CCC Plus can be done through the DMAS MediCall audio response system (1-800-884-9730 or 1-800-772-9996) or the DMAS web-based internet option, available on the Virginia Medicaid Web Portal, at: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal. As members are assigned to a CCC Plus health plan, the status of the enrollment is reflected in the member eligibility information data available on the 21st of every month for the first of the following month. For example, Medicaid enrolled providers can see assignment information beginning on July 21 for individuals who have an August 1st start date in the Tidewater Region.

Both options are available at no cost to the provider. The web-based, automated response system (ARS) limits the provider's verification submission to 10 members at a time. CCC Plus enrollment can also be verified through the member's health plan.

Eligibility Verification and MCO Enrollment	
Automated Response System (ARS) www.virginiamedicaid.dmas.virginia.gov	• Web-based Internet option • Available 24/7 free of charge to registered providers • Allows providers to check up to 10 members at a time • Medicaid Expansion will show as "MEDICAID EXP"
MediCall Telephonic System Toll Free 1-800-772-9996 and 1-800-884-9730 Richmond and Surrounding Counties (804) 965-9732 and (804) 965-9733	• Telephone audio response system • Available 24/7; free of charge to providers • Caller may check up to three dates of service for each member and inquire on up to three members per call • Medicaid Expansion will be spoken as "Medicaid Expansion"
Electronic Data Interchange (EDI) Eligibility Transaction (270/271)	• For Batch 270 transactions submitted by 9:00 p.m., the 271 batch response transactions will normally be available for pickup by 6 a.m. the following business day. Not available on the weekend. • Batch process is limited to 100,000 eligibility requests per Service Center per day • 271 – responds with "MEDICAID EXP" in the R701-ENRL-BENEFIT-PLAN field*

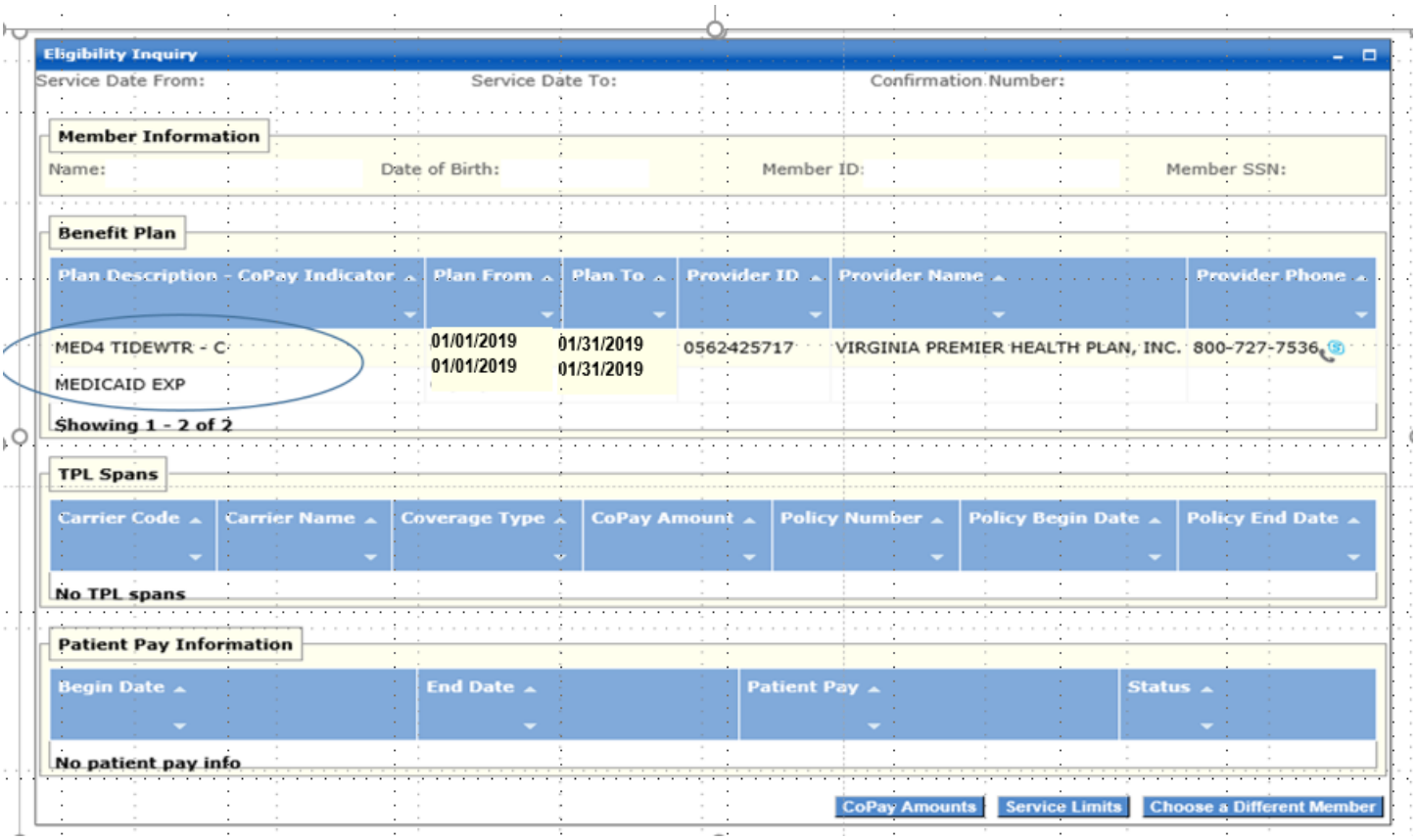
Further information is available here: https://www.virginiamedicaid.dmas.virginia.gov ; select the "EDI Support" tab, "EDI Companion Guides". Under heading "5010 Companion Guides", select 270/271 Health Insurance Eligibility Request/ Response Verification for Covered Benefits (5010) and "Virginia Department of

