BlueCross BlueShield of Texas

Blue Choice PPO℠ and Blue High Performance Network®(BlueHPN)®
Provider Manual
Appendix - Terms, Definitions and Rules

TERM	BLUE CROSS AND BLUE SHIELD OF TEXAS (BCBSTX) DEFINITION
Important Note	Throughout this provider manual there will be instances when there are references unique to Blue Choice PPO, Blue High Performance Network, Blue Edge, EPO and the Federal Employee Program. These specific requirements will be noted with the plan/network name. If a Plan/network name is not specifically listed or "**Plan**" is referenced, the information will apply to **all PPO** products**.**
Accessibility	The Provider will assure that its Covered Services are readily available, accessible, and provided during regular business hours on business days in a prompt and efficient manner that is at all times in accordance with Provider's scope of practice, applicable community standards, and as set forth in the Provider Manual. The Provider will provide such Covered Services in the same manner, in accordance with the same standards, and within the same time availability as such services are provided to other patients without regard to the degree or frequency of utilization of such Covered Services by Covered Persons or the Product in which such individual is enrolled.
Additional Claims Submission Requirements	The Provider will count the date of admission but not the date of discharge when computing the number of hospital days that Covered Persons was confined. The Provider will submit separate Claims for expenses of the mother and the newborn child(ren). The Provider must include a discharge diagnosis when submitting Claims to Blue Cross and Blue Shield of Texas (BCBSTX). The Provider must not submit any interim Claims for Covered Services for which a Diagnosis Related Group (DRG Rate) or Case Rate is applicable.
Administrative Services Only (ASO)	An arrangement in which an organization funds its own employee benefit plan such as a health plan but BCBSTX provides specific administrative services.
Affiliate	Any corporation, firm, limited liability company, partnership or other legal entity that directly or indirectly controls, or is controlled by, or is under common control with, a Party, which may include subsidiaries, parent entities and sister companies. As used in this definition, "control" means (i) ownership of fifty percent (50%) or more of the shares of stock entitled to vote for the election of directors, in the case of a corporation; or (ii) any ownership of fifty percent (50%) or more of the equity interests in the case of any other type of legal entity; or (iii) status as a general partner in any partnership; or (iv) any other arrangement whereby a Party legally controls, or has the right to legally control, the governing body of a corporation or other legal entity.

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation,
a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

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Amounts in Excess of Cost-Sharing	The Provider may not charge Covered Persons any amounts in excess of the applicable Cost Sharing for Covered Services, including any access fees for "concierge" services or any other additional charges as a condition of accessing Provider's services.
Appeals and Grievance Procedures	The Provider will cooperate with BCBSTX's Policies and Procedures related to the appeals and grievance process, including, but not limited to, furnishing all relevant information to BCBSTX, in resolving any grievance or appeal related to the provision of Health Care Services furnished to Covered Persons under this Agreement. The Provider will forward to BCBSTX any Medical Records related to any grievance or appeal at Provider's expense within ten (10) days of BCBSTX's request unless a grievance or appeal is expedited, in which case the Provider will immediately provide the Medical Records to BCBSTX. The Provider will comply and cooperate with BCBSTX's adjudication process for any grievance or appeal. Any Covered Person complaints or grievances received by Provider related to BCBSTX will be forwarded to BCBSTX within ten (10) days of Provider's receipt of such complaint(s) or grievance(s) prior to initiating any dispute under Article IV related to either whether a Health Care Service provided by Provider is a Covered Service or the amount of compensation due Provider under this Agreement for providing a Covered Service, Provider must exhaust any applicable BCBSTX internal appeal process as set forth in Policies and Procedures or as otherwise communicated by BCBSTX to Provider.
Batch Submission	BCBSTX and BCBSTX's clearinghouse may not refuse to process or pay an electronically submitted Clean Claim because the Claim is submitted together with or in a Batch Submission with a Claim that is deficient. As used herein, the term "Batch Submission" means a group of electronic Claims submitted for processing at the same time within a Health Insurance Portability and Accountability Act (HIPAA) standard ASC X12N837 Transaction Set and identified by a batch control number.

