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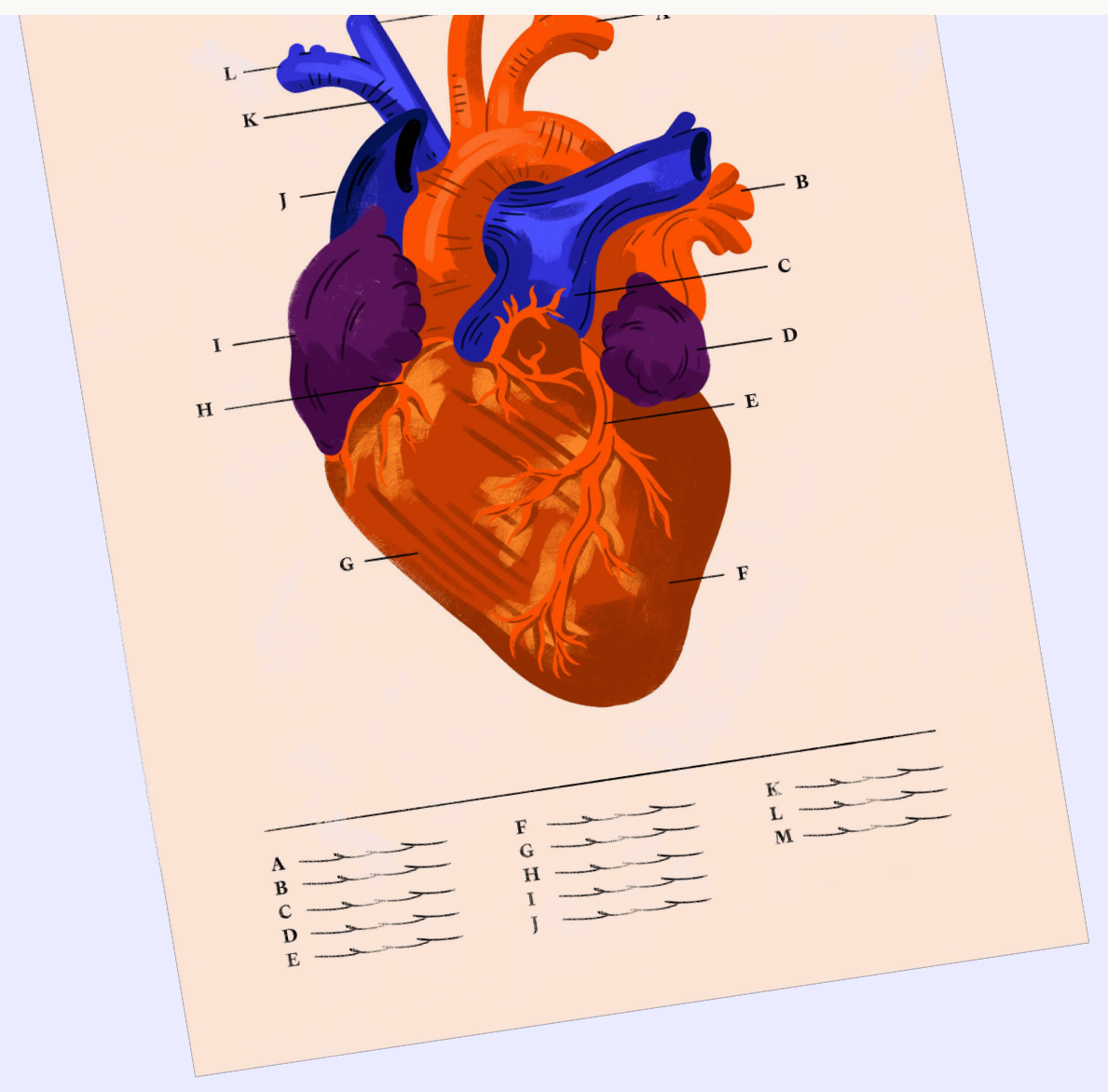
