

# Welcome to the April Monthly Provider Forum

Provider Network Management



Delivering the Next  
**Generation**  
of Health Care

# TOPICS

- EPSDT Updates  
(Ashleigh Hercules)
- Quality Management  
(Kathryn Heston)
- Vision Insourcing
- Balance Billing Members
- Member Rights and Responsibilities
- Verifying Member Eligibility
- Third Party Liability and Coordination of Benefits
- Common Billing Errors
- Prior Authorization Process
- Access and Availability
- Medicare/Medicaid Alignment Educational Overview
- Upcoming Events
- Account Executive Territory assignments
- Questions

# EPSDT

Ashleigh Hercules

EPSDT Program Manager



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# Well Child Visit Core Components

**Physical Examination:** checking ears, eyes, nose, mouth, heart, lungs, abdomen, joints, and nervous system.

**Growth Measurements:** recording height, weight, and head circumference (*for infants*).

**Developmental & Behavioral Screenings:** assessment of milestones to ensure age-appropriate progress, autism screening, depression and suicide risk screening.

**Immunizations:** administration of vaccines according to the American Academy of Pediatrics (AAP), American Academy of Family Physicians (AAFP), and the American Medical Association (AMA).

**Anticipatory Guidance:** counseling for parents on nutrition, physical activity, sleep, safety, and mental health.

**Age-Specific Screenings:** oral health assessments and fluoride varnish applications, lead, vision, hearing, anemia, and sexually transmitted infections.

# Childhood Well Visits

## Well-Visits are Recommended at:

- Newborn
- 3 – 5 days
- 1 month
- 2 – 3 months
- 4 – 5 months
- 6 – 8 months
- 9 – 11 months
- 12 months *(rate drop)*
- 15 months *(rate drop)*
- 18 months *(rate increase)*
- 24 months *(rate drop)*
- 30 months *(rate drop)*
- 3 – 20 years old; *once per year (rates continue to drop)*



**Members 12 years of age  
&  
18 – 20 years of age have  
the lowest well-child visit  
rates**


# EPSDT Referrals

- ❑ EPSDT referral codes are to be appended in section **10d** of the claim form (*HCFA 1500*).
  
- ❑ Members that have been referred for specialty treatment are contacted and offered assistance with scheduling appointments (*treatment to be provided within 90 calendar days*).
  
- ❑ Providers can also submit referrals via the “Let us Know Form” & the “Obstetrical Needs Assessment Form” (ONAF).

EPSDT REFERRAL CODES & MODIFIERS	
REFERRAL CODES	APPLY TO CLAIM WHEN REFERRING PATIENT FOR:
YB	BEHAVIORAL HEALTH
YD	DENTAL / DENTISTRY
YH	HEARING / AUDIOLOGY
YM	MEDICAL CARE
YO	DEVELOPMENTAL DELAY
YV	VISION / OPTOMETRY
MODIFIERS	APPLY TO CLAIM WHEN BILLING FOR:
EP	COMPLETE EPSDT SCREENING
52	INCOMPLETE EPSDT SCREENING

**Referral Codes** – to be added in section **10d** on the HCFA 1500 (*claim form*)

**“YO” Referral Code** – also applicable to ages **birth to three** (*if a provider suspects developmental delay, refer the child through Birth to Three Regional Programs*)



AmeriHealth Caritas  
Delaware

# Quality Management

## Kathryn Heston



# Quality Performance Measures

AmeriHealth Caritas Delaware's Quality Performance Measures (QPM) are as follows:

- QPM #1: Glycemic Status Assessment for Patients with Diabetes HbA1c control <8% (HEDIS GSD)
  - CPT II codes required to denote adequate control <8%.
- QPM #2: Cervical Cancer Screening (HEDIS CCS)
- QPM #3: Breast Cancer Screening (HEDIS BCS)
- QPM #4: Controlling High Blood Pressure (HEDIS CBP)
  - CPT II codes required to denote adequate control <140/90.
- QPM #5: Prenatal and Postpartum Care - Timeliness of Prenatal Care (HEDIS PPC)
- QPM #6: Plan All Cause Readmission Rate (HEDIS PCR)

For more information, the HEDIS Provider Guide is available on Navinet.

AmeriHealth Caritas Delaware collaborates with providers on HEDIS initiatives to improve health outcomes for our members. Contact the Quality Management department at [bnowell@amerihealthcaritasde.com](mailto:bnowell@amerihealthcaritasde.com).