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BCBSTX Insurance Cards	The Provider will use reasonable efforts to cross-reference the applicable Covered Person's BCBSTX insurance card with his or her driver's license, passport or State identification card, or other acceptable form of identification, and, if necessary, contact BCBSTX to confirm that the person presenting the BCBSTX insurance card is the Covered Person listed on the insurance card. The Provider will verify the identity, eligibility, and coverage of each Covered Person prior to furnishing Covered Services to such Covered Person and from time to time throughout the course of such Covered Person's treatment. If the Provider does not verify the identity, eligibility, and coverage of the Covered Person, the Provider agrees that the Claim may be denied by BCBSTX. If BCBSTX makes an Erroneous Payment, the Provider agrees that BCBSTX is entitled to recovery of such Erroneous Payment.
Charges for Non-Covered Services	The provisions of this section do not prohibit Provider from collecting charges from a Covered Person for Non-Covered Services, so long as Provider obtains written consent from such Covered Person or such Covered Person's legal representative or designee, in advance of providing the Health Care Services, on a Non-Covered Service waiver form containing an acknowledgment from the Covered Person that the (1) that the Health Care Services are Non-Covered Services, (2) that BCBSTX will not be responsible for payment of such Non-Covered Services, and (3) that the Covered Person will be financially responsible to the Provider for such Non-Covered Services. Notwithstanding the foregoing, Health Care Services which are not separately reimbursable by BCBSTX due to bundling or other Claim edits may not be billed to or collected from Covered Persons, even if the Covered Person has agreed in writing to be responsible for paying any of the charges for such Health Care Services. Such Health Care Services are Covered Services but are not separately payable by BCBSTX.

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Claim	An itemized statement of provider's charges for Health Care Services provided by the provider to a particular Covered Person.
Claim Format	Claims may be submitted (1) electronically in the CMS National Standard Format (NSF) or the current version of the ANSI 837 format or (2) on a completed current version of the applicable CMS Claim form. When submitting charges, Provider will bill BCBSTX its standard retail price (i.e., the highest price Provider bills any other carrier) for the Health Care Services rendered.
Claims in Error	If Provider submits a Claim to BCBSTX and later determines that the Claim contained an error (e.g., the wrong diagnosis, date of admission, etc.), then Provider will send a corrected Claim to BCBSTX in accordance with applicable Policies and Procedures. The documentation necessary to substantiate a corrected Claim is forwarded to BCBSTX upon request.
Clean Claim	A clean claim is set forth by applicable Law for Covered Services performed at a provider location included in this Agreement.
Collection of Cost Share	Provider agrees to diligently pursue and collect from Covered Persons all applicable Cost Share amounts at the time and in the manner described in the applicable Coverage Agreement and in accordance with the Policies and Procedures. In no event will Provider offer, advertise or otherwise publicize any waiver or other reduction of any Cost Share amount.

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Communication of Treatment Options	Nothing contained in this Agreement is intended to prohibit or discourage Provider from discussing with or communicating in good faith to a current, prospective or former patient, or patient's legal representative or designee, information or opinions regarding (1) the patient's health care, including but not limited to the patient's medical condition or treatment options, including alternative medications, regardless of BCBSTX coverage limitations, or (2) the Policies and Procedures.
Complaints	BCBSTX will maintain a complaint procedure as required by Law and the Policies and Procedures.
Concierge Services	This is a relationship between a patient and a physician in which the patient pays an extra or additional fee to the provider. This may or may not be in addition to other charges.
Cooperation	The Provider will cooperate with BCBSTX in facilitating cost-effective, quality-driven Covered Services for Covered Persons, including, but not limited to, cooperation and participation in programs such as pre-admission testing and pre-service review. Provider will make commercially reasonable efforts to do business with BCBSTX electronically when such electronic business opportunity is made available by BCBSTX, including electronically checking eligibility status and Claims status, receiving Electronic Remittance Advice, Provider Remittance Advice or Provider Claims Summary documents (or their equivalent), and submitting requests for Claims adjustments for Covered Persons. The Provider will use commercially reasonable efforts to use BCBSTX's website, as applicable, for additional functionalities (such as notification of admission) after BCBSTX notifies Provider that such functionalities are available for the applicable Covered Person.