Medical Assistance Services Companion Guide For 270/271 Batch Health Care Eligibility Inquiry and Response Transactions Version 1.9 Updated 05/25/18".



Medicaid Expansion example

A sample screen shot from the **Automated Response System (ARS)** is below. In this example, the individual is in Medallion 4 "MED4" and is a Medicaid Expansion "MEDICAID EXP" member, as shown on line 2 in the plan description area.



<u>CCC Plus Costs</u>

There are very few member co-pay responsibilities in the CCC Plus program:

- ❖ NO premiums
- ❖ NO co-payments for doctor or specialist visits
- ❖ SOME co-payments for prescriptions for Part D drugs
- ❖ NO co-payments or premiums for extra benefits
- ❖ CONTINUE to pay long-term services and supports patient pay amounts (as determined by the Member's Medicaid eligibility worker through the local Department of Social Services.)

<u>Services for the Medicaid Expansion Population</u>

There are few differences between these two populations. There are four mandatory covered benefits for Medicaid Expansion members. Those benefits are:

- Annual wellness exams
- Adult immunizations
- Smoking cessation
- Nutritional counseling

How to Become a Medicaid Provider

All providers who wish to participate with Virginia Medicaid can complete their request via online enrollment through the Virginia Medicaid web-portal. If you are unable to enroll electronically through the web, you can download a paper application from the web-portal and follow the instructions for submission. Please go to www.virginiamedicaid.dmas.virginia.gov to access the online enrollment system or to download a paper application. If you have any questions regarding the online or paper application process, please contact Provider Enrollment Services at 1-888-829-5373 or 1-804-270-5105.
Most individuals enrolled in the Medicaid program have their services furnished through DMAS-contracted Managed Care Organizations (MCOs) and their network of providers. For providers to participate with one of the MCOs, in addition to enrolling with Virginia Medicaid, they must be credentialed by the MCO and contracted in the health plan's network. The credentialing process can take at least three months to complete. Contact information for contracting and credentialing for each MCO within the Medallion 4.0 and CCC Plus programs is available below.