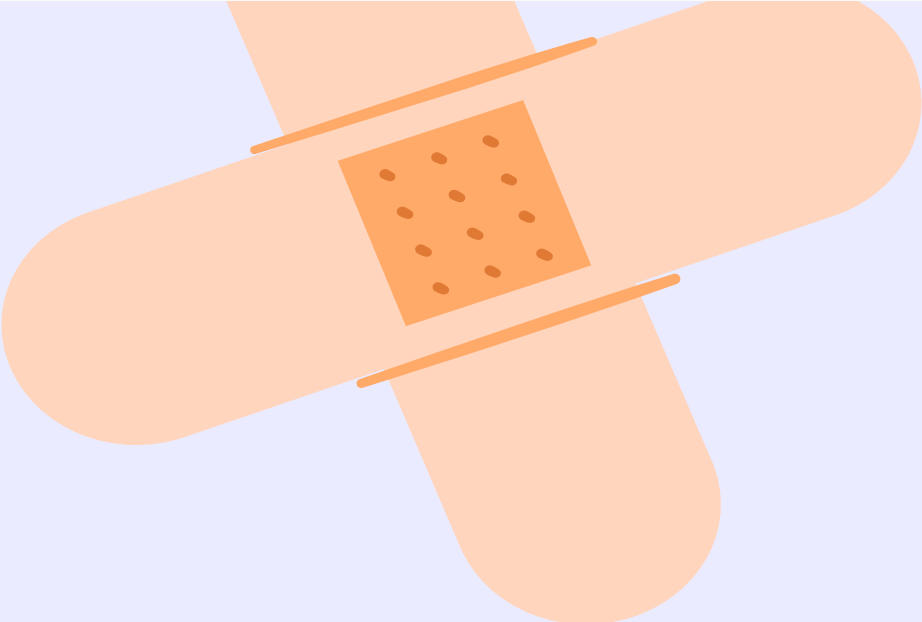
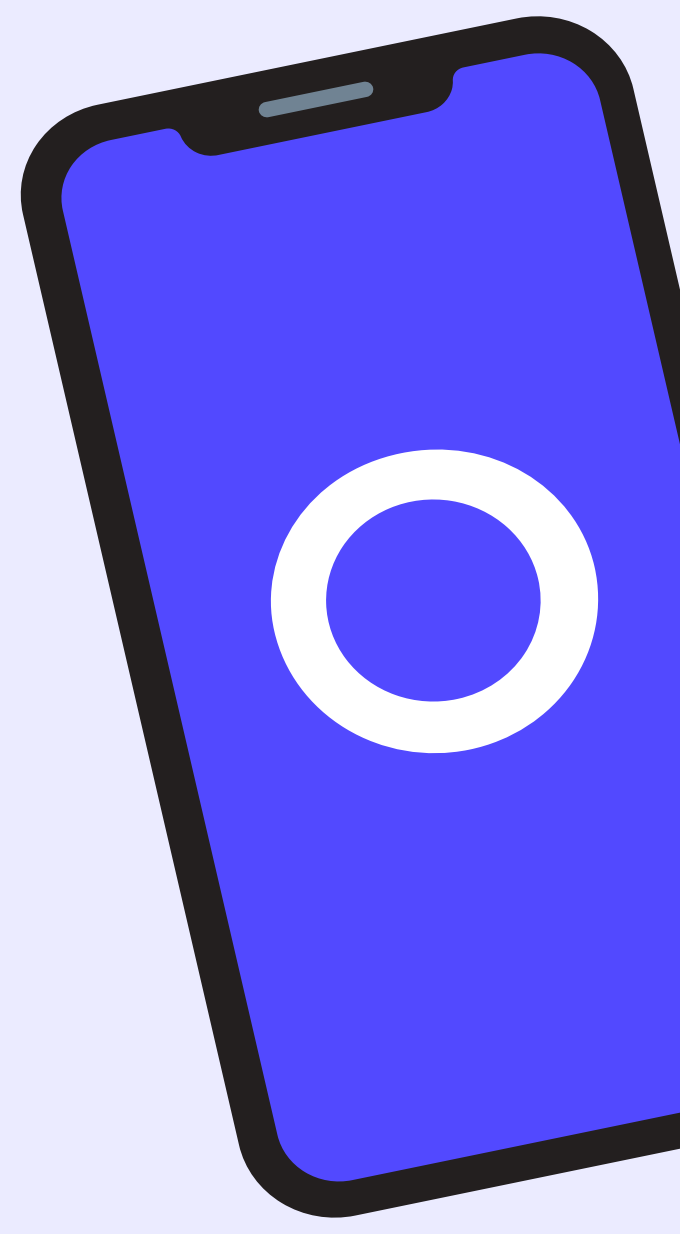