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Coordination of Benefits (COB)	Provider agrees to cooperate with BCBSTX in the coordination of benefits, to make inquiries regarding, and provide relevant information to BCBSTX relating to, any other coverage held by the Covered Person, and to abide by the COB, subrogation and duplicate coverage policies, procedures, and rules of BCBSTX as set forth in the Policies and Procedures, Coverage Agreement and this Agreement. Provider will report to BCBSTX any fact of which it or its agents have knowledge which indicates that the condition requiring Health Care Services from Provider arises from any employment related or occupational injury or disease, or may be compensated under any State or Federal Workers' Compensation or Employer's Liability law, or that the Covered Person has other insurance in effect which may provide health care benefits. Primary and Non-Primary responsibility will be determined based on the Coverage Agreement and the other coverage held by the Covered Person.
Cost Share	The portion of provider's payment for a Covered Service for which a Covered Person is responsible, including, but not limited to, copayments, coinsurance, deductibles, reduction of benefits, and any other applicable financial responsibility of the Covered Person, pursuant to his or her Coverage Agreement.
Coverage Agreement	Any policy, contract, Plan document or certificate entered into or issued by a Plan, which entitles Covered Persons to receive benefits for Covered Services, and which identifies the Covered Services that the Plan, or the Plan or the Administrative Services Only (ASO) Group's designee, has agreed to adjudicate, and, to the extent appropriate, pay for, on behalf of Covered Persons. A Coverage Agreement can be pursuant to an insurance arrangement, an administrative services arrangement, or an arrangement whereby a Plan contracts with BCBSTX to utilize Participating Providers. The Coverage Agreement explains the benefits, limitations, exclusions, terms, and conditions of a Covered Person's health coverage.

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Covered Person	Any person entitled to receive Covered Services pursuant to (i) the terms of a Coverage Agreement, and (ii) the Provider Networks covered under the terms of this Agreement, at the time Health Care Service(s) are furnished.
Covered Person Identification	BCBSTX or the Covered Person's ASO Group, as applicable, will provide appropriate insurance card identification to Covered Persons identifying them as Covered Persons under Coverage Agreements. BCBSTX will make available to Provider electronic eligibility information regarding Covered Persons.
Credentialing	With Provider's cooperation in accordance with Provider's responsibility under the Contract, BCBSTX or its delegate will maintain Credentialing and Recredentialing and peer review processes for determining the eligibility of Provider, as applicable, to participate in BCBSTX's network. BCBSTX will Credential and Recredential and review the qualifications of Provider, as applicable, at least every three (3) years. BCBSTX may amend its Credentialing and Recredentialing Policies and Procedures at any time, at its discretion and upon Notice to Provider. BCBSTX retains the right to approve, deny, suspend or terminate any Provider's participation with BCBSTX based on its Credentialing and Recredentialing review.
Culturally Competent	The Provider will ensure that it provides information regarding treatment options in a culturally competent manner, including, without limitation, the option of no treatment and ensure that each Covered Person with disabilities or who speaks or understands only languages other than English has an effective means of communication with Providers in making decisions regarding treatment options.
Designees	The provider's vendors and independent contractors that assist Provider in the performance of its obligations under this Agreement but excluding Providers and Provider's employees.

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Duplicate Claim	The Provider may not submit a Duplicate Claim prior to the 46th day (for non-electronically filed Claims) or the 31st day (for Claims filed electronically) after the date the original Claim is presumed to be received by BCBSTX. As used herein, "Duplicate Claim" means any Claim submitted by Provider for the same Health Care Service provided to a particular individual on a particular date of service that was included in a previously submitted Claim. The term does not include corrected Claims.
Facilities, Equipment and Staff	The Provider will provide and maintain facilities and/or equipment that are of adequate capacity, clean and safe, are readily accessible to Covered Persons and, where appropriate, properly licensed, certified or registered. The Provider will assure the appropriate supervision of, licensure of, certification of, and insurance coverage in accordance with the provider's contract for, all providers, provider's employees and Designees. Provider's supervision of physicians will be conducted by a provider medical director who is an appropriately licensed physician designated by the provider. If any provider , provider's employee or Designee violates any of the provisions of Law or the Policies and Procedures or commits any act or engages in any conduct for which provider's license and/or certification may be revoked or suspended (whether or not such license and/or certification is revoked or suspended) or is otherwise disciplined by such licensing authority or any professional organization having authority over such employee or contracting agent, BCBSTX may immediately require such employee or Designee to cease providing Covered Services to Covered Persons under this Agreement and/or may immediately terminate this Agreement upon Written Notice of such termination.
Hospital-Based Physician/ Group	A physician/group consisting in whole or part of anesthesiologists, pathologists, radiologists, an emergency department physician, or neonatologists to whom a facility has granted clinical privileges and whose physicians provide Health Care Services to patients of the facility under those clinical privileges.

