PROVIDER NEWS

A newsletter for the Highmark Blue Cross Blue Shield West Virginia providers

HIGHMARK

Issue 9, September 2025

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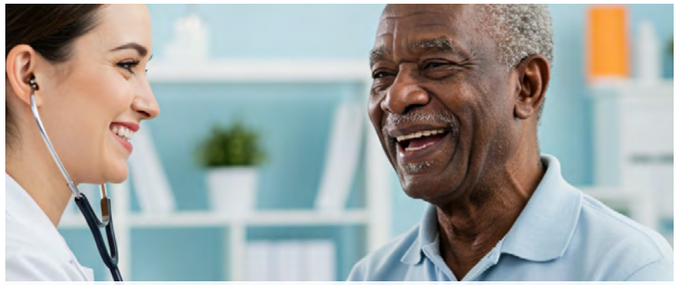

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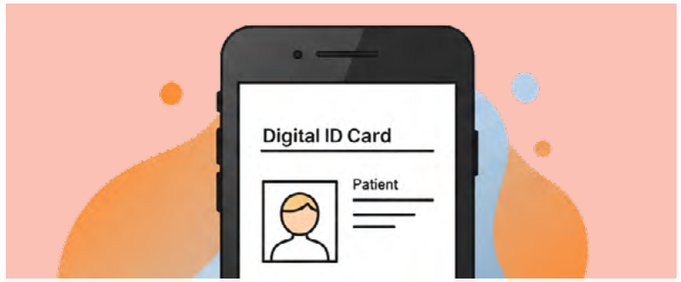

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Upcoming Site of Care Program Impacts Certain OUTPATIENT SURGERIES

Effective **Jan. 1, 2026**, Highmark will launch a program that outlines site of care clinical review requirements for certain low-risk outpatient surgeries. This initiative aims to improve efficiency by encouraging utilization of freestanding Ambulatory Surgery Centers (ASCs) or office-based settings, where appropriate.

Evidence has shown that for select procedures and patients, ASC and office-based settings are more convenient, and represent better value for patients.

While Highmark strongly encourages the utilization of ASCs or office-based settings for eligible procedures, we recognize that certain clinical situations may necessitate a hospital outpatient setting. Providers may perform the procedures in a hospital outpatient department setting under specific criteria, including:

- **Patient complexity and comorbid conditions.**
- **Geographic limitations (e.g., access to ASCs in rural areas).**
- **Clinical judgment and other factors.**

Site of care clinical review requirements will apply to Highmark fully insured Commercial, Affordable Care Act (ACA), and Medicare Advantage (MA) members. Please confirm member benefits to ensure in-network site of care requirements apply.

(Continued)

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Medical Policy Updates

Two new medical policies — Medical Policy Z-109 (Commercial) and Medical Policy Z-129 (Medicare Advantage) — outline the procedures and site of care clinical review requirements. Site of care clinical review will be applicable to a wide variety of surgical procedures, as defined in the medical policies. Highmark regularly reviews its policies to ensure alignment with nationally recognized clinical evidence, safety, and compliance guidelines. As such, the procedures covered under our site of care policies are subject to change and may vary across lines of business.

The policies will be published on Highmark's Medical Policy Search sites on **Oct. 1, 2025**. You can access the search sites on the Provider Resource Center (PRC). Click on **Policies & Programs > Medical Policies** and then the search sites for your state:

West Virginia – Commercial and Medicare Advantage

Submitting Authorization Requests

Providers can submit authorization requests for site of care clinical review through Availity Essentials®, our provider portal. Submitting electronically leads to faster reviews and response times.

Additional information on authorization submission can be found under **Claims & Authorization** on the Provider Resource Center or in the *Highmark Provider Manual*: Chapter 5, Unit 2 (Authorizations).

To ensure you receive important updates on Highmark policy and program changes, join our mailing list and receive our monthly newsletter in your email inbox.

We are confident that this collaborative approach will enhance the quality of care while ensuring affordability and access for all our members. We appreciate your cooperation and partnership in this important initiative.

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Medicare Advantage Network Updates: **What Providers NEED TO KNOW**

As part of our ongoing commitment to providing our members with access to high-quality, affordable, comprehensive care, Highmark continually evaluates our provider networks to ensure they meet evolving member and market needs.