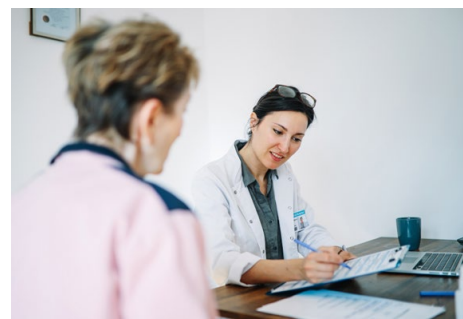
# ACDE Programs

Program	Program Description	Link
CARE Card Member Incentives	Based on claims, including CPT II codes, members can receive rewards for completing preventive screenings	<a href="https://www.amerhealthcaritasde.com/member/benefits/carecard">https://www.amerhealthcaritasde.com/member/benefits/carecard</a>
findhelp Wellness Registry	Community resources directory to provide links to community organizations, some with no cost to the member.	<a href="https://www.amerhealthcaritasde.com/member/resources/community-resources">https://www.amerhealthcaritasde.com/member/resources/community-resources</a>
ACDE Sponsored Wellness Programs	Programs include Care Coordination, Mission GED, Weight Watchers, Keys to Your Care, DSMP, HHA BPSM.	
ACDE Mobile Wellness Center (MWC)	MWC travels the state to provide screenings, including HbA1c, BP, lead, and flu for members and BP and BMI for non-members. Calendar on site.	<a href="https://www.amerhealthcaritasde.com/member/resources/mobile-wellness-center">https://www.amerhealthcaritasde.com/member/resources/mobile-wellness-center</a>
Wellness Center (Bear, DE)	Programming includes health screenings, dance/yoga classes, cooking demos, baby showers, NDPP, Chat & Chews. Calendar on site.	<a href="https://www.amerhealthcaritasde.com/apps/wellness-resources/community-wellness-center">https://www.amerhealthcaritasde.com/apps/wellness-resources/community-wellness-center</a>



# Consumer Assessment of Healthcare Providers and Systems® (CAHPS®) Survey

- Member satisfaction is measured through CAHPS® 5.1H Questionnaire for Medicaid. The survey seeks feedback directly from health plan members. The following surveys are in process for 2026:
  - CAHPS® 5.1H Adult Medicaid Plan.
  - CAHPS® 5.1H Child Medicaid Plan with Children with Chronic Conditions (CCC).
  - The Adult CAHPS® 5.1H survey includes questions related to behavioral health.
- Questions are grouped into categories to reflect satisfaction with service and care as follows:
  - Rating of health plan
  - Rating of health care
  - Rating of personal doctor
  - Rating of specialist
  - Getting needed care
  - Getting care quickly
  - Customer service
  - How well doctor communicates



# Consumer Assessment of Healthcare Providers and Systems® (CAHPS®) Survey

- The CAHPS® survey is conducted by the Plan in the spring and is administered by an NCQA-accredited vendor (Press-Ganey).
- Why are CAHPS® surveys so important?
  - Member experience is critical to a strong accreditation score.
  - CAHPS survey results report how we interact with our members and provide them with the highest possible care.



***The CAHPS® surveys are in process for 2026.*** Please encourage your patients to complete and return the survey if they receive one.

