



OhioHealth Provider FAQ: Timely Filing, Appeals, and Plan Closure Transition

April 2026

What's Changing?

- OhioHealth has made the decision to exit the role of administrator of health plans and wind down OhioHealth benefit offerings at the end of 2026. The OhioHealth Network will terminate at that time.
 - As OhioHealth winds down its TPA operations, we are updating contract provisions related to **timely filing** and **appeals** for dates of service (DOS) on or after **Saturday, August 1, 2026**.
 - This FAQ explains what is changing, what is not, and what providers need to know during the transition and runout period.
-

Background & Contract Amendments

Q: Why is OhioHealth making changes to provider contracts?

A: OhioHealth is exiting the role of health plan administrator and winding down OhioHealth benefit offerings by the end of 2026. These contract updates will allow for timely and accurate payment during the transition and upcoming claims runout period.

Q: What is changing in my provider agreement?

A: For Claims with a DOS on or after August 1, 2026:

- Timely filing will be reduced from 365-days to 120-days.
- Appeals must be submitted within 90 days of the paid date referenced on the Explanation of Benefits (EOB) or remittance date.

Q: Which version of the provider agreement do I have and how does the amendment apply? A: The amendment applies to all active OhioHealth Network agreements, regardless of the signing year. Each provider will receive an amendment that aligns the timely filing and appeals language to these new standards.

Providers may have one of the following agreement types:

- OhioHealth Medical Plans, Inc. (OhioHealth)
- OhioHealth Group, Ltd.
- US HealthPlan

For all agreements, this amendment ensures consistent application of the updated terms across all network providers.

Q: Do I need to sign and return the amendment?

A: The amendment will specify whether a signature is required. Most updates will be effective automatically unless the document indicates that an executed signature is needed.

Q: Who do I contact if I have questions about the amendment?

A: For questions or concerns with the amendment, please reach out to OhioHealthy Provider Services at (855) 571-1378.

Q: What happens if I don't agree to the amendment?

A: Declining the amendment may impact network participation status. Please contact OhioHealthy Provider Services at (855) 571-1378 to discuss your options.

Timely Filing – New 120-Day Requirement

Q: What is changing and when?

A: For claims with a DOS on, or after August 1, 2026, timely filing is being reduced from 365-days, to 120-days.

Q: How is the 120-day window calculated?

- Professional claims: From date of service
- Facility claims: From date of discharge

Q: Does the 120-day rule apply to all claim types?

A: Yes. Professional, facility, ancillary, and all other claim types will follow the 120-day standard.

Q: Does this change affect claims with DOS prior to August 1, 2026?

A: No. Claims with DOS prior to August 1, 2026, will continue following the timely filing requirements in place at the time the services were rendered.

To ensure payment for claims with DOS prior to August 1, 2026, all claims must be submitted no later than July 31, 2027. Claims submitted after this date will not be eligible for payment, as funding will no longer be available.

Q: What happens to claims submitted after the 120 days?

A: Claims submitted after 120 days will be denied for untimely filing, unless a valid exception applies.

Q: Are there any exceptions (e.g., coordination of benefits, retroactive eligibility)?

A: Exceptions may apply when delays are outside provider control (e.g., retroactive eligibility updates, delayed coordination of benefits data). Supporting documentation must be included for an exception to be considered.

Q: Does the claim need to be received within 120 days, or submitted within 120 days?

A: Claims must be received by OhioHealthy within the 120-day submission timeframe.

Q: How do I dispute a timely filing denial?

A: Submit a timely filing dispute through the OhioHealthy appeals process with documentation proving original submission. If you would like to submit an appeal, you can initiate the appeals process by filling out this [appeal form](#) or calling us at 855-571-1378.

Q: Does the 120-day rule apply differently for resubmissions or corrected claims?

A: Yes. Corrected/resubmitted claims must also be within 120 days of the DOS/date of determination (DOD), unless the original claim was timely and proof of timely submission is provided.

Q: What documentation should I keep?

A: With the transition to **120-day timely filing** and **90-day appeals** requirements, it is important for providers to maintain complete and accurate documentation to support timely submission, resubmissions, and any corrected claims or appeals. Proper documentation helps demonstrate that claims were submitted within required timeframes and can be critical if follow-up or dispute resolution is needed.