Aligned with this commitment, Highmark is updating select Medicare Advantage networks, effective **Jan. 1, 2026**. Impacted providers and members will receive letters outlining these changes and what they may mean for them.

Note: These changes do **not** impact Commercial or Affordable Care Act (ACA).

As a Highmark participating provider, here are some steps you can take to confirm you know the networks in which you participate — and ensure your patients do not incur any unexpected costs.

1) Verify Your Network Status

You can view your network status using our self-service tools.

PROFESSIONAL PROVIDERS:

- Use the Provider Data Maintenance (PDM) tool on Availity Essentials® to confirm your participation status in all Highmark networks.
  - » Log into Availity.
  - » Navigate to Highmark's Payer Spaces.
  - » Select the appropriate health plan payer.
  - » Find PDM under "Applications."
  - » Select an organization.
    - – A PDM user guide is available under "Resources" in Highmark's Payer Spaces.

(Continued)

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FACILITY AND ANCILLARY PROVIDERS:

Call Provider Service at **800-543-7822** and a representative can provide details on your network status.

2) Check Member Eligibility

Verify member eligibility and benefits before appointments through Availity's **Patient Registration** feature. This helps ensure members receive in-network care and avoid unexpected costs.

You will need the Member ID, date of birth, and specific service information.

3) Verify Network Status for Referrals

Confirm that the provider you are referring a member to is in-network for the member's specific plan.

You or your patients may use our online **Provider Directory** to verify in-network provider participation at any time.

- Visit Highmark.com/Find-Care.
- Scroll down on the page and find the region that's closest to your address, then select **Find Care**.
- Select **Find a Doctor** under the **Find Care** section.
- On the pop-up window, click "Choose a location and plan." Enter your **ZIP Code** and then click on the **Don't know your alpha prefix? Browse a list of plans** link to select a plan from the list.
- Choose how you want to search.
  - You can enter a doctor name or specialty, a facility name or type, or just **search all**.

A link to the **Provider Directory** is also available on the Provider Resource Center under Provider Network in the main website menu.

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UPDATE to Highmark's Medicare Advantage Professional Physician Office Laboratory Fee Schedule

Effective Jan. 1, 2026, Highmark is updating our standard Medicare Advantage (MA) professional physician office laboratory fee schedule, which applies to the following Highmark service areas — Delaware, New York, Pennsylvania, and West Virginia.

This update is part of Highmark's continued effort to align with industry standard values, including the Clinical Laboratory Fee Schedule created by the Centers for Medicare and Medicaid Services (CMS).

Background

Adjustments to the MA standard professional physician office laboratory fee schedule and pricing methodology enables Highmark to:

- Make changes that reflect current factors and trends in the marketplace.
- Continue to bring our fee schedules in closer alignment with Highmark's value-based reimbursement strategies through uniform standard fees based on a percentage of CMS pricing.

How to Access Updated Laboratory Fees

You can review updated fees via the single-code lookup function within Availity Essentials® beginning **Dec. 1, 2025**.

Log into Availity, select **Claims & Payments** from the task bar, and then click **Fee Schedule Listing**. Once there, input your organization's information, select your Highmark plan, and complete the remaining required fields. Next add the procedure code, including any required modifier. Click **submit** and you will receive the fee for this specific procedure.

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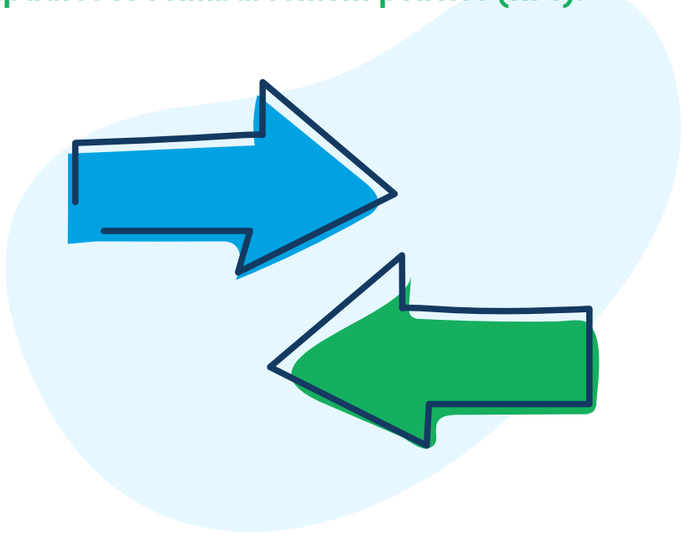
New and Updated Reimbursement Policies

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

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



UPCOMING

Dec. 1, 2025

RP-029 Surgical Techniques, Procedures and Related Services

Policy will be made applicable to Medicare Advantage.