DECEMBER UPDATES

Provider Newsletter



Contents

What's going on this month

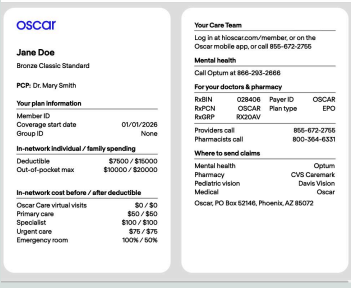
- Meet the 2026 Oscar member ID card
- Upcoming changes in 2026
- Tips to finish out 2025 strong

And much more!

Provider News Updates

Meet the Oscar 2026 Member ID Card

Below is a look at Oscar’s 2026 member ID cards. They look the same whether patients use the digital or physical version. You can also view a patient’s ID card right in the Provider Portal by searching their Oscar member ID.



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Jane Doe

Bronze Classic Standard

PCP: Dr. Mary Smith

Your plan information

Member ID	
Coverage start date	01/01/2026
Group ID	None

In-network individual / family spending

Deductible	$7500 / $15000
Out-of-pocket max	$10000 / $20000

In-network cost before / after deductible

Oscar Care virtual visits	$0 / $0
Primary care	$50 / $50
Specialist	$100 / $100
Urgent care	$75 / $75
Emergency room	100% / 50%

Your Care Team

Log in at hioscar.com/member, or on the Oscar mobile app, or call 855-672-2755

Mental health

Call Optum at 866-293-2666

For your doctors & pharmacy

RxBIN	028406	Payer ID	OSCAR
RxPCN	OSCAR	Plan type	EPO
RxGRP	RX20AV		

Providers call	855-672-2755
Pharmacists call	800-364-6331

Where to send claims

Mental health	Optum
Pharmacy	CVS Caremark
Pediatric vision	Davis Vision
Medical	Oscar

Oscar, PO Box 52146, Phoenix, AZ 85072

Open Enrollment Info

Your first look at Oscar’s 2026 formulary

Oscar’s 2026 Formulary is now live. It gives you an early look at which medicines will be covered starting January 1. Checking it now can help you choose affordable, safe options for your patients and avoid surprises at the pharmacy.

The updated Formulary also makes it easier for your practice to plan ahead by streamlining prior auth needs, reducing medication denials, and supporting smoother starts to treatment in the new year. Taking a moment to familiarize yourself with these updates can help your team avoid delays and keep patients on track with their care.

View the 2026 Formulary

Out-of-network request process change in 2026

Starting in 2026, Oscar is updating how out-of-network (OON) care requests are reviewed. These changes will make the process more consistent and help ensure each request is reviewed correctly based on a member’s benefit plan.

What's not changing:

- All out-of-network services will still require an authorization to determine medical necessity.

What is changing:

- Oscar will now also review whether a member qualifies for an out-of-network exception under their benefit plan.
- Both reviews—the medical necessity review and the exception review—must be approved before OON care can be covered.
- These decisions will be sent separately. If either one is missing or not approved, the OON service will not be covered.

How to submit an Out-of-Network Request

1. Submit the standard Out-of-Network Authorization Request Form for all OON services.
2. Also submit the Out-of-Network Gap Exception Form, which is included with the standard form. Sending both forms together helps the review go smoothly.
3. Members may start a request, but Oscar recommends that providers submit it so all needed clinical details are included.

You’ll find more information in the 2026 Provider Manual.

Click the link below to access both the Out-of-Network Authorization Form and the Out-of-Network Exception Form.

Out of Network & Network
Gap Exception Form

Quick tips to help you and your patients start 2026 strong

As the year comes to an end, we know you’re busy while continuing to care for Oscar members. During this season, a few simple reminders can help your patients stay on top of their health needs before the year and their coverage resets.