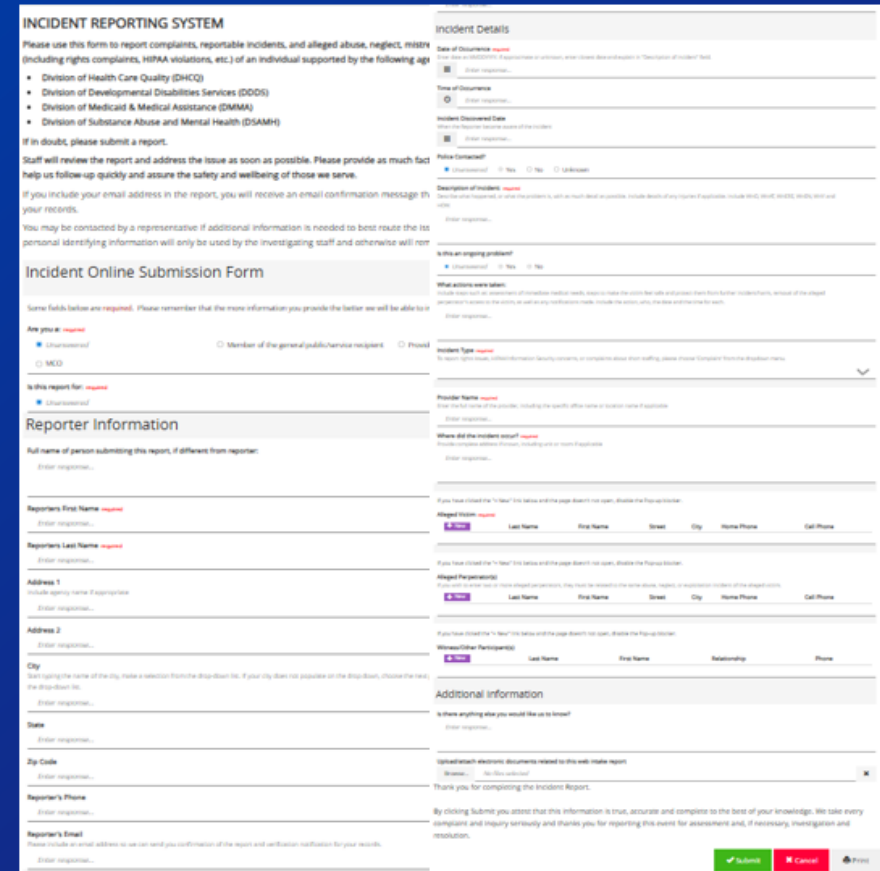
# Medical Record Reviews

- The plan conducts medical record audits to ensure compliance with AmeriHealth Caritas DE medical record standards and preventive health guidelines.
  - Providers include but are not limited to primary care providers (PCPs), Obstetrics and Gynecology (OB/GYN) practitioners, high-volume/high-impact specialists, and other practitioners as appropriate.
- Practitioners are required to achieve an audit score of 90% or greater to meet AmeriHealth Caritas DE's Medical Records Review standards.
  - Practitioners who do not achieve a score of 90% will have a re-audit within 120 days of the initial review to ensure the deficiencies are corrected.
- The plan's Medical Record Standards and Guidelines are available in the Provider Manual, located on AmeriHealth Caritas DE 's website under [Provider Manuals and Forms](#).
- **Please note:** The timing of the medical record review audit overlaps with AmeriHealth Caritas DE's HEDIS requests for medical records so you may receive multiple medical record requests during the same time frame for the same members. However, providing EMR access to AmeriHealth Caritas DE QM staff reduces the number of medical records that providers would need to submit.
  - For questions or to arrange EMR access, please contact Brooke Nowell, Director Quality Management at [bnowell@amerihealthcaritasde.com](mailto:bnowell@amerihealthcaritasde.com).

# Critical Incidents

## Critical Incident Reporting

- The incident workflow begins with the discovery of a reportable incident. Incidents must be reported as soon as possible, but within 24 hours of discovery.
- The online incident reporting form can be used by anyone and does not require a login.
- Open a web browser and navigate to the Delaware Health and Social Services (DHSS) Incident Reporting Form.  
<https://hssdedhssprod.wellsky.com/assessments/?WebIntake=9A2787C9-BDCF-449A-BFD7-59B32DD77BE7>
- Complete the Online Incident Report form by providing as much information as possible. DHSS staff will review and forward to the Plan to address and assure the safety and wellbeing of our members.




The screenshot displays the 'INCIDENT REPORTING SYSTEM' web form. It is divided into several sections: 'Incident Details', 'Reporter Information', and 'Additional Information'. The 'Incident Details' section includes fields for 'Date of Occurrence', 'Time of Occurrence', 'Incident Documented Date', 'Police Contacted?', and 'Description of Incident'. The 'Reporter Information' section includes fields for 'Reporters First Name', 'Reporters Last Name', 'Address 1', 'Address 2', 'City', 'State', 'Zip Code', 'Reporter's Phone', and 'Reporter's Email'. The 'Additional Information' section includes a checkbox for 'Upload attach electronic documents related to this web intake report' and a 'Submit' button. The form also includes instructions and a disclaimer at the bottom.