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Incidental Services	The cost of incidental services in support of such Covered Services, including without limiting the foregoing technical charges for equipment and its purchase, rental and maintenance. Compensation for such incidental services may not be billed separately by Provider or another Provider or other entity; provided that professional services necessary for the treatment of the Covered Person that require the use of equipment that is supplied or arranged for by Provider may be billed separately by the person providing those professional services.
In-Network Services	Covered Services provided to Covered Persons in accordance with the Coverage Agreements' requirements for in-network benefits as set forth in the applicable Coverage Agreement
Medical Records	Provider will establish and maintain an accurate medical record, which may include an electronic record for each Covered Person with whom Provider has had an encounter that, at a minimum, (i) will include such information about the Covered Person and a description of all services rendered to the Covered Person as dictated by generally accepted practices and standards, (ii) will be maintained for the period of time required by Laws, and (iii) in all instances as required by the Policies and Procedures ("Medical Records"). The Provider will ensure that a Covered Person's Medical Records are legible, complete, dated, timed and authenticated.

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Medically Necessary or Medical Necessity	Health care services that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that is (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and (c) not primarily for the convenience of the patient, physician or other health care Provider, and not more costly than an alternative service or sequence of treatment of that patient's illness, injury or disease. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.
Notice	A notification required by the Provider's Agreement or Law, that is not a required Written Notice, but is a notification to one Party by the other Party: (i) by U.S. mail or email, or, (ii) from BCBSTX to provider only, provider newsletter or website, and (iii) will be considered received as of: (a) the date on which the recipient receives the notification, or the date upon which the recipient refuses or otherwise fails to accept delivery, or (b) for U.S. mail, on the third business day following its deposit in the U.S. mail, or (c) in the case of BCBSTX, for Provider newsletter or website, the date that the newsletter or website notification is posted by BCBSTX.

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Overpayment Recovery	In the event that BCBSTX determines an overpayment, including a duplicate payment, has been made, Provider will promptly make repayment to BCBSTX when requested. If the Provider fails to promptly make such repayment when requested, the Provider will allow overpayments to be deducted from future payments, for the same or different Covered Persons, with an explanation of the action taken. Likewise, any underpayments will be added to future payments by BCBSTX to the Provider. Any dispute arising from such deduction or payment will be resolved in accordance with the terms of the dispute resolution procedures as outlined in this Agreement.
Participating Provider	Licensed and credentialed Health Care Service Providers and practitioners that have an agreement with BCBSTX to provide In-Network Services to Covered Persons according to the terms of their Coverage Agreements and the Policies and Procedures.
Pass Through Billing Prohibited	The Provider may bill BCBSTX only for Covered Services performed directly by Provider or its employees. The Provider may not bill, charge, seek payment for or submit any Claims to BCBSTX, nor may Provider cause such Claims to be submitted to BCBSTX, nor will Provider have any recourse against BCBSTX or any Covered Person for amounts related to Claims related to such pass-through billing.

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Payment in Full	The Provider will submit to BCBSTX all Claims, in the form of Clean Claims, for Covered Services rendered to Covered Persons, whether or not the costs for such Claims may be the responsibility of a third-party, such as an auto carrier or workers' compensation insurer or where there are a third-party lien and other liability. When Provider submits a Claim to BCBSTX seeking payment under the terms of this Agreement, all terms are applicable, and Provider will accept BCBSTX reimbursement as full and final payment for Health Care Services rendered, excluding any applicable Cost Share. If it is later determined that another person or entity is liable to the Covered Persons, Provider may not refund the payment to BCBSTX and seek reimbursement from the liable person or entity. Notwithstanding the above, Provider will cooperate with BCBSTX in the collection on BCBSTX's behalf of third-party payments including workers' compensation, third-party liens and other third-party liability according to the procedures set forth in the Policies and Procedures.
Payment	For Covered Services provided to Covered Persons that are documented on a Clean Claim and otherwise meet the standards for payment under this Agreement, Provider will accept, through: (i) Cost Share and (ii) payment from BCBSTX, the amounts set forth in this Agreement as full reimbursement for arranging and providing Covered Services to Covered Persons, in accordance with the terms of this Agreement and its applicable Attachments, Policies and Procedures, and the Coverage Agreement. To qualify for payment of a Claim under this Agreement, Provider will submit such Claims in the format, time frame, and manner set forth in this Agreement and Policies and Procedures. Provider agrees BCBSTX may make adjustments to amounts previously paid to Provider in accordance with the terms of this Agreement. Provider agrees and understands that BCBSTX will not pay for Non-Covered Services. Provider agrees that only Clean Claims for Covered Services that are performed at a location included in this Agreement are eligible for reimbursement.