Managed Care Credentialing Contact Information

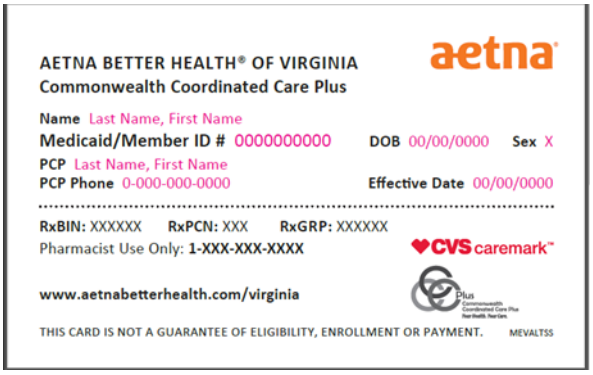
Aetna Better Health of VA	Vacredentialing-aetna@aetna.com
Anthem HealthKeepers Plus	Acute: Taylor Rhodes William.Rhodes@anthem.com Phone: 804-354-3089 Fax: 804-354-4601 LTSS: Marvin Brown Marvin.Brown@anthem.com Phone: 757-408-5138
Magellan Complete Care of VA	MCCVAprovider@magellanhealth.com Phone: 1-800-424-4524
Optima Health	Medical/Facility Providers: Email: MedProviderApp@Sentara.com Medical New Provider Application Phone: 757-552-8892 Fax: 757-552-7576 Behavioral Health Providers BHCredentialing@Sentara.com Behavioral Health New Provider Application LTSS Providers: Nancy C Everitt, HEOPS, Inc. dba The CENTIPEDE Health Network Email: neveritt@HEOPS.com joincentipede@heops.com PH: 855-359-5391 Fax: 866-421-4135

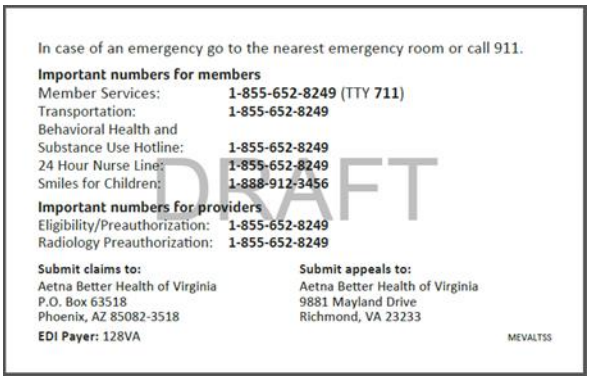
UnitedHealthcare	HCBS Providers: • Contact: Adrienne Collins • Phone: 952-406-6982 • Email: Adrienne_r_collins@uhc.com Behavioral Health Providers: • Email : VACCCBH@optum.com • Web : www.providerexpress.com and then select: o Quick Links >> o Join Our Network Hospitals, Ancillary, Physicians & SNFs: • Phone: 877-842-3210 • Web: www.uhcprovider.com From the menu icon select: Resource Library; Join Our Network
Virginia Premier	VPCred@virginiapremier.com 855-813-0385 Name: Kimberly Paige Email:Kimberly.Paige@vapremier.com Phone: 804-819-5151 ext. 55352 Fax: 804-819-5171

The ID cards Medicaid Expansion members receive will look the same as ID cards for CCC Plus members.

