Provider Perspective

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Quarter 4 2025

SANFORD HEALTH PLAN

Team Integrations:

Sanford, Security Health Plan integrating internal teams

As part of the new, combined operating structure between Sanford and Security Health Plans, we are integrating our provider relations and other internal teams to align resources, support long-term growth and deliver consistent, high-quality service.

While Sanford and Security Health Plans maintain separate brand identities in our respective markets, stakeholders will interact with team members across both legacy organizations. We will continue to share updates on our integration work and any subsequent changes to our processes and procedures. In the meantime, please don't hesitate to reach out with questions.

CMS Rate Letter Information

Notice: Critical Access Hospitals (CAHs), Swingbeds, Rural Health Clinics (RHCs)

Requirement for Submission of CMS Rate Letter(s)

Sanford Health Plan's Medicare Advantage reimbursement for certain facility types is based on current Centers for Medicare and Medicaid (CMS) Rate Letters. This includes participating and nonparticipating critical access hospitals (CAHs), swingbeds and rural health clinics (RHCs) (collectively, facilities). Sanford Health Plan cannot access facility rate letters directly from CMS and, therefore, requires facilities to provide updated letters in a timely manner to ensure claims are accurately priced.

To avoid future claim denials, facilities should ensure the rate on file with Sanford Health Plan is no more than one year old. To update your rate, send a copy of your rate letter to:

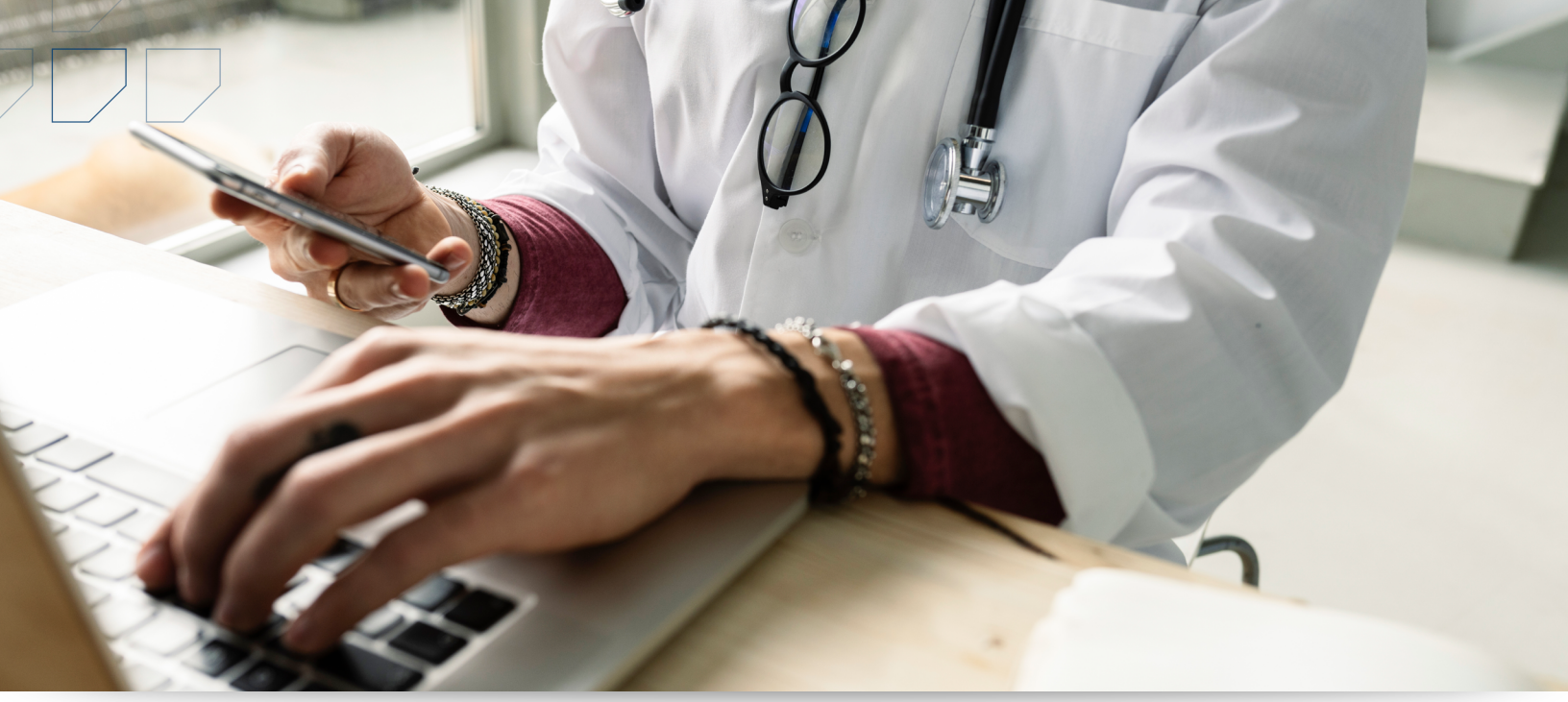
By fax to: (715) 221-9874

OR

By email to: shp.provider.claim@securityhealth.org

Notice: Beginning January 1, 2026, claims with dates of service from facilities with a CMS rate letter on file with a CMS effective date older than 12 months will be denied with ANSI code 147. For example, if the CMS rate letter on file has an effective date of 10/1/2025, any claim with a date of service on or after 10/1/2026 will be denied.

Upon receipt of an updated CMS rate letter from the facility, Sanford Health Plan will have up to 30 days from our date of receipt to implement the new rates for processing dates going forward. Sanford Health Plan will not adjust claims retroactively, UNLESS the CMS rate letter indicates a decrease in reimbursement. In this instance, Sanford Health Plan will reprocess dates of service back to the CMS effective date in the rate letter.



Claims and Admin Platform Changes:

Sanford Health Plan to transition claims, administrative services platform for Medicare Advantage

Sanford Health Plan is transitioning, effective January 1, 2026, 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).

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.

A detailed FAQ is available on our website, but these are the key things to know about the upcoming transition:

- Continue to submit electronic claims as usual, using the existing payor ID (RP035). The electronic claims submission process and the payor ID are not changing. Availity will route claims to the appropriate platform based on date of service.
- While electronic claims submission is preferred, paper claims can be submitted as follows based on date of service:

PRIOR to Jan.1, 2026	ON and AFTER Jan.1, 2026
Sanford Health Plan PO Box 31041 Tampa, FL 33631-3041	Sanford Health Plan Attn: Claims P.O. Box 8000 Marshfield, WI 54449 Fax: (715) 221-9874

- Electronic remittances and electronic fund payments will continue to be available through Zelis.
- Customer service numbers for providers and members are being updated by date of service as follows:

PLAN	PRIOR to Jan.1, 2026	ON and AFTER Jan.1, 2026
Align powered by Sanford Health Plan (MA, MAPD) Align DUAL Partnership (D-SNP)	(888) 278-6485	(877) 509-4979
Great Plains Medicare Advantage (GPMA, I-SNP)	(844) 637-4760	(877) 492-5189

Manage My Clinic comes with tools like:

- Medicare Advantage members will receive updated ID cards for plan year 2026. Please update your patient records with the information from the new cards.

Please share this information with your teams. We will continue to share more information in our "Fast Facts" newsletter and on our website in the "Fast Facts" section.

Peer-to-Peer Discussion

Sanford Health Plan has an option available for a peer-to-peer discussion on initial denials between the requesting provider and a health plan physician or pharmacist.

A peer-to-peer discussion provides an opportunity for a collaborative clinical discussion prior to submitting an appeal to:

- Discuss the clinical documentation submitted and reviewed by the health plan
- Share the clinical criteria used by the health plan to make the determination
- Allow the provider to provide additional information and any other relevant clinical support for the request

An urgent peer-to-peer request is scheduled within 24 hours and a routine request within 14 days.

If you would like to schedule a peer-to-peer review, call the Utilization Management Department at (800) 752-5863 or submit a peer-to-peer request through our website using the link below.

Fill out the Peer-to-Peer Review Request Form

Prior Authorizations for Newborns

When a baby is born, there may be a short delay in receiving insurance eligibility information. During this time, the newborn's record may not yet appear in the portal, which can prevent online submission of prior authorizations for services such as NICU stays.

What to do:

Please fax all prior authorization requests for newborns until eligiility is confirmed.

How to submit:

1. Visit **sanfordhealthplan.com**
2. Navigate to **For Providers > Provider Resources > Prior Authorizations**
3. Download and complete the paper form
4. Fax the form to the number listed on it

Thank you for helping us ensure timely care for our newest patients!

Statement on Vaccine Coverage

Sanford Health Plan is committed to maintaining and ensuring affordable access to vaccines. Our coverage decisions for immunizations are grounded in ongoing, rigorous review of scientific and clinical evidence, and continual evaluation of multiple sources of data.