RP-033 Anesthesia Services

A section for Epidural Anesthesia will be added and direction for modifiers QK and QY reductions will be clarified. Codes 62273, 62281, 62282, and 01967-01969 will be added.

RP-077 Intraoperative Neurophysiological Monitoring

Direction will be added for codes 95941 and G0453. Code 95941 will no longer be separately reimbursed.

Jan. 1, 2026

RP-068 Mid-Level Practitioners and Advanced Practice Providers

This policy will be updated for Medicare Advantage to add direction for the pharmacist specialty, which will be reimbursed at 85% of the fee schedule allowance.

NEW: RP-083 Spravato® (esketamine)

This new policy — applicable to Commercial and Medicare Advantage markets — will provide direction on the billing of esketamine (Spravato) services.

Jan. 5, 2026

RP-027 Hemodialysis and Peritoneal Dialysis

This policy will be made applicable to Medicare Advantage. Codes 99242-99245 and 99252-99255 will be removed. Codes 90993, 90999, 99233, 99291, 99292, 99341, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, S9335, and S9339 will be added.

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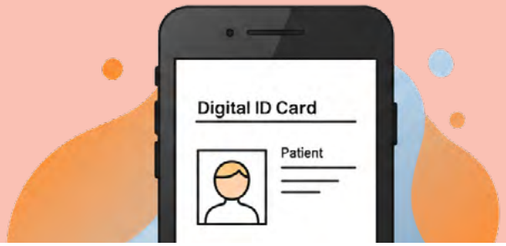
Navigating Digital Member ID Cards



With everyone going paperless these days — including many health plans — Highmark will offer "digital only" member ID cards to our Commercial members in 2026. Beyond member convenience, digital ID cards offer real-time eligibility and benefits information as well as greater security. Commercial members may "opt into" digital only cards; those that do will not receive a physical ID card.

In fact, most Highmark members already have access to digital ID cards on their MyHighmark app and we know some prefer not to carry a physical card. Your office is also probably seeing digital ID cards from other payers.

Highmark eligibility and benefits should always be verified in our provider portal Availity Essentials® regardless of whether a digital or physical member ID card is presented.

If your office workflow includes documenting eligibility by scanning or copying a physical ID card, you have options.

Our member ID cards can be printed or saved as a PDF from Availity:

- Hover over the **Patient Registration** tab and click **Eligibility and Benefits Inquiry**
- Search for the patient using one of the search options, including:
  - Member ID/Policy Number + Date of Birth
  - Member Last Name + First Name + Date of Birth
  - Member ID/Policy Number + Member First Name + Last Name
- Select the member when they populate by clicking **Submit**
- The next screen will display the **Eligibility & Benefits Detail**
- Click the **Member Card** button, which will bring up the front and back of the card
- Click the **Print** button to print or save the card as a PDF

Members also may download or take a screen capture of their card in their MyHighmark app and email or text it to your office. Members can find their card in their MyHighmark app:

- Go to the **My Benefits** tab
- Click on their plan name — this will bring up their digital card with an option to view the front or back of the card right on their phone
- Card options in the app include **Print Card** or **Download Card**

If you are not already accessing Availity for eligibility and benefits checks, please click here to register with Availity.

Note: *Member cards are not available in Availity for Federal Employee Plan (FEP) members or BlueCard (members of a non-Highmark Blue Cross and/or Blue Shield plan.)*

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RadCard Authorization Moving from eviCore to Highmark

Effective Dec. 2, 2025, the management of advanced imaging and cardiology (RadCard) authorization is transitioning from eviCore to Highmark.

