Medicare Advantage claims administration Frequently Asked Questions

Updated February 2026

Q: What is changing?

A: Sanford Health Plan is transitioning to a new vendor platform for claims and administrative service for Medicare Advantage (MA) lines of business, including Align powered by Sanford Health Plan (MA, MAPD), Align DUALPartnership (D-SNP) and Great Plains Medicare Advantage (GPMA, I-SNP).

Q: Why is this change happening?

A: This transition is part of our work to insource the Medicare Advantage administrative operations previously managed by vendor partners, allowing us to offer a more customized, responsive member and provider experience.

Q: When is this change happening?

A: The transition to the new platform is effective Jan. 1, 2026.

Q: Are members affected by this change?

A: All Medicare Advantage members with active coverage for 2026 will receive new ID cards prior to Jan. 1, 2026; the cards will have updated contact information and instructions.

Q: Will there be a new provider portal and how do I sign up?

A: Yes, a new provider portal for Medicare Advantage will be available on our website. Please begin the process of designating a portal administrator and requesting access to the provider portal by filling out and returning this form, which is linked here.

Q: What services require prior authorization and how are requests submitted?

A: Here's what you need to know for dates of service on and after Jan. 1, 2026:

- **All chemotherapy and radiation therapy service authorizations** will be managed by our vendor, Eviti. The specific list of services requiring prior authorization will be available on our website soon.
    - Authorization requests can be submitted online here.
- The full list of services requiring authorization, along with product- and service-specific request forms, are available on our websites:
    - Align powered by Sanford Health Plan

    - Great Plains Medicare Advantage
- Electronic submission of prior authorizations will soon be available through the new provider portal.

Q: How do I submit a prior authorization request for service dates after Jan. 1, 2026? (UPDATED)

A: Prior authorizations can be submitted through the new Sanford Health Plan provider portal or faxed to (715) 221-6616.

Q: How do I check member eligibility and benefits? (UPDATED)

A: To check eligibility through the portal for dates of service prior to Jan. 1, 2026, continue to use https://ehealth-shp.healthsuiteadvantage.com/.

For dates of service on or after Jan.1, 2026, please refer to the new Sanford Health Plan provider portal.

Q: Is the electronic payor ID changing?

A: No, there is no change to payor IDs; providers should continue to use the existing payor ID (RP035).

A: Is the claims submission process changing? (UPDATED)

A: **The electronic claims process is not changing**. Providers should continue submitting electronic claims as usual, using the existing payor ID (RP035). Availity will route claims to the appropriate platform based on date of service.

Electronic claims submission is preferred; however, all paper claims, regardless of date of service, submitted after Jan. 1, 2026, should be mailed to the following address:

Sanford Health Plan
Attn: Claims
P.O. Box 8000
Marshfield, WI 54449-8000

Claims can also be faxed to (715) 221-9650.

Q: Where do I submit claims for supplemental benefits not covered by Medicare? (UPDATED)

A: Claims for supplemental benefits must be submitted to the appropriate vendor as indicated below:

Dental claims for supplemental dental services must be submitted to Delta Dental:

- Delta Dental: MN, ND, NE
    - Electronic Payer ID: 07000

    - Paper Claims: Delta Dental, P.O. Box 9120, Farmington Hills, MI 48333-9120
- Delta Dental: SD, IA
    - Electronic Payer ID: SDCMS
    - Paper Claims: Delta Dental, P.O. Box 9215, Farmington Hills, MI 48333-9215

Delta Dental's customer service can be reached at (866) 502-9753 (TTY-711) from 8 a.m. to 5 p.m. CST Monday through Friday.

Vision claims for supplemental vision services, including routine vision exams, refractions and hardware, must be submitted to VSP Vision at vsp.com. Provider customer service is available at (844) 344-4768.

Hearing claims for supplemental hearing services, including routine hearing exams and hearing aids, must be submitted to Nations Hearing at https://nationshearing.com/alignsanfordhealthplan. Provider customer service is available at (877) 212-0858.

Q: Will claims with dates of service spanning 2025 into 2026 need to be split?