Providers should retain the following documentation:

- **Submission confirmations** (e.g., portal confirmations, clearinghouse reports, fax confirmations, or mail tracking receipts)
- **Clearinghouse acceptance reports**
- **Original claim copies**

This documentation serves as proof of timely filing and supports any necessary resubmissions or appeals within the updated timeframes.

Q: How long should documentation be kept?

A: Providers should retain this documentation for **at least 12 months from the DOS or claim submission**, or longer if required by contract, state, or federal regulations. Maintaining records for this period ensures adequate support for any follow-up activity, including corrected claims, appeals, or audit requests.

Q: If OhioHealthy is secondary coverage, may claims still be submitted after December 31, 2026?

A: Yes, when OhioHealthy is the secondary coverage, claims with a DOS on, or before December 31, 2026, claims can be submitted after December 31, 2026. Any claim with a DOS after December 31, 2026, should not be submitted to OhioHealthy.

Appeals – New 90-Day Requirement

Q: What is the new requirement?

A: Appeals for claims with a **DOS on, or after August 1, 2026**, must be received within **90-days** of the date of payment on the EOB/remittance date. Claims with a DOS prior to August 1, 2026, will have 365-days to appeal from the date of payment on the EOB/remittance date.

Q: What types of actions qualify for appeal?

- Claim denials
- Reductions or downcoding
- Partial payments
- Overpayment determinations (if disputing)

Q: How is the 90-day window calculated?

A: The 90-day appeal window is calculated from the date of payment on the EOB or remittance advice.

Q: How do I submit an appeal?

A: If you would like to submit an appeal, you can initiate the appeals process by filling out this [appeal form](#) or calling us at 855-571-1378.

Q: Is there a second-level appeal?

A: If offered, second-level appeals must also be submitted within 90-days of receiving the first-level determination. You can use the address below for the second level of appeal.

OhioHealthy
Appeals Department
P.O. Box 4278
Clinton, IA 5273-4278

Q: What documentation should be included with the appeal?

- Clinical notes, operative reports
- Corrected claims
- Supporting coding/clinical guidelines
- Proof of timely filing (if relevant)

Q: Where do I submit appeals?

A: Submission pathways will be provided by OhioHealthy Provider Services. Existing addresses and numbers remain in place during runout. If you would like to submit an appeal, you can initiate the appeals process by filling out this [appeal form](#) or calling us at 855-571-1378.

Q: Will I receive confirmation of appeal receipt?

A: Yes. You will receive written or electronic confirmation.

Q: What is the appeals turnaround time?

A: OhioHealthy will provide determinations within the standard timeframe (e.g.30-days) communicated in your provider agreement or the appeals policy.

Q: How do I determine which timely filing or appeals rule applies if a member's care spans dates before and after August 1, 2026?

A: The applicable timely filing and appeals requirements are based on how the claim is billed:

- **Inpatient/Facility claims (billed on a single claim):**

Claims are typically governed by the **admission date**. If the admission date is prior to August 1, 2026, the **pre-amendment timely filing and appeals rules** will apply to the entire claim.

- **Professional or split-billed services:**

If services are billed separately (e.g., professional claims or split facility billing), the requirements are determined by the **DOS** for each claim or claim line.

- Dates **prior to August 1, 2026** → prior rules apply
- Dates **on or after August 1, 2026** → updated rules apply

Providers should review how the claim is submitted to determine which timeframe and corresponding requirements apply.

Q: Can I still appeal claims for DOS before December 31, 2026, during the runout period?

A: Yes, as long as appeals are made within policy limits.

Claims Accuracy & Corrections

Q: What if I believe a claim was processed incorrectly?

A: If a potential error has been identified, please submit a request for review or corrected claim as soon as possible.

Q: What is the deadline for submitting a corrected claim or payment correction?

A: The deadline for submitting a corrected claim or a payment correction, is 90-days from the date of payment, unless otherwise specified in your contract, or tied to appeal rules.

Q: How do I return an overpayment before or after December 31, 2026?

A: To return an overpayment, please follow the overpayment return instructions on your remittance notice, or contact OhioHealthy Provider Services at (855) 571-1378.

Q: Will recoupments still occur after plan closure after December 31, 2026?