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Plan	A BCBSTX ASO Group, or any other Health Care Services Corporation (HCSC) Plan, Blue Cross and/or Blue Shield Plan licensed by the Blue Cross and Blue Shield Association (BCBSA) and a subsidiary of such Plan, or any other BCBSTX Affiliate, or employer, with respect to which BCBSTX has contracted to provide access to Participating Providers.
Policies and Procedures	Pertains to the Provider Manual and any other policies, programs, rules, guidelines, protocols, and administrative procedures adopted by BCBSTX that relate to, without limitation, Credentialing and Recredentialing processes, medical policies, Utilization Management (UM) and Care Management (CM) processes, quality improvement, peer review, Covered Person grievance, concurrent review or any other BCBSTX programs. For purposes of this definition, "Care Management" means a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet a Covered Person's health needs, using communication and available resources to promote quality, cost-effective outcomes and ongoing individual needs, as developed and approved by the Covered Person's physician. The Provider will comply with all BCBSTX Policies and Procedures which are hereby incorporated and made a part of, this Agreement Electronic access to the Policies and Procedures will be provided to the Provider. The Policies and Procedures are subject to change at any time, including, but not limited to, all BCBSTX medical policies. In the event of a conflict between the terms of this Agreement and the terms of the Policies and Procedures, the terms of this Agreement will govern.
Post-Service Medical Necessity Reviews (PSMNR)	Post-Service Medical Necessity Reviews (PSMNR) may occur after the service was rendered. During a PSMNR, we review clinical documentation to determine whether a service or drug was medically necessary and covered under the member's benefit plan. We may ask you for the information we do not have.

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Prior Authorization	The Provider will follow Prior Authorization requirements, including such requirements set forth in Policies and Procedures. The Provider will provide Covered Services to Covered Persons only upon a proper Prior Authorization, as applicable, except in cases requiring Emergency Care. If for any reason, Provider does not follow Prior Authorization requirements, Provider may be assessed a Penalty (as set forth in the Policies and Procedures) for such failure and/or may not be reimbursed in full by BCBSTX for Health Care Services/Covered Services rendered to a Covered Person without required Prior Authorization. Prior Authorization of Covered Services does not constitute a guarantee of payment to Provider. BCBSTX may not use retrospective review to deny, reduce or delay payment on the basis that the Health Care Service was not Medically Necessary for Health Care Services that were prior authorized as Covered Services unless such retrospective review causes BCBSTX to conclude that such Prior Authorization was based upon: (i) clinical findings in the medical record that vary materially from the clinical findings communicated to BCBSTX by Provider, (ii) a proposed course of treatment that varied materially from the actual Health Care Services rendered by Provider, (iii) a material misrepresentation or omission by Provider, or (iv) otherwise erroneous information obtained from Provider that informed or impacted the Prior Authorization.
Prior Authorization Exemption	Under Texas House Bill 3459 (HB3459), providers may qualify for an exemption from submitting prior authorization requests for specific health care service(s) for all fully insured (TDI is indicated on the ID card) and certain Administrative Services Only (ASO) groups.
Proper Referral and Prior Authorization	For Point of Services (POS), health maintenance Organizations (HMO) or other Coverage Agreements requiring the selection of a Primary Care Provider (PCP), Covered Services must generally be provided by Covered Persons' PCP or obtained through a network of Participating Providers with a Proper Referral and with a Prior Authorization where required. For Preferred Provider Organization (PPO), Exclusive Provider Organization (EPO) or other Coverage Agreements not requiring the selection of a PCP, Covered Persons must follow the requirements set forth in their Coverage Agreement; generally, in-network benefits are available when Covered Persons use network Participating Providers with proper Prior Authorization as applicable.