A: Please follow the guidance below for each claim type.

Outpatient claims that span two calendar years
Claims should be billed based on the date of service, and each claim should contain only charges for the appropriate year. Dates of service for 2025 should be on one claim and 2026 dates of service should go on a separate claim. If providers submit outpatient claims with dates of service for both years, the claim will be denied ANSI 268. (The claim spans two calendar years. Please resubmit one claim per calendar year.)

Professional claims that span two calendar years
Claims should be billed based on the date of service, and each claim should contain only charges for the appropriate year. Dates of service for 2025 should be on one claim and 2026 dates of service should go on a separate claim. If providers submit outpatient claims with dates of service for both years, the claim will be denied ANSI 268. (The claim spans two calendar years. Please resubmit one claim per calendar year.)

Inpatient hospital claims spanning two calendar years
If the claim start date is in 2025, and the patient is discharged in 2026, the entire inpatient claim should be billed as it is today; it will be processed through the RAM platform.

Home Health spanning two calendar years
If the claim start date is in 2025 and the 30-day claim date spans into 2026, the entire claim should be billed as it is today and will be processed through the RAM platform.

Q: Does new platform use CMS logic in reimbursing long-term care and skilled nursing facilities? Has it been tested for accuracy?

A: The new platform will use CMS logic for reimbursing long-term care and skilled nursing facilities. We use a vendor, Cognizant, that contracts with Microdyn for pricing. Claims testing will begin once we receive CMS Q1 updates; this follows our standard process to ensure reimbursement matches CMS pricing.

Q: What clinical criteria will be used for medical necessity determinations, and where can I access the criteria?

A: For authorization requests submitted for dates of service on or after Jan. 1, 2026, InterQual's clinical criteria will apply for Sanford Medicare Advantage Plans. InterQual's criteria are available on the new provider portal.

Q: What policies will be used to process claims?

A: Sanford Health Plan uses industry standard claim editing software, including Optum Claims Edit System (CES), for primary editing and Cotiviti as a second pass editing vendor. We take into consideration historical claims experience, as well as policy guidelines from the following sources:

- CMS National and Local Coverage Determinations
- National specialty academy guidelines
- AMA CPT Procedure Code Definition & Guidelines
- National Correct Coding Initiative (CCI)
- Modifier usage
- ICD Diagnosis Code Guideline
- Global Surgery period
- Evaluation & Management Guidelines
- Add-on code usage
- Professional, technical and global policy
- Diagnosis to Procedure
- Place of Service
- Age appropriateness
- Revenue Code Validation

Q: Is the claims payment timeframe changing?

A: Yes. Payment for claims with dates of service on or after Jan. 1, 2026, will finalize on the 5th, 10th and 15th business days of the month as well as the last calendar day of the month, whether or not it is a business day.

Q: Are new EFT/ERA forms needed to receive payments? (UPDATED)

A: No. Electronic remittances and electronic fund payments will continue to be available through Zelis.

Claims with date of service in 2025 or earlier: Payment and provider remit files will continue to flow through Zelis as they do now for both paper and electric claims.

Claims with dates of service in 2026: Providers who have historically received e-payments from Zelis for Align powered by Sanford Health, Align DSNP or Great Plains Medicare Advantage may need to enroll in e-payments under Security Health Plan's Zelis Payer ID 248 to continue receiving e-payments for these plans moving forward.

Providers can enroll in Zelis electronic payments two ways:

1. Zelis Payer ID 248 Log In: securityhealthplanofwi.epayment.center.
2. Call ZPN provider services at (877) 828-8770. Please indicate Security Health Plan, Zelis Payer ID 248.

Organizations that don't enroll in e-payments under Payer ID 248 may begin to receive paper checks for claim payments.

Q: How will the remittance advice be affected? (UPDATED)

A**: For 2025 dates of service,** payment and provider remit files will continue to flow through Zelis as they do now for both paper and electric claims.