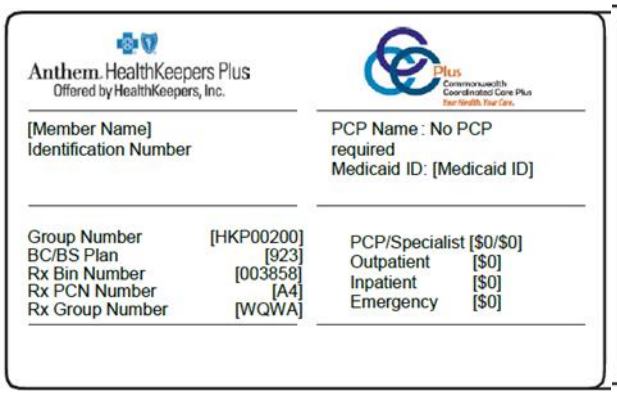
Sample of Member ID Cards for each Health Plan

Aetna Better Health of Virginia:

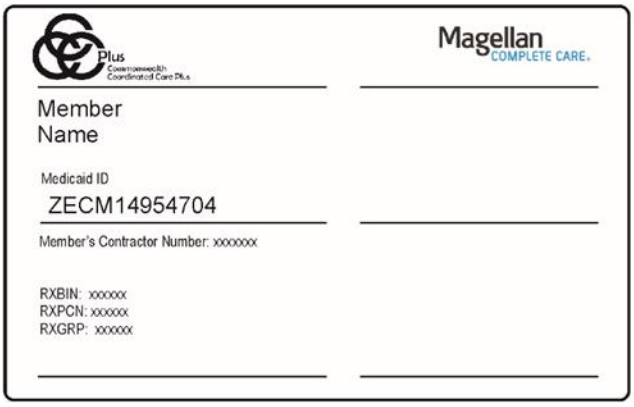


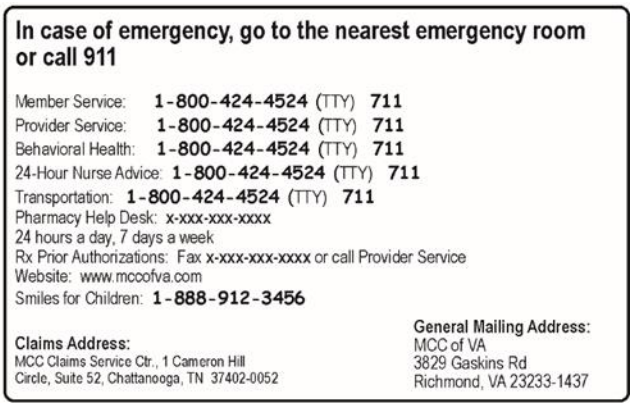


Anthem HealthKeepers Plus:



Magellan Complete Care of Virginia:





Optima Health Community Care:

Plus Commonwealth Coordinated Care Plus

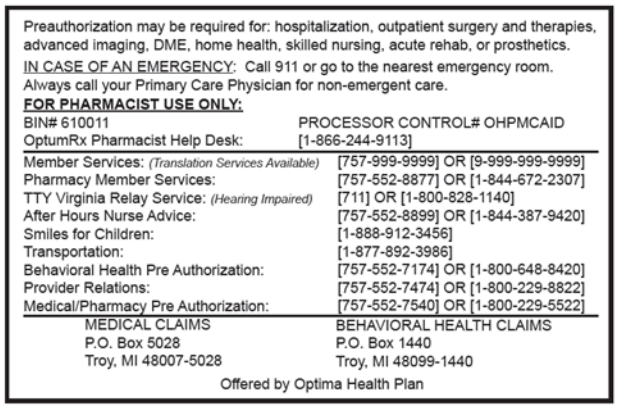
OptimaHealth

OPTIMA HEALTH COMMUNITY CARE

Member Name: JOHN DOE
Member Number: 9999999*99
Group Number: 999999
Member Effective Date: 99-99-99
PCP Name: 999999999999999999999
PCP Phone: 999-999-9999