# Critical Incidents

## Critical Incidents Reporting Categories



Delaware



- Abuse
- Neglect
- Mistreatment
- Exploitation
- Injury, fall, or unexpected medical issue
- Medication Diversion
- Medication Administration Error
- Elopement
- Unsafe Behavior
- Death
- Theft/Missing Items
- Environmental
- Complaint
- Other/Unsure



## Critical Incidents

# WellSky Providers Workflow

## Delaware DHSS

The Online Incident Reporting form is used to report complaints, reportable incidents, and alleged abuse, neglect, mistreatment or financial exploitation (including rights complaints, HIPAA violations, etc.) of an individual supported by the following agencies:

- Division of Developmental Disabilities Services (DDDS)
- Division of Substance Abuse and Mental Health (DSAMH)
- Division of Health Care Quality (DHCQ)
- Division of Medicaid & Medical Assistance (DMMA)



**DHSS Providers Workflow**  
Completing the DE DHSS Online Incident Reporting Form



- For additional questions and training, please refer to the DHSS Providers Workflow found at the site provided below:

<https://training.wellsky.com/delaware/>

# Quality of Care Concerns and Quality of Care Grievances

Quality of care (QOC) issues are any issues **impacting the quality of care that a member receives**, including issues affecting safety, access to services, member health care outcomes, or the member experience. This includes QOC concerns, Fatal Five+ diagnoses, and QOC grievances.

Individuals with intellectual and developmental disabilities (I/DD) are at high risk for morbidity and mortality related to the “Fatal Five +” conditions, which include:

- Aspiration
- Constipation
- Dehydration
- Seizures
- Sepsis
- Gastroesophageal reflux disease (GERD)

# Quality of Care Concerns and Quality of Care Grievances

- QOC issues can be reported by any individual including, but not limited to, a member, a family member, a provider, the state, or the Plan's staff, including case managers and care coordinators.
  - Upon receipt of a QOC concern or QOC grievance, a written request for records is sent to the practitioner or facility.
  - QOC concerns and QOC grievances are processed, and action is taken according to the severity and potential for future harm associated with the incident.
  - An outcome letter, based on the Chief Medical Officer's determination, is sent to the provider within one week of the determination date.
  - For QOC grievances, a member resolution letter is sent to the member within two business days.
  - AmeriHealth Caritas Delaware resolves the issue within 30 calendar days of receiving notification of the issue.
-

# Quality of Care Concerns and Quality of Care Grievances

- All QOC concerns and QOC grievances are assigned an Outcome Determination level of 1 or above and are summarized and reported to the Peer Review Committee and Quality Assessment Performance Improvement Committee (QAPIC).
  - When appropriate, the provider may be required to develop corrective action plans to prevent recurrence of the event.
  - Based on outcomes, this information may be included in the practitioner/provider's file for review by AmeriHealth Caritas Delaware's Peer Review committee, which monitors and review individual participating providers' practice methods and patterns, including quality outcomes, prescribing patterns, morbidity/mortality rates, and all grievances filed against the participating provider relating to medical treatment. The Peer Review Committee will determine if the information is forwarded to the Credentialing Committee.
- The QM department tracks and trends all QOC concerns and QOC grievances.



# Performance Improvement Projects (PIPs)

AmeriHealth Caritas Delaware utilizes PIPs to achieve in clinical and non-clinical care areas that impact health outcomes and member satisfaction. Member and provider input is encouraged in the development of the PIP, including barrier assessment, opportunities and interventions.

AmeriHealth Caritas Delaware's 2025 PIPs include the following:

1. State Mandated Pregnant and Postpartum People (PPP) with Opioid Use Disorder (OUD) PIP: Increase the use of methadone and/or buprenorphine therapy for OUD treatment for pregnant and postpartum members with OUD by five percent through targeted case management services and provider education of the SAMHSA guidelines for Medication for Opioid Use Disorder (MOUD) as evidenced by paid pharmacy and medical claims.
2. EPSDT Referral Codes PIP: Increase use of EPSDT Referral codes for members identified during the EPSDT appointment for referral to specialty services, as measured by the increased number and rate of EPSDT Referral codes submitted in claims for this population by five percent over the next three years.

Educational flyers for all PIPs will be distributed with the Provider Forum Slides. Please feel free to share with your office staff.