A: Recoupments will be handled based on timely filing and appeal rules in place at the time of the claim DOS.

Providers should ensure all claim activity is completed within the applicable timeframes to allow for appropriate processing.

Q: How far back can I review claims for potential issues?

A: Providers may review any claims still within applicable timely filing or appeals windows.

Q: Where can I access claims history and remittances?

A: Claims and EOB information is available through the standard [provider portal](#) and clearinghouse channels. A rolling three years worth of claims data will be available.

Q: What steps should my billing team take in order to ensure my claims are paid prior to plan closure December 31, 2026?

- Audit claims for services rendered to identify any that have not yet been submitted for payment or that have outstanding balances, ensuring timely submission and resolution within required filing deadlines
- Submit any unbilled claims immediately
- Review the past 90 days of EOBs for potential appeals
- Confirm payer settings reflect updated filing deadlines
- Call Provider Relations with any questions

Q: What if an employer terminates mid-year after the December 31, 2026 closure date? Will claims still be honored?

A: Coverage through December 31, 2026, is guaranteed unless the employer terminates coverage earlier in the year.

OhioHealthy Plan Closure & Runout

Q: When does OhioHealthy end operations?

A: The OhioHealthy Medical Plan will terminate all coverages on December 31, 2026 at 11:59:59 PM.

Q: What is the runout period?

A: Providers have until July 31, 2027 to submit claims with a DOS on, or before December 31, 2026.

Q: What does the July 31, 2027, runout deadline mean?

A: All claims with a DOS prior to December 31, 2026, must be received on, or before July 31, 2027 to be eligible for payment.

Q: What is the last eligible DOS for OhioHealthy claims?

A: Services must be rendered on, or before December 31, 2026 to be eligible for payment from OhioHealthy.

Q: What if claims are in process at the time of closure?

A: Claims already under review will continue through adjudication.

Q: How long do I have for claims with a DOS before August 1, 2026?

A: Claims with DOS prior to August 1, 2026 will continue following the **timely filing requirements outlined in your existing contract**, and will not be subject to the new 120-day filing window.

However, to ensure funding and payment, **all claims must be submitted no later than July 31, 2027.**

Q: For a facility stay that begins before August 1, 2026 and extends beyond that date, which date is used to determine the applicable filing rules?

A: For facility stays billed on a single inpatient claim, the applicable timely filing and appeals requirements are determined by the **admission date**.

- If the admission date is **prior to August 1, 2026**, the claim will follow the **existing contract timely filing and appeals rules**.
- If the admission date is **on or after August 1, 2026**, the claim will follow the **updated requirements under the amendment**.

If services are billed separately (e.g., professional claims or split billing), the applicable rules are based on the **DOS** for each claim or claim line.

Q: If I have questions after plan closure, who should I contact?

A: During runout, please continue to contact OhioHealthy Provider Services (855) 571-1378.; all contact pathways will remain available until December 31, 2027.

Q: Will the claim submission addresses change?

A: No. All existing submission addresses, portals and phone lines remain active through runout.

Q: Will the payer ID, clearinghouse routing, Provider Services staffing/contact hours or mailing address change during transition or runout?

A: No. OhioHealthy Provider Services hours will remain the same until December 31, 2027. There are no other changes unless otherwise communicated

Q: Are authorizations still required through December 31, 2026?

A: Yes. Authorizations will still be required for services taking place prior to December 31, 2026.

Q: What happens to authorizations for services scheduled after January 1, 2027?

A: Any service received on, or after January 1, 2027 will not be covered by OhioHealthy; authorizations will not be issued. A transition report with authorization history will be sent to the members new third-party-administrator.

Q: Will the OhioHealthy provider portal remain accessible during runout?

A: Yes. Portal access is not termed.

How long will I be able to access historical remittances?

A rolling three years worth of claims data will be available.

Luminare & Administrative Support

Q: Who is Luminare, and what is their role?

A: OhioHealthy is the licensed third-party administrator. OhioHealthy outsources the payment of claims to Luminare Health. Luminare will continue supporting claims and appeals processing during the runout period, through December 31, 2027.

Q: How do I submit claims or appeals during runout?

A: Use the same submission channels and processes currently in place. If you would like to submit an appeal, you can initiate the appeals process by filling out this [appeal form](#) or calling us at 855-571-1378.