Key Reminders:

- **Use Remaining Benefits:** Many benefits reset on January 1, including deductibles, FSAs, and other services. Remind patients to check their plan and schedule any needed visits, labs, or follow-up care before the year ends.
- **Close Care Gaps:** The end of the year is an important time for patients to finish overdue checkups, screenings, and assessments. Review care gaps during visits and use the care gap banner in the Oscar Provider Portal to see what’s still needed. Make sure completed services are recorded with the right codes.
- **Refill Medications:** Ask patients to refill their medicines before the year ends, especially if they take them for chronic conditions.
- **Chronic Care Management:** For patients with ongoing health needs, make sure you close care gaps, finish follow-up visits with specialists, and refill prescriptions before January.
- **Mental Health Check-In:** The holidays can be stressful. Encourage patients to check in on their mental health, use the behavioral health resources listed in the section below, and refill any mental health medications they need.
- **Review 2026 coverage:** Ask patients to look at their 2026 plan so they understand any changes to costs or coverage. They should make sure their providers and pharmacies are still in-network and download their new Oscar ID card.

Sharing these reminders helps patients start the year prepared and helps your practice avoid delays, coverage questions, and refill issues in January. A little planning now can make the new year run more smoothly!

Go to Provider Portal

Support patients with Oscar’s behavioral and mental health resources

A new year often brings changes, and that can create uncertainty, especially with health insurance. At Oscar, we want to make these transitions easier for you and your patients. We offer many behavioral and mental health resources to support your patients’ well-being and help you provide strong, compassionate care.

Here’s how you and your patients can find helpful resources:

- Visit **provider.hioscar.com** and click the “Behavioral Health Resources for Oscar Providers” tab on the left to explore tools and information.
- Members can log in to their Oscar account to access mental health resources directly.
- **Community Resources**
  - Members can also visit **oscar.findhelp.com** to find free local resources like food, housing, and transportation.
- **Optum Health Resources (Oscar partner):**
  - Follow-Up After Hospitalization for Mental Illness
  - On-Demand Behavioral and Mental Health Webcasts
  - Substance Use Disorder (SUD) Screening Tools
  - SUD: Initiation and Engagement in Treatment for Teens
  - SUD: Initiation and Engagement in Treatment for Adults
  - Opioid Use Disorder Quick Reference Guide
  - Calm App: Oscar members get access to this app, which helps with stress, sleep, and anxiety.

Let’s work together to make sure your patients have the support they need for a healthy and positive year ahead!

We now use Availity as our Clearing House. Change Healthcare is no longer supported.

We want to let you know about an important change in how you check **Oscar member eligibility and the status of your claims**. Oscar has partnered with Availity to manage these requests, and this change makes Availity the main electronic hub for our providers.

You now need to use **Availity** to electronically check:

- **Patient Eligibility:** Verifying if an Oscar member's plan is active.
- **Claim Status:** Checking on a claim you have submitted.

You are no longer able to check eligibility or claim status through Change Healthcare.

What You Need to Do

1. If you don't have an Availity account, register for a free account:

- Go to **www.availity.com**
- Click **“Register”** and follow the instructions.

2. If you use another clearinghouse, check with them. Please contact them to make sure they will route your Oscar requests to Availity.

You still have easy access to support:

- **Provider Portal:** Check member eligibility and claim status anytime.
- **Phone Support:** Call us at 855-672-2755 for eligibility, claims, or other questions.

We are here to help you through this transition, and we value your partnership!

Organizational Updates

Hear our CEO, Mark Bertolini, talk about the future of affordable healthcare

In a recent CNBC interview, Oscar's CEO Mark Bertolini explained how Oscar is working to make healthcare simpler, easier to use, and more affordable.

Key takeaways for you:

- **More engaged members.** Oscar is adding new digital tools and giving members better access to their health information. This can help members take a more active role in their care and may give you more chances to guide and coordinate their treatment.
- **Better teamwork.** Oscar is working to improve how payers, providers, and members work together. We want to support you with care management, preventive services, and programs that lead to better health and fewer barriers.
- **A long-term commitment to providers.** As Oscar continues to grow, we're focused on improving processes, workflows, and collaboration to make it easier to work with us and care for our members.