*Provider feedback and engagement is always **welcomed and encouraged** in development and ongoing management of PIPs. Please email [kheston@amerihealthcaritasde.com](mailto:kheston@amerihealthcaritasde.com) with any suggestions/questions.*

# Questions?



# Vision Insourcing



# Vision Benefit Update

## “Important Update on Vision Services for AmeriHealth Caritas Delaware “

On January 1, 2025, AmeriHealth Caritas Delaware introduced changes to how vision benefits are administered for both children and adults. As part of this update:

- Avesis no longer serves as the administrator of vision benefits for our members.
- AmeriHealth Caritas Delaware now directly manages vision benefits through our carefully curated network of ophthalmologists, optometrists, and optician suppliers.



# Vision Benefits Continued

## What does this mean for providers?

- Avesis has continued to process claims for eligible members for any dates of service prior to January 1, 2025.
- All claims for vision services should follow AmeriHealth Caritas Delaware's updated processes.

## Looking to Add Vision Services?

If you'd like to join our network or have any questions about this transition, our dedicated Provider Account Executives are here to assist you every step of the way.

We are committed to ensuring a seamless experience during this transition and enhancing the quality of care for our members through a robust and comprehensive vision network.



# Balance Billing Members



# Balance Billing Members

AmeriHealth Caritas Delaware members should not be balance billed by any participating provider. AmeriHealth Caritas Delaware continues to receive numerous complaints from our members who have been inappropriately balance billed for services rendered by a participating provider. As a reminder, reference the language below from the AmeriHealth Caritas Delaware Provider Manual — Section IX: Claims Submission Protocols and Standards.

## Balance Billing Members

Under the requirements of the Social Security Act, all payments from AmeriHealth Caritas Delaware to participating Plan providers must be accepted as payment in full for services rendered. Members may not be balanced billed for medically necessary covered services under any circumstances. All providers are encouraged to use the claims provider complaint processes to resolve any outstanding claims payment issues.

# Member Rights and Responsibilities



# Member Rights and Responsibilities

As a reminder, our network providers, and other providers of service may not discriminate against members based on race, sex, religion, national origin, disability, age, sexual orientation, or any other basis prohibited by law. Please review the Rights and Responsibilities of our AmeriHealth Caritas Delaware members outlined on page 19 of the [AmeriHealth Caritas Delaware Provider Manual](#)

# Verifying Member Eligibility



# Verifying Member Eligibility

AmeriHealth Caritas Delaware member eligibility varies. As a participating provider, you are responsible for verifying member eligibility with AmeriHealth Caritas Delaware before rendering services, except when a member requires emergency services.

## Eligibility may be verified by:

- Visiting the provider area of AmeriHealth Caritas Delaware's website, **[www.amerihealthcaritasde.com](http://www.amerihealthcaritasde.com)**, to access NaviNet, a free, web-based application for electronic transactions and information through a secure multi-payer portal.
- Calling Provider Services at **1-855-707-5818** and utilizing the automated real-time eligibility service without speaking to a representative, just follow the prompts for Member.

# Verifying Member Eligibility

## Eligibility

- Using AmeriHealth Caritas Delaware’s real-time eligibility service. Depending on your clearinghouse or practice management system, our real-time service supports batch access to eligibility verification and system-to-system verification, including point of service (POS) devices.
- Asking to see the member’s Plan ID card. Members are instructed to keep their ID cards with them at all times. The member’s ID card includes:
  - The member’s name, date of birth, the effective date of enrollment
  - AmeriHealth Caritas Delaware ID number and Medicaid ID number
  - Copayment information for covered services, if applicable
  - The Plan’s name, address, and Member Services telephone number
  - The Plan’s 24-hour Nurse Call Line/nurse triage telephone number
  - The Pharmacy toll-free call center telephone number
  - Procedures to be followed for emergency services
  - For DSHP and DSHP Plus members without Medicare dual coverage, the member’s PCP
  - For DSHP Plus Long-term services and supports (LTSS) members, “LTSS” listed on the front and back of the card.

**NOTE:** AmeriHealth Caritas Delaware ID cards are not returned to the Plan when a member becomes ineligible. Presentation of an AmeriHealth Caritas Delaware ID card is not proof that an individual is currently a member of the Plan. You are encouraged to request a picture ID to verify that the person presenting is the person named on the ID card. If you suspect a non-eligible person is using a member’s ID card, please report the occurrence to our Fraud Waste and Abuse Hotline at **1-866-833-9718**.