Medicaid #: 999999999999
DOB: 99-99-9999

Detailed benefit information is available at optimahealth.com



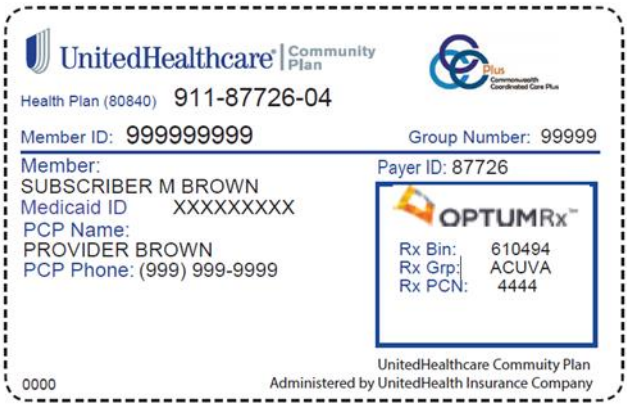
Preauthorization may be required for: hospitalization, outpatient surgery and therapies, advanced imaging, DME, home health, skilled nursing, acute rehab, or prosthetics.
IN CASE OF AN EMERGENCY: Call 911 or go to the nearest emergency room.
Always call your Primary Care Physician for non-emergent care.
FOR PHARMACIST USE ONLY:

BIN# 610011	PROCESSOR CONTROL# OHPMCAID
OptumRx Pharmacist Help Desk:	[1-866-244-9113]
Member Services: *(Translation Services Available)*	[757-999-9999] OR [9-999-999-9999]
Pharmacy Member Services:	[757-552-8877] OR [1-844-672-2307]
TTY Virginia Relay Service: *(Hearing Impaired)*	[711] OR [1-800-828-1140]
After Hours Nurse Advice:	[757-552-8899] OR [1-844-387-9420]
Smiles for Children:	[1-888-912-3456]
Transportation:	[1-877-892-3986]
Behavioral Health Pre Authorization:	[757-552-7174] OR [1-800-648-8420]
Provider Relations:	[757-552-7474] OR [1-800-229-8822]
Medical/Pharmacy Pre Authorization:	[757-552-7540] OR [1-800-229-5522]

MEDICAL CLAIMS	BEHAVIORAL HEALTH CLAIMS
P.O. Box 5028	P.O. Box 1440
Troy, MI 48007-5028	Troy, MI 48099-1440

Offered by Optima Health Plan

UnitedHealthcare Community Plan:



UnitedHealthcare Community Plan

Plus Commonwealth Coordinated Care Plus

Health Plan (80840) 911-87726-04

Member ID: 999999999 Group Number: 99999

Member:
SUBSCRIBER M BROWN
Medicaid ID XXXXXXXXX
PCP Name:
PROVIDER BROWN
PCP Phone: (999) 999-9999

Payer ID: 87726

OPTUMRx

Rx Bin: 610494
Rx Grp: ACUVA
Rx PCN: 4444

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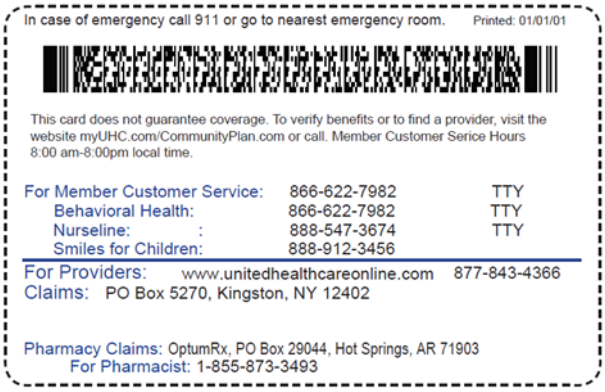
UnitedHealthcare Community Plan
Administered by UnitedHealth Insurance Company