Stay tuned for more updates on Oscar's priorities and upcoming initiatives. We can't do any of this without our dedicated provider partners.

Watch the full interview here

Reminder: Changes to claims sent without PA

We've made a change to help you manage claims more efficiently!

Historically, Oscar's prior authorization process placed claims in a "pend" status in situations where we did not have authorization records on file. This process left claims open (unfinalized) while we allowed for submission of medical records. We realized this process was not industry standard, so we took feedback from our provider partners to make changes to enhance the process.

Rather than sending "pend-denials" **we will now be sending finalized denials** helping to make the next steps, including submitting a dispute or a corrected claim, clearer to our provider partners and aligned with industry standards.

How to submit a prior authorization

- The easiest and fastest way to submit a prior authorization is through the Provider Portal. Using the portal ensures quicker processing and lets you easily check the status of your request.
- If you need to submit an authorization outside the portal, you can use the Authorization Request Form (available by state). Faxes should go to the number listed on the form, or you can call 1-855-672-2755 for assistance.
- Some services may be reviewed by a third-party vendor; if that applies, you'll be directed to contact them.
- In certain states, other submission methods may be available—check the State Specific Supplement in the Provider Manual for details.
- For full details on required information, see the "Authorization Request Requirements" section of the Provider Manual (p. 47).

Claim Denials

- The previous pend used CARC 252 (additional documentation is required) and RARC M127 (the patient's medical record for this service is missing) indicating that Oscar is requesting medical records before making a determination on this claim.
- The new denial will use CARC 197 (Precertification, authorization, notification, or pre-treatment documentation is absent) for missing authorization and CARC 198 (Precertification, notification, authorization, or pre-treatment is exceeded) for exceeded authorization. These will be claim determinations and Oscar will not be requesting medical records.
- If you receive a claim with this denial and you believe a request for authorization or notification was made appropriately, you may submit a dispute. It is recommended that you include the authorization reference number or a copy of Oscar's response to your request.
- If you believe that the claim qualifies for a retrospective authorization review, you may also submit a dispute requesting this. It is recommended that you include relevant medical records to ensure that, if eligible, the review can be completed. If medical records are not included or are insufficient, Oscar may reach out to request them.

We're here to support you! If you have questions, reach out to our Provider Services team at (855) 672-2755, option 4. You'll also see these updates in the 2025 Provider Manual.

Reminder: Submit claim disputes the easy way - via the Provider Portal or with our new cover forms

The quickest and easiest way to submit your claim dispute and track its status in real time is through our Provider Portal. We've simplified the process so you can submit disputes with just a few clicks!

However, if you choose to submit your dispute through fax or mail, **you must include the necessary cover sheet** for it to be processed. If not, your dispute will be returned until the form is used, which could delay resolution. Using the cover sheet the first time ensures your dispute is processed smoothly and without extra steps, which will save you time and follow-up.

Our claims dispute forms can be found at hioscar.com/providers/cover-forms.

How do you know which form to use?

- If you are challenging a claims determination:
  - Use the Claims Dispute Provider Form
- If you are challenging an authorization denial for medical necessity or experimental/investigational procedures:
  - Use the Clinical Appeals Provider Form
- If you are sending us additional documentation regarding an individual claim (including medical records, itemized bills, acquisition invoices)
  - Use the Claims-Related Documents Provider Form
  - This form is NOT to be used for initial claim submission

We recommend saving these cover forms to your files for easy future reference. Find the documents by clicking the button below.

Provider Forms

Your work makes a difference

As the year comes to a close, we want to extend our sincere appreciation for the care you provide to Oscar members and your communities every day. Your expertise, compassion, and commitment make a meaningful difference, and we're grateful for the trust you place in us as your partner. In 2026 and beyond, we remain dedicated to strengthening the provider experience, supporting your work, and removing barriers so you can focus on delivering high-quality care.

Wishing you a peaceful, restorative holiday season. We look forward to continuing our work together in the New Year!