# Third Party Liability and Coordination of Benefits



# Third Party Liability Coordination of Benefits

Third Party Liability (TPL) is when the financial responsibility for all or part of a Member's health care expenses rests with an individual entity or program (e.g., Medicare, commercial insurance) other than AmeriHealth Caritas Delaware. Coordination of Benefits (CO) is a process that establishes the order of payment when an individual is covered by more than one insurance carrier. Medicaid HMOs, such as AmeriHealth Caritas Delaware, are always the payer of last resort. This means that all other insurance carriers (the "Primary Insurers") must consider the health care provider's charges before a claim is submitted to AmeriHealth Caritas Delaware.

Therefore, before billing AmeriHealth Caritas Delaware when there is a primary insurer, health care providers are required to bill the primary insurer first and obtain an Explanation of Benefits (EOB) statement from the primary insurer. Providers may then bill AmeriHealth Caritas Delaware for the remaining balance on a claim by submitting the claim along with a copy of the primary insurer's EOB.

# Claims with Explanation of Benefits (EOBs)

Claims with Explanation of Benefits (EOBs) from primary insurers, including Medicare, must be submitted within 60 days of the date on the primary insurer's EOB.

In the event of an accidental injury (personal or automobile) where a third-party payer is deemed to have liability and makes payment for services that have been considered and paid under the AmeriHealth Caritas Delaware contract, the Plan will be entitled to recover any funds up to the amount owed by the third-party payer.

While this is a requirement in most cases, there are exceptions when providers are not required to bill the third party prior to AmeriHealth Caritas Delaware.

## **The exceptions are:**

- The claim is for prenatal care for a pregnant woman.
- The claim is for preventive pediatric services (including EPSDT) that are covered by the Medicaid program. Following reimbursement to the provider in these cost avoidance exception cases, AmeriHealth Caritas Delaware shall actively seek reimbursement from responsible third parties and will adjust claims accordingly.

# Common Billing Errors



# Most Common Provider Billing Errors

CDD- Duplicate Claim

TFO- Submitted after plan filing limit

X01- No authorization on file

ST- Member termination

Z11-EOB from primary carrier required

A corrected claim may be submitted within 365 days from the date of service. Please ensure you are appending the correct resubmission code to your corrected claims to reduce claim denials errors or duplicate claim denials.

To reduce claim submission errors providers are encouraged to do the following:

- Ensure claims have not been submitted previously
- Ensure claims are submitted within the plan filing limits of 120 days from the date of service or 60 days from the primary carriers' EOB
- Confirm members' eligibility, by utilizing Navinet, calling Provider Services, or utilizing the state DMES system
- Ask patient(s) to present all insurance information at the time of visit, and confirm via Navinet or DMES that there is no other insurance on file.

# Prior Authorization Process





# Prior Authorization Process

AmeriHealth Caritas Delaware has worked with NantHealth | NaviNet to bring you, **Medical Authorizations**, a robust, intuitive, and streamlined online authorizations workflow.

In addition to submitting and inquiring on existing Authorizations, you will also be able to:

- Verify if **No Authorization is Required**
- Receive **Auto Approvals**, in some circumstances
- Submit **Amended Authorization**
- **Attach supplemental documentation**
- Sign up for **in-app status change notifications** directly from the health plan
- Access a **multi-payer Authorization log**
- Submit inpatient concurrent reviews online if you have Health Information Exchange (HIE) capabilities (fax is no longer required)
- Review inpatient admission notifications and provide supporting clinical documentation

Want to learn more about Medical Authorizations? **Video tutorials** and **step-by-step instructions** are available via the NaviNet Plan Central page and the NantHealth Help Center.

# Access and Availability



# Access and Availability

AmeriHealth Caritas Delaware ensures timely access to care through appointment and availability standards:

## After-Hours Accessibility

- 24/7 PCP availability is required.
- Providers must use an answering machine service for after hour non-emergency issues.
- Members must receive instructions or be contacted within 30 minutes
- The after-hours coverage must be accessible using the medical office's daytime phone number.
- For emergency issues, both the answering service and answering machine must direct the member to call **911** or go to the nearest emergency room.

## Emergency and Maternity Care Access

### Emergency Services (Life Threatening)

- Members should call 911 or go to the nearest ER, regardless of network status.
- Services must be available 24/7 and provided immediately

### Maternity Care Appointment Standards

- Initial/First Trimester: Within 3 weeks.
- Second Trimester: Within 7 days
- Third Trimester: Within 3 days.
- High-Risk Pregnancies: Within 3 days of identification or immediately if emergency.