Member Notification Responsibilities

Q: Is the provider responsible for notifying members of the OhioHealthy plan closure?

A: Providers may need to notify attributed OhioHealthy patients of the plan termination. Please consult your legal/compliance team regarding required notices.

Q: When should member notifications of the OhioHealthy closure be sent?

A: Notification should occur no later than October 1, 2026.

Q: When mailing letters to members to communicate the OhioHealthy plan closure, what should the letters include?

A: OhioHealthy plan closure termination letters should include:

- Plan termination date
- New coverage options (if known)
- Continuity of care rights
- Instructions on contacting their employer/plan sponsor

Q: What do I tell members who ask which plan they should enroll in next year?

A: Please direct members to their employer's Human Resources team for questions about plan enrollment and/or benefits in 2027.

Q: If a patient is mid-treatment at the end of the year, and treatment needs to continue after December 31, 2026, how will that claim be processed?

A: Continuity-of-care rules will apply when allowed by the employer/plan sponsor of the new plan. Please review member benefits and contact the employer's new carrier with questions. OhioHealthy provider services is available for guidance for questions about claims with a DOS on, or before December 31, 2026.

Provider Network Status After Closure

Q: Will my provider contract automatically terminate?

A: Yes. All OhioHealthy network agreements will terminate December 31, 2026.

Q: Does this affect my participation in other OhioHealth networks/products?

A: No. This change applies only to OhioHealthy Medical Plan, Inc. (OhioHealthy) agreements.

Q: Will credentialing for other OhioHealth products be affected?

A: No. Credentialing status remains unchanged unless separately modified by those products.

Q: Will I receive a formal termination notice?

A: Yes. Termination notices were mailed by OhioHealthy on April 30, 2026.

Q: I haven't received a letter, what should I do?

A: Please call the provider service center at 855-571-1378.

Q: What happens to my provider directory listing?

A: OhioHealthy will remove the provider directory portal on December 31, 2026. A searchable PDF provider directory from 2026 will be available on the OhioHealthy web portal through December 31, 2027.

Q: Do I need to recredential with other OhioHealth-affiliated products because of this change?

A: Questions regarding OhioHealth-affiliated products and any recredentialing requirements can be directed to the OhioHealth Credentialing Verification Office (CVO) at OhioHealthCredentialing@ohiohealth.com.

Q: How long should I retain claims submission records for audit?

A: Typical recommendation: 6 - 7 years or according to state/federal requirement.

Practical Checklist Reminders

- Audit all open claims and resubmit immediately if lack of payment or processing error has occurred
- Review last 90-days of EOBs for possible underpayments or denials.
- Send member notification letters by October 1, 2026 (if applicable).

- Submit all claims with DOS prior to December 31, 2026 no later than July 31, 2027.
- Update billing systems to reflect new 120-day filing and 90-day appeal rules for DOS on, or after August 1, 2026.
- Retain full documentation of submissions and EOBs.
- Review and submit all outstanding 2026 claims.
- Remove OhioHealthy from scheduling/eligibility systems as of January 1, 2027

Important Dates for OhioHealthy Transition



OhioHealthy Transition Timeline

Date	Event	Details / Notes
August 1, 2026	New Filing & Appeals Rules Begin	<ul style="list-style-type: none"> • 120-days for timely claim filing • 90-days for appeals • Applies to DOS on or after 8/1/26
December 31, 2026	OhioHealthy Plan Ends	<ul style="list-style-type: none"> • Last day of covered services • All OhioHealthy network agreements terminate at 11:59:59 PM
January 1, 2027	OhioHealthy Plan Officially Closed	<ul style="list-style-type: none"> • No new services covered • Provider directory listings removed • Runout processing begins
July 31, 2027	Final Claims Submission Deadline	<ul style="list-style-type: none"> • All claims with DOS prior to 12/31/26 must be received by this date • End of runout period

Transition & Runout Overview

Period	Start	End	Description
Transition Period	August 1, 2026	December 31, 2026	New timely filing (120-days) and appeals (90-days) rules apply to DOS on/after 8/1/26. Plan remains active through 12/31/26.
Runout Period	January 1, 2027	July 31, 2027	Claims may continue to be submitted for DOS before 12/31/26. No new services covered. All operations move to claims runoff.