We will continue to cover all immunizations that were recommended by the Advisory Committee on Immunization Practices (ACIP) as of Sept. 1, 2025, including COVID-19, influenza and RSV vaccines, with no cost-sharing for members through the end of 2026.

Manage My Clinic (MMC)

We continue towards the full implementation of Manage My Clinic for the Sanford Health Plan Provider Portal. This tool allows your clinic to manage who has access to your patient information. Typically, this is a clinic or site administrator. **To support this transition, individual portal registration will close on December 15, 2025. Once this change is made, any new users will be required to register through their administrator.**

Manage My Clinic comes with tools like:

- Reactivate users
- Inactivate users who have left employment
- Complete quarterly verification of active users
- Request or update access

For Sanford Health Plan to roll this out to your facility successfully, we need you to designate an individual who will be able to verify all users under your tax ID(s) and be able to complete the tasks listed above regularly.

If you're ready to transition to this tool at this time, please reach out via email to providerrelations@sanfordhealth.org

Sanford Health Plan Provider Portal

The Sanford Health Plan Provider Portal offers a convenient, secure way for providers to manage day-to-day interactions with Sanford Health Plan. It is a central tool to access key information, making it a great way to simplify administrative processes for your practice.

Frequently Used Features:

Eligibility and Claims

- Check member eligibility
- Review claim status
- View/print EOPs and remittance advice

Authorizations and Appeals

- Submit prior authorizations
- Check authorization status
- Submit claim reconsideration requests

View Benefits and Sanford Policies

- Check copay amounts
- Pull member's plan documents to view covered benefits
- View member accumulations to deductible and max out of pocket

Other Resources and Support

- Review policies and medical guidelines
- Submit direct questions

Understanding the Value of HEDIS Measures

The Healthcare Effectiveness Data and Information Set (HEDIS) is one of the most widely used tools in health care performance measurement. Developed by the National Committee for Quality Assurance (NCQA), HEDIS includes more than 90 measures across six domains of care, from preventive screenings to chronic disease management. These measures allow providers, health plans and patients to assess the quality of care being delivered and identify opportunities for improvement.

For providers, strong HEDIS performance reflects a commitment to delivering evidence-based, patient-centered care. Many measures align with routine preventive practices such as immunizations, cancer screenings and blood pressure control. Others focus on closing care gaps for chronic conditions like diabetes, asthma or cardiovascular disease. By proactively addressing these measures, providers not only help patients achieve better outcomes but also support value-based care initiatives and pay-for-performance programs.

Accurate documentation and timely data submission are key to success. Simple steps—such as coding correctly, encouraging follow-up visits, and reminding patients about overdue screenings—can make a significant difference.

Ultimately, HEDIS is more than a reporting requirement. It is a roadmap to higher-quality care, improved patient satisfaction, and stronger collaboration across the health care system.

Contact Us

CONTACT FOR: Member eligibility and benefits, member claim status, provider directory, complaints, appeals, report member discrepancy information

Customer Service (800) 752-5863
Monday-Friday, 8 a.m.–5 p.m. CST
memberservices@sanfordhealth.org

CONTACT FOR: Preauthorization/precertification of prescriptions or formulary questions

Pharmacy (855) 305-5062
pharmacyservices@sanfordhealth.org

CONTACT FOR: Preauthorization/precertification for medical services

Utilization Management (800) 805-7938
um@sanfordhealth.org

CONTACT FOR: Assistance with fee schedule inquiries, check adjustments and reconciling a negative balance, request explanation of payment (EOP), claim reconsideration requests, W-9 form, change/update information, provider education

Provider Relations (800) 752-5863
providerrelations@sanfordhealth.org

CONTACT FOR: Requests to join the network and contract-related questions and fee schedule negotiation

Provider Contracting (855) 263-3544
sanfordhealthplanprovidercontracting@sanfordhealth.org

CONTACT FOR: Align powered by Sanford Health Plan Medicare Advantage PPO

Customer Service (888) 278-6485 | TTY: (888) 279-1549
Utilization Management (800) 805-7938
Pharmacy Dept (844) 642-9090

CONTACT FOR: Great Plans Medicare Advantage (ISNP)

Customer Service (844) 637-4760 | TTY: (888) 279-1549
Utilization Management (800) 805-7938
Pharmacy Dept (855) 800-8872

Hearing or speech impaired TTY | TDD 711

SANFORD HEALTH PLAN

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