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Provider Network	A network of Participating Providers which has contracted with BCBSTX to provide Health Care Services to Covered Persons on certain terms and conditions related to the applicable network(s) and Products covered under this Agreement.
Recommended Clinical Review	Recommended Clinical Review are optional reviews for medical necessity submitted before services are completed for a Covered Service that does not require prior authorization and helps limit the situations where a service may be denied based upon medical necessity retrospectively.
Release of Information	Notwithstanding anything in else in this Agreement, Provider authorizes BCBSTX to publicly release general cost, utilization and other performance information and data concerning Provider or Provider's provision of Covered Services, or data in Claims or Clean Claims, as BCBSTX deems appropriate, consistent with BCBSTX's existing for future consumer transparency programs, tools and initiatives, as permissible by Law.
Responsibility for Medical Treatment	Provider acknowledges and agrees that provider, and not BCBSTX, are solely responsible for arranging or providing Covered Services to Covered Persons under this Agreement. All decisions regarding the treatment and care of Covered Persons are the sole responsibility of the provider, and such decisions are neither directed nor controlled in any way by BCBSTX. The Provider will continually monitor and evaluate the quality and appropriateness of patient care and/or services, including the performance of Providers, Provider employees and all other Provider personnel who furnish services under arrangements with the provider, including but not limited to identifying and implementing.
Return of Overpayments.	Overpayments determined by Provider on a Claim(s), including duplicate payments, will be refunded to BCBSTX, but in any event no later than thirty (30) days following such determination regardless of whether the refund is requested by BCBSTX.
Serious Reportable Event	As defined by the National Quality Forum (NQF), adverse events that are serious, but largely preventable, and of concern to both the public and health care Providers and as may be more fully described in the Policies and Procedures.

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Termination for Loss of Insurance Coverage	Failure to maintain any of the insurance coverages required in accordance with this Section will be grounds for termination of this Agreement. The Provider will indemnify BCBSTX for any loss incurred as a result of Provider's failure to maintain such coverage, which obligation to indemnify will survive the termination of this Agreement.
Termination Notices Under this Article	Notices concerning termination under this Article shall identify the specific Provider Networks included in the Notice of termination. Termination Notices shall be deemed insufficient to terminate any Provider Network not included in such Notice.
Timing of Claims Submission	The Provider will promptly submit a Claim for Covered Services to BCBSTX in accordance with applicable Policies and Procedures. For a Clean Claim for which COB applies, the filing period does not begin for submission of the Claim to the secondary payer until Provider receives Notice of the payment or denial from the primary payer. If the Provider is an institutional Provider, the filing period does not begin until the date of discharge. If Provider fails to submit a Claim in compliance with this paragraph, Provider forfeits the right to payment unless Provider has certified that the failure to timely submit the Claim is a result of a catastrophic event. The Provider will include a discharge diagnosis when submitting Claims to BCBSTX.
Under/Overpayments.	Barring any systematic practice to underpay Provider by BCBSTX, BCBSTX and Provider agree that underpayments and/or overpayments amounting to less than $50.00 on an individual entire Claim will be considered to have been paid in accordance with the terms of this Agreement and will not be appealed by Provider or BCBSTX. Rather, Provider or BCBSTX will write-off such under and/or overpayment difference unless BCBSTX's agreement with the applicable ASO Group requires otherwise.

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Utilization Management (UM) or Utilization Review	The evaluation by BCBSTX, or its authorized agent, vendor or subcontractor, or an ASO Group, or its UM Agent, as applicable, of the Medical Necessity, appropriateness and efficiency of the use of Health Care Services, in accordance with the provisions of the applicable Covered Person's Coverage Agreement, this Agreement, and Policies and Procedures, including, but not limited to, for purposes of Prior authorization or pre-certification for benefits, concurrent review and retrospective review.
Written Notice	A type of written notification required by this Agreement (other than Notice) which from either Party is sent by U.S. certified mail, postage pre-paid, return receipt requested and will be deemed received: (i) on the same date as proof of delivery as evidenced by the certified mail green card, or (ii) on the date upon which the recipient refuses or otherwise fails to accept delivery.