For 2026 dates of service:

Electronic: remits and payments will continue to flow through Zelis; however, 2026 dates of service will be on separate remittance advice from 2025 dates of service. Providers who have historically received e-payments from Zelis for Align powered by Sanford Health, Align DSNP or Great Plains Medicare Advantage may need to enroll in e-payments under Security Health Plan's Zelis Payer ID 248 to continue receiving e-payments for these plans moving forward.

Providers can enroll in Zelis electronic payments two ways:

1. Zelis Payer ID 248 Log In: securityhealthplanofwi.epayment.center.
2. Call ZPN provider services at (877) 828-8770. Please indicate Security Health Plan, Zelis Payer ID 248.

Organizations that don't enroll in e-payments under Payer ID 248 may begin to receive paper checks for claim payments.

Paper: remittance advice for 2026 dates of service will have a different look but will contain all the same information. Images of the statements will be available on the new provider portal.

Q: What is the process for sending appeals/claim reconsiderations starting Jan. 1, 2026?

A: Please note the following guidance:

- Sanford Health Plan does not accept post-service appeals until the claim has been received and denied. If a finalized claim has not been received, the appeal will be returned to the provider.
- Appeals should be submitted using Sanford Health Plan's provider appeal form found on our website.
    - Align: https://www.sanfordhealthplan.com/align
    - Great Plains Medicare Advantage: https://greatplainsmedicareadvantage.com/providers-partners/
- Any appeal that is received without an appeal form, or with an incomplete form, will not be processed as a provider appeal and will be returned to the provider.
- Non-contracted providers need to complete the waiver of liability form as required by section 50.1.1 of the Parts C & D Enrollee Grievances, Organization/Coverage Determinations and Appeals Guidance. The waiver of liability form must be included with the appeal. By completing a waiver of liability, you waive the right to collect payment from the member, except for any applicable cost-sharing, regardless of the determination made on the appeal.
- Appeals must be submitted within **65** calendar days of the provider's statement/explanation of payment on which the charge was denied or reduced.
- For claim appeals for dates of service **after** Jan. 1, 2026, submit completed appeals to the following address:
    - **Email**: SHP-MA-ProviderAppeals@sanfordhealth.org
    - **Mail**: Sanford Health Plan

      Attn: Provider Appeals
      P.O. Box 8000
      Marshfield, WI 54449-8000

    - **Fax**: 715-221-9650

Q: Is there a limit to runout time for adjustments or corrected claims?

A: The runout timeframe for claims processed prior to Dec. 31, 2025, will be Dec. 31, 2026. The runout time for the RAM (Healthsuites) provider portal will be the same, Dec. 31, 2026.

Q: Is the process changing for critical-access hospitals, rural health clinics and swing-bed facilities to update their CMS rate letter?

A: Yes. Beginning Jan. 1, 2026, claims received from facilities with a CMS rate letter on file with an effective date older than 12 months, will be denied with ANSI code 147.

Facilities should ensure the rate on file with Sanford Health Plan is not more than a year old. This can be done by sending a copy of the rate letter to the following address:

Attn: Medicare Policy & Reimbursement Specialist
Fax: (715) 221-9874
Email: shp.provider.claim@securityhealth.org

Upon receipt, Sanford Health Plan has up to 30 days to implement the new rates. Sanford Health Plan will not adjust claims retroactively unless the rate letter indicates a decrease in reimbursement. In this instance, Sanford Health Plan will reprocess dates of service back to the effective date in the CMS rate letter.

Q: How will I be supported through this transition?

A: Our goal is to make this transition as easy and simple as possible. Continue to use our website and provider manual for guidance. Updates will be provided in both the Provider Perspective and Fast Facts newsletters and, as always, please reach out to our provider experience team for assistance as needed.

Q: Who can providers and members contact with questions?

A: Providers and members can reach out for assistance as follows:

Products/Plans	For dates of service before Jan. 1, 2026	For dates of service on and after Jan. 1, 2026
Align powered by Sanford Health Plan (MA, MAPD), Align DUAL Partnership (D-SNP)	(888) 278-6485 (TTY 711)	(877) 509-4979 (TTY 711)
Great Plains Medicare Advantage (GPMA, I-SNP)	(844) 637-4760 (TTY 711)	(877) 492-5189 (TTY 711)