You'll need to submit RadCard auth requests via the **Authorizations & Referrals** process within the Availity Essentials® portal.

As part of this change, Highmark will leverage Availity's AuthAI tool to streamline the review of RadCard authorization requests.

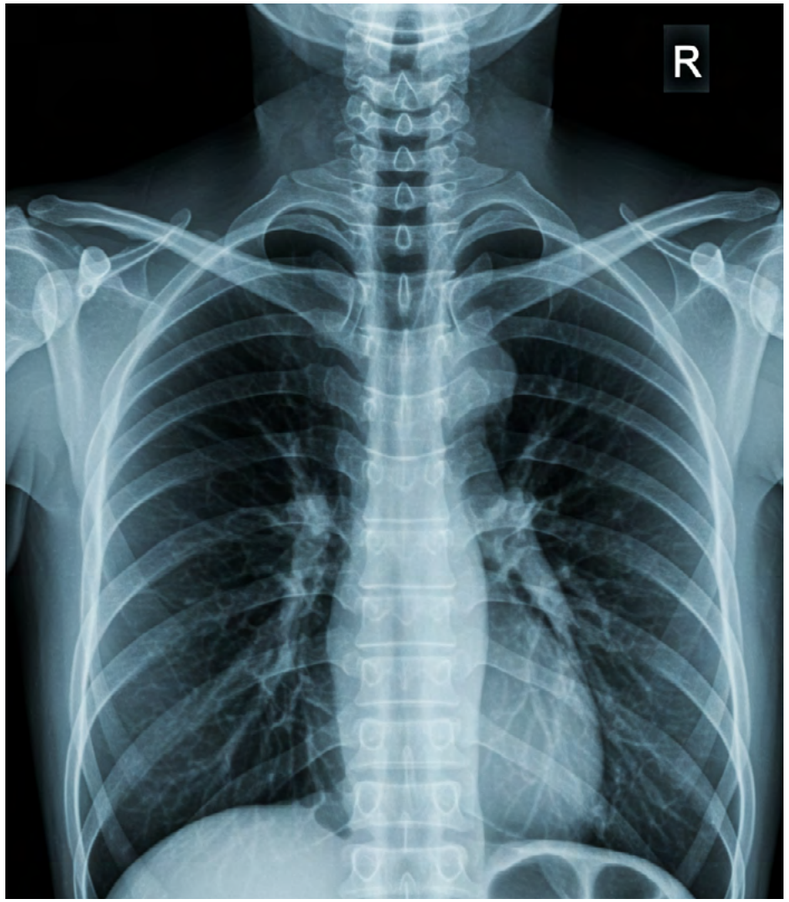
During the submission process within Availity, you may be asked for additional information to assist with quicker decisions regarding the request.

What This Means for You

- This change may lead to faster authorization determinations.
- When submitting authorization requests, you may be prompted by Highmark to provide additional information, which will help accelerate the decision-making process.
- This system upgrade is part of our transition from Predictal to Availity's **Authorizations & Referrals** for initial medical authorization requests.

Stay Informed

Sign up for our mailing list to receive timely updates and announcements via email.



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Additional Drugs DESIGNATED AS VOLUNTARY for Highmark's Medical Injectable Drug Program

Effective Jan. 1, 2026, Highmark is designating additional drugs as **voluntary** for the Medical Injectable Drug Program.

Highmark continually evaluates the program and makes changes as appropriate. When drugs are added as voluntary, this means physicians may choose to purchase and bill Highmark directly for those drugs and will receive reimbursement as outlined in the program.

Please use Availity Essentials® to access the proposed rate on the effective date for each drug listed below:

HCPCs	Drug Name
Q5153	Opuviz
Q5147	Pavblu
Q5149	Enzeevu
Q5150	Ahzantive
Q5135	Tyenne IV and SC
Q5098	Imuldosa IV and SC
Q5099	Steqeyma IV and SC
Q5100	Yesintek IV and SC
Q5137	Wezlana SC
Q5138	Wezlana IV
Q9996	Pyzchiva SC
Q9997	Pyzchiva IV
Q9998	Selarsdi IV and SC
Q9999	Otulfi IV and SC
Q5133	Tofidence
J1299*	Soliris
Q5151	Epysqli
Q5152	Bkemv
Q5134	Tyruko

**Applicable Site of Care (SOC) rates apply only to Home Infusion Therapy (HIT) and Ambulatory Infusion Suites (AIS) providers.*

Accessing Fee Schedules

Once you log into Availity, select **Claims & Payments** from the task bar and then **Fee Schedule Listing** from the right side. You can also access fee schedules by going to **Payer Spaces** in Availity, and then select **Provider Resource Center (PRC)** under Applications. Once you arrive at the PRC, choose **Claims & Authorization** and then click **Fee Schedule Information**.