In case of emergency call 911 or go to nearest emergency room. Printed: 01/01/01

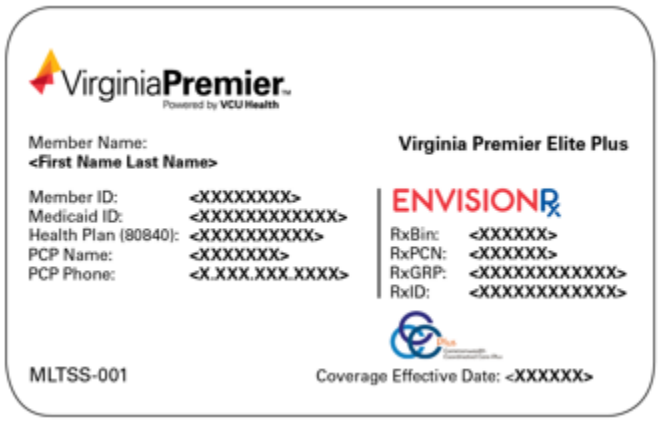
This card does not guarantee coverage. To verify benefits or to find a provider, visit the website myUHC.com/CommunityPlan.com or call. Member Customer Serice Hours 8:00 am-8:00pm local time.

For Member Customer Service:	866-622-7982	TTY
Behavioral Health:	866-622-7982	TTY
Nurseline:	888-547-3674	TTY
Smiles for Children:	888-912-3456	

For Providers: www.unitedhealthcareonline.com 877-843-4366
Claims: PO Box 5270, Kingston, NY 12402

Pharmacy Claims: OptumRx, PO Box 29044, Hot Springs, AR 71903
For Pharmacist: 1-855-873-3493

Virginia Premier Health Plan:



VirginiaPremier
Powered by VCU Health

Member Name:
<First Name Last Name>

Virginia Premier Elite Plus

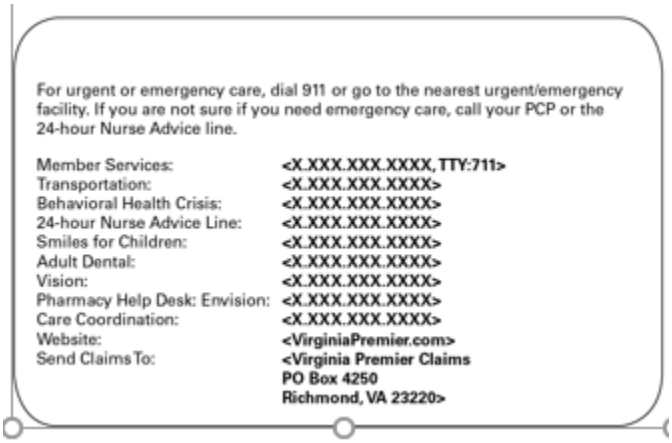
Member ID: <XXXXXXXX>
Medicaid ID: <XXXXXXXXXXX>
Health Plan (80840): <XXXXXXXXX>
PCP Name: <XXXXXXX>
PCP Phone: <X.XXX.XXX.XXXX>

ENVISIONRx

RxBin: <XXXXXX>
RxPCN: <XXXXXX>
RxGRP: <XXXXXXXXXXX>
RxID: <XXXXXXXXXXX>

MLTSS-001

Coverage Effective Date: <XXXXXX>



For urgent or emergency care, dial 911 or go to the nearest urgent/emergency facility. If you are not sure if you need emergency care, call your PCP or the 24-hour Nurse Advice line.

Member Services:	<X.XXX.XXX.XXXX, TTY:711>
Transportation:	<X.XXX.XXX.XXXX>
Behavioral Health Crisis:	<X.XXX.XXX.XXXX>
24-hour Nurse Advice Line:	<X.XXX.XXX.XXXX>
Smiles for Children:	<X.XXX.XXX.XXXX>
Adult Dental:	<X.XXX.XXX.XXXX>
Vision:	<X.XXX.XXX.XXXX>
Pharmacy Help Desk: Envision:	<X.XXX.XXX.XXXX>
Care Coordination:	<X.XXX.XXX.XXXX>
Website:	<VirginiaPremier.com>
Send Claims To:	<Virginia Premier Claims PO Box 4250 Richmond, VA 23220>