# Access and Availability (cont.)

## Office Waiting Time

- Not to exceed **one hour**.
- Exceptions occur when the provider 'works in' urgent cases, when a serious problem is found, or when a patient has an unknown need that requires more services or education than anticipated at the time the appointment was made.
- When wait times must be extended due to the identified exceptions, waiting patients **must** be notified of the delay as soon as possible.
- If the delay will result in more than a **90-minute** wait, the patient must be offered a new appointment.

## Primary Care Practitioner (PCP) and Specialty Care Appointments

- PCPs should be located within **30 miles** from the members' residence.  
Appointment standards are below:

**Emergency condition - PCP** (high temperature, persistent vomiting or diarrhea, sudden or severe onset of symptoms, which do not require emergency room services)

- within the **same day** of member request (same-day appointment).

**Urgent medical condition** (persistent rash, recurring high-grade temperature, non-specific pain or fever)

- within **two calendar days** or **48 hours** of member request.

## Routine appointment

- within **three weeks**

# Access and Availability (cont.)

## 24/7 Nurse Call Line

The **24/7 Nurse Call Line** is a service that members can call **24 hours a day, seven days a week**. Nurses are available to answer questions and give information when the doctor's office is closed or even if it's the middle of the night and the member is not feeling well. The nurse can help decide and determine what kind of care the member may need. See the 24/7 Nurse Help Call Line topic.

# Medicare/Medicaid Alignment Educational Overview



# Enrollment Period

## **Medicare Open Enrollment Period — Oct. 15 to Dec. 7**

- Members can enroll in, drop or switch coverage.

## **Medicare Advantage Open Enrollment Period — Jan. 1 to March 31**

- Members enrolled in a Medicare Advantage plan can switch to a different Medicare Advantage plan or return to Original Medicare.

*\*Medicaid enrollment is year-round for new enrollees. Annual open enrollment is Oct. 1 to 31.*

## **Contracting to align Medicare/Medicaid networks**

- Review current Medicare and Medicaid provider lists for gaps and/or overlaps.
- Ongoing educational seminars — AmeriHealth Caritas Delaware will continue hosting seminars through December on enrollment, benefits and networks.

# Billing

- Always bill to the primary plan.
- AmeriHealth Caritas dual-aligned members will require only one claim submission. AmeriHealth will process both Medicare and Medicaid claims from the initial submission.
- EDI claim submission is recommended.

# Annual Training Requirement

As a D-SNP, AmeriHealth Caritas VIP Care, is required by the Centers for Medicare and Medicaid Services (CMS) to provide annual training of its Model of Care (MOC) and providers who care for our beneficiaries are required to complete and attest to receiving this training.

Providers may receive training in the following ways:

- In person from a training seminar or a Network Management Account Executive.
- Access an online interactive Model of Care training module on our website, [www.amerihealthcaritasvipcare.com](http://www.amerihealthcaritasvipcare.com), under the Provider Training and Education link.
- Review faxed Model of Care training materials.
- Receive or request printed Model of Care training materials by calling your Provider Network Management Account Executive.

Providers may attest to completing the training through the online attestation form found at: <https://www.surveymonkey.com/r/AmeriHealthCaritasVIPCareDEMOCAttestation>.

# Upcoming Events



# Upcoming Events

## AmeriHealth Caritas Delaware's Job Fair

### Event Details:

**Date:** May 12<sup>th</sup>, 2026

**Time:** 10:30 a.m. – 1:30 p.m.

**Location:** Milford Public Library (Smith Room)  
11 S E Front Street Milford, DE 19963

Please follow the link below or scan the QR code to register for our Provider Cultural Competency Training. This training will only be offered virtually.



[ACDE Job Fair Registration](#)

# Upcoming Events

## Provider Cultural Competency Training

### Event Details:

**Date:** May 21<sup>st</sup>, 2026

**Time:** 12:00 p.m. – 1:00 p.m.

**Location:** Virtual Training

Please follow the link below or scan the QR code to register for our Provider Cultural Competency Training. This training will only be offered virtually.



[Provider Cultural Competency Training Registration](#)

# PNM Account Executive Territory Assignments

Please visit the link below to access all PNM Account Executives and their territory assignments

<https://www.amerihealthcaritasde.com/provider/resources/account-executives.aspx>

For general inquiries, contact Provider Services at **1-855-707-5818**.

# Questions?