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Rx Processing Changes for Three Drugs Effective Jan. 1, 2026

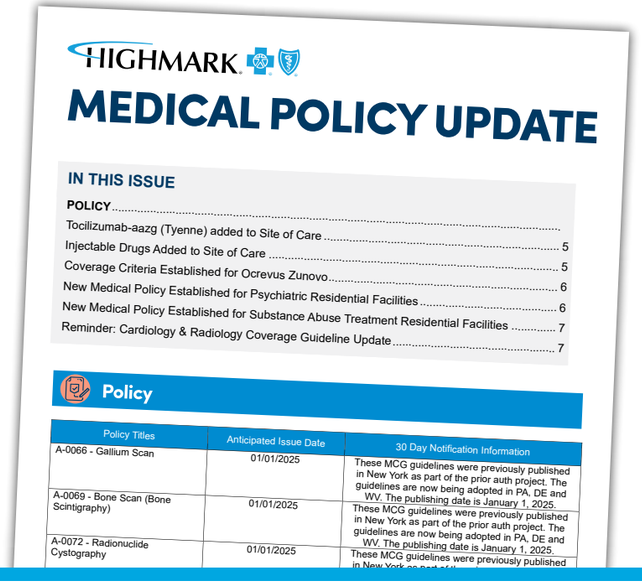
At Highmark, we're taking action to ensure our members are accurately billed for the treatment they receive and that providers are accurately reimbursed for the care they deliver.

Highmark implemented the **Channel Alignment Program** to ensure that drugs — which are more appropriately billed through the pharmacy benefit — are **not** billed under the medical benefit.

As part of Channel Alignment Program, Highmark will shift certain drugs to process from members' medical coverage to their prescription drug coverage, according to the terms of their Highmark plan. **Effective Jan. 1, 2026**, the following drugs (and procedure codes) will be included in this program.

Procedure Code	Drug Name
J3357	Stelara SC
Q9997	Pyzchiva
Q5137	Wezlana

Have You Seen This Month's Medical Policy Update Newsletter?



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MEDICAL POLICY UPDATE

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Policy

Policy Titles	Anticipated Issue Date	30 Day Notification Information
A-0066 - Gallium Scan	01/01/2025	These MCG guidelines were previously published in New York as part of the prior auth project. The guidelines are now being adopted in PA, DE and WV. The publishing date is January 1, 2025.
A-0069 - Bone Scan (Bone Scintigraphy)	01/01/2025	These MCG guidelines were previously published in New York as part of the prior auth project. The guidelines are now being adopted in PA, DE and WV. The publishing date is January 1, 2025.
A-0072 - Radionuclide Cystography	01/01/2025	These MCG guidelines were previously published

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How to Credential with Highmark Using the Certify Platform

Effective Nov. 3, 2025, Highmark will incorporate the CertifyOS platform into our credentialing processes for professional and organizational providers in New York, Pennsylvania, and West Virginia.

What Is Changing

Professional Providers
You should continue to enroll in our health plan by registering with the Council for Affordable Quality Health Care (CAQH) and continue to use the Initial Credentialing Request Form; at the end of the form, you will click a link for the Certify intake portal.

Organizational Providers
Instead of three different credentialing applications on the Provider Resource Center (PRC), there will be a single enrollment form that can be used by all organizational providers, including:

- Facility and Ancillary
- Behavioral Health
- Urgent Care Center/Medical Aid Unit and Retail Clinic

The new form, which will be available on Nov. 3, will link to the Certify portal.

Getting Started... with Certify

Once on the Certify portal, set up your user account. Follow the prompts. You'll need the following information, as applicable to your provider type:

- National Provider Identifier (NPI) number
- CAQH ID
- Drug Enforcement Administration (DEA) number
- Board certification
- Proof of liability insurance
- Email address
- Resume or CV
- Social Security number

Important: All uploaded documents should be in PDF format.

To begin the credentialing process, providers must complete the **Highmark Provider Application** located within the Certify intake portal.

Do I still need to complete the CAQH application?

Yes, you will need to complete the CAQH application. Be sure to add Highmark as an authorized plan or grant global authorization.

Will I need to provide additional documentation?

Some providers may need to supply additional documents — such as Proof of Malpractice Insurance, Certificate of Insurance (COI), or Licensure — relevant to the credentialing and re-credentialing process. If you receive a request for additional documents, we ask that you respond in a prompt manner.

By completing the Certify and CAQH applications, am I now credentialed?

Your participation and ability to treat Highmark members doesn't begin until you have successfully been credentialed by Highmark. Please do not see members or submit claims until you have been notified of acceptance into Highmark's credentialed networks.

For more on our credentialing process, go here.

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NEW WV LAW Allows Optometrists to Perform Laser Surgery

Effective July 9, 2025, Senate Bill 565 amended the West Virginia Code related to optometry, expanding the scope of practice to include laser surgery for providers who meet specific certification requirements.

To perform laser procedures, optometrists must obtain an **Ophthalmic Laser Utilization Certificate** from the West Virginia Board of Optometry. If you have a laser certificate, please submit a copy of your laser certification to Highmark via this link.

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SHORT TAKES: Availity Auth Training, Onboarding Webinar, and More

Availity Auth Process – On-Demand Training

To allow for additional testing, the transition to the **Authorizations & Referrals** process in Availity Essentials®, which was scheduled for Sept. 23, 2025, has been temporarily delayed. The new go-live date will be posted on the Provider Resource Center.

You can prepare for the transition by viewing a recording of a live training session — as well as other on-demand demos on the authorization process — in the Availity Learning Center (ALC).

To access the ALC:

- Log into Availity.
- Go to the **Help & Training** tab on the homepage.
- Click Get Trained from the drop-down menu to view recorded demos and webinars.
- Select: Authorization Request and Follow-up for Highmark Providers – Recording.

Onboarding Webinar for Providers New to Highmark

Learn best practices for navigating Highmark systems, accessing provider manuals and tools, utilizing Availity Essentials, and more. Held on the third Thursday of each month, these webinars will feature live Q&A with our experts.

Who Is Invited

- Providers new to the Highmark network.
- Providers new to a practice or facility.
- Existing provider staff seeking updated information or a refresher.

To attend the session on **Thursday, Oct. 16, 12–1 p.m.**, click here.

Network Exception Question: Answer "No" Unless Requesting Out-of-Network Exception

Highmark recently rolled out new functionality in the Predictal Auth Automation Hub that allows providers to request a gap exception/Out-of-Network referral when submitting a prior authorization request.

However, for the vast majority of prior auth submissions, the answer to the Network Exception question is "**No**". *If you select "Yes" incorrectly, it will delay your prior authorization request.*

For all in-network prior authorization requests, providers should select "**No**". To learn more, go here.

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Breast Cancer Awareness Month: Tips for Rescheduling Patients before January

Consistency matters when it comes to annual breast cancer screenings. You and your team know that. So do most of your patients. But life gets in the way sometimes, and annual appointments can get missed or canceled. When that happens, these patients can easily slip through the system.

Breast Cancer Awareness Month, which occurs during October, is always a good time to re-engage patients. Media coverage creates greater awareness about the importance of annual screenings. The following tips can help your practice reschedule patients:

- **Prompt Outreach:** Contact the patient as soon as possible after the missed appointment, ideally within 24-48 hours.
- **Multiple Communication Channels:** Use a combination of phone calls, text messages, and email to reach the patient.
- **Offer Flexibility:** Provide a range of rescheduling options, including different dates and times.
- **Streamlined Scheduling Process:** Make it easy for patients to reschedule by offering online scheduling tools or direct access to a scheduling coordinator.
- **Address Barriers:** Inquire about the reasons for the missed appointment and offer assistance in overcoming any barriers, such as transportation or childcare issues. Highmark's Community Support Platform is an excellent resource to share with patients, who may be struggling with social health needs. See the article in July *Provider News* about the positive impact this online tool is making.

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Closing HEDIS® Gaps

By reaching out to patients due for a screening and rescheduling them, your practice will be well-positioned to close any HEDIS® gaps regarding the **Breast Cancer Screening (BCS-E) measure**. This health standard applies to individuals 50 to 74 years old who had at least one screening mammogram from Oct. 1, 2023, through Dec. 31, 2025.

All types of mammograms, including screening, diagnostic, film, digital, or digital breast tomosynthesis (3D screenings), count toward the measure; however, breast MRIs, ultrasounds, or biopsies do **not**.

BCS-E codes include but are not limited to:

- **Mammogram CPT:** 77061, 77062, 77063, 77065, 77066, 77067
- **Mastectomy ICD10 (history of):** Z90.13
- **CPT:** 19180, 19200, 19220, 19240, 19303, 19304, 19305, 19306, 19307

HEDIS Resource

For more information on BCS-E, along with other measures, download Highmark's HEDIS guide.

Log into Availity Essentials®, select your state, go to **Payer Spaces**, choose **Provider Resource Center** from the applications, and then click here.

Educational Materials for Members

Highmark provides a variety of free resources to support your efforts in promoting breast cancer awareness and screening, including:

- Breast Cancer Brochure
- Breast Cancer Screening Reminder Card
- Breast Cancer Screening Flyer (Spanish version available)
- Health Screening and Vaccination Tracker (Spanish version available)

To order these free resources for your office go to **Provider Resource Center (PRC) > Educational Resources – Member & Provider > Inventory Request Form**. Select your region and then the item and quantity you wish to order. Click **ADD TO CART** and fill in the shipping details.

**HEDIS® — an acronym for Healthcare Effectiveness Data and Information Set — is a registered trademark of NCQA.*

Highmark does not recommend particular treatments or health care services. This information is not intended to be a substitute for professional medical advice, diagnosis, or treatment. You should determine the appropriate treatment and follow-up with your patient. Coverage of services is subject to the terms of each member's benefit plan. Additionally, state laws and regulations governing health insurance, health plans and coverage may apply and will vary from state to state.

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Combatting Childhood Obesity: How Highmark is Helping Parents and Providers

Childhood obesity continues to be a concern, with nearly 20% of America's youth considered obese, according to the Centers for Disease Control and Prevention (CDC).

As you know, children with obesity are at increased risk for health problems, including type 2 diabetes, cardiovascular disease, non-alcoholic fatty liver disease (NAFLD), sleep apnea, and asthma.

What Can Be Done

To help parents and providers combat childhood obesity, Highmark offers expanded preventive health benefits for children ages 2 to 18 with a body mass index (BMI) in the 85th percentile or greater. These members are eligible for three follow-up visits per year to the annual preventive exam specifically for obesity and a blood pressure check.

Highmark's preventive health benefit also includes:

- Unlimited nutritional counseling visits per year specifically for obesity
- One set of recommended lab work annually that includes:
  - Cholesterol screening
  - Hemoglobin A1c OR fasting glucose
  - AST (aspartate aminotransferase)

For coding information, click here.

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Expert Guidance

Childhood Obesity Awareness Month — which occurs during September — provides an excellent opportunity to discuss the benefits of healthy eating habits and regular physical activity with parents and patients. These two types of counseling are both part of the **Weight Assessment and Counseling in Children/Adolescents (WCC)** HEDIS® measure, which includes three components:

- Body Mass Index (BMI) Percentile
- Nutrition Counseling
- Physical Activity Counseling

In the member's medical record, you will need to document that each component of the WCC measure was discussed with the patient, while utilizing the appropriate codes.

Your recommendations play a critical role in motivating patients to make healthier choices. Even small, positive changes can have a significant impact on a child's long-term health trajectory.

Additional Resource

For more information on the WCC benchmark, as well as other HEDIS measures, download Highmark's HEDIS guide.

Log into Availity Essentials®, select your state, go to **Payer Spaces**, choose **Provider Resource Center** from the applications, and then click here.

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Staying Up to Date with the *Highmark Provider Manual*

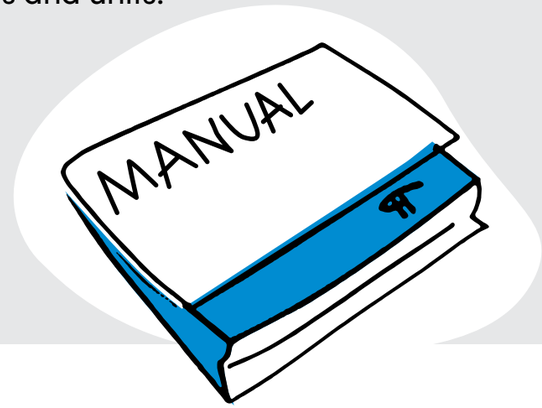
Ensure you are regularly reviewing the *Highmark Provider Manual* for our most recent guidance on:

- 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 1, Unit 2: Online Resources & Contact Information**
- **Chapter 1, Unit 4: Highmark Member Information**
- **Chapter 2, Unit 2: Medicare Advantage Products & Programs**
- **Chapter 6, Unit 4: Professional (1500/837P) Reporting Tips**

To see the full list of recent changes, visit the *What's New in the Highmark Provider Manual* page.



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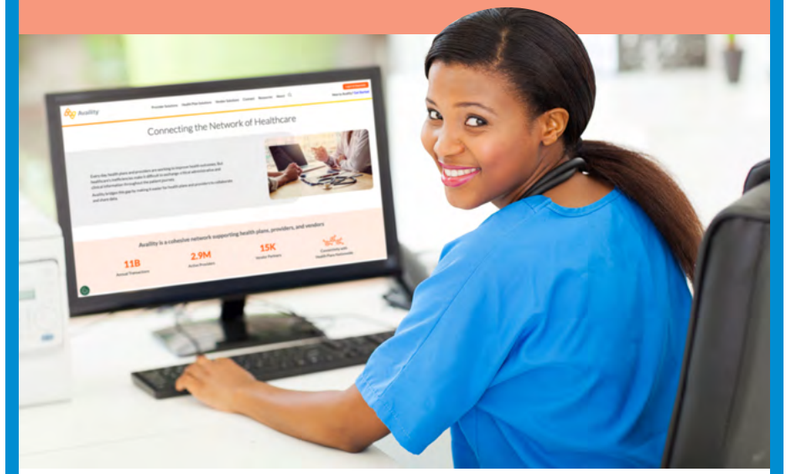

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About This Newsletter

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

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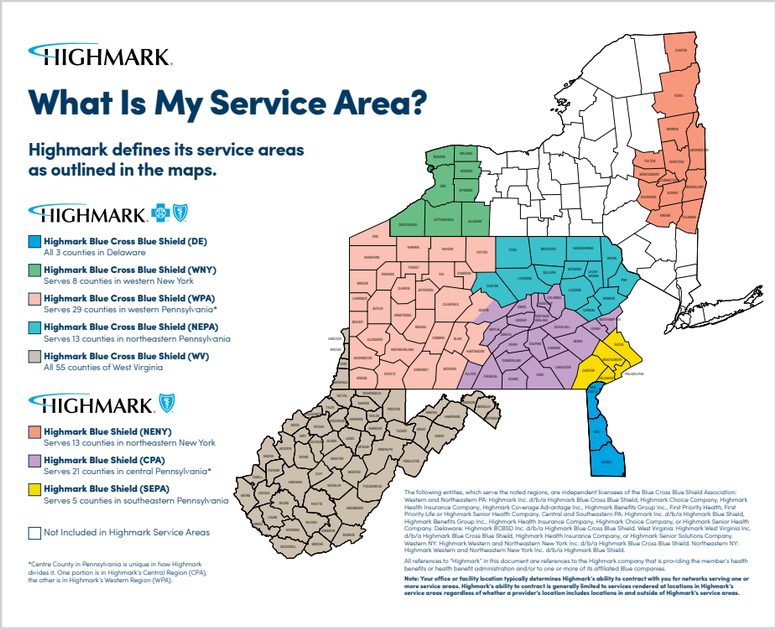
Highmark Quick Reference

To contact Highmark, click here.

Service Areas



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