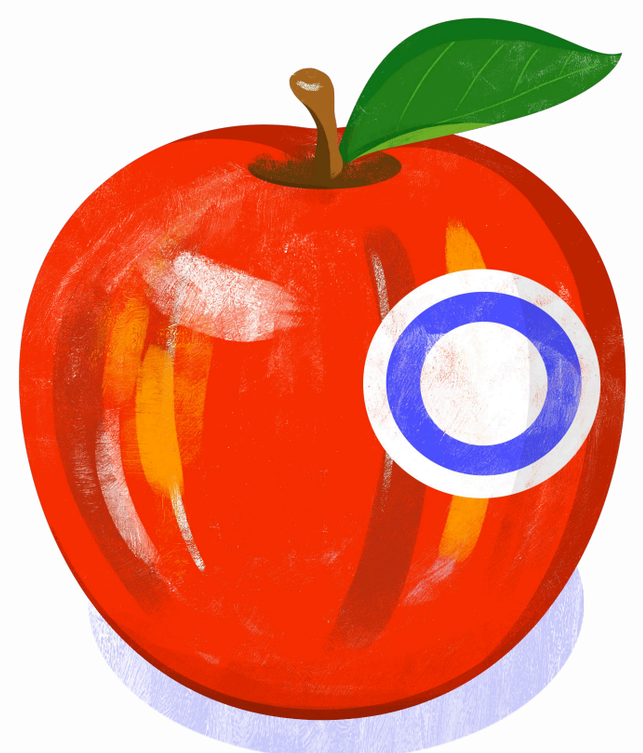
Friendly Reminder

Appointment wait time standards

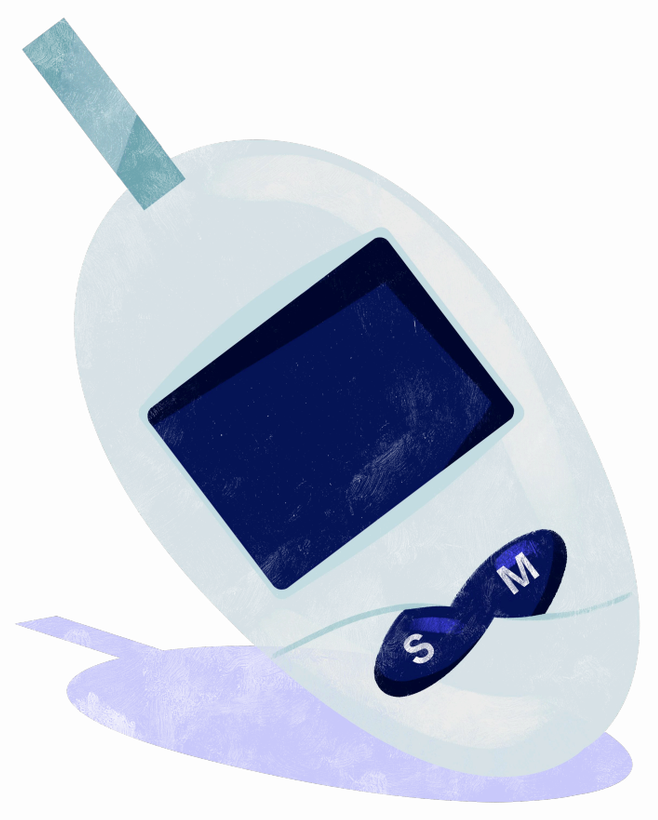
Many Americans experience long wait times for healthcare, and some even delay or skip care because they can’t see a doctor promptly. **These delays are linked** to lower patient satisfaction, negative perceptions of care quality, and higher no-show rates. Prolonged wait times can also lead to worsening health conditions, delayed diagnoses, and potentially preventable hospitalizations.

We know you’re already committed to providing timely, high-quality care to your patients. Here’s a quick reminder about the appointment timeframes established by CMS for qualified health plans:

Behavioral health
appointments within
10 days*
business



Routine Primary Care
appointments within
15 days*
business



Specialty Care
appointments within
30 days*
business

We understand the demands on your time and appreciate your continued efforts to meet these important standards. Thank you for your partnership and commitment to caring for our members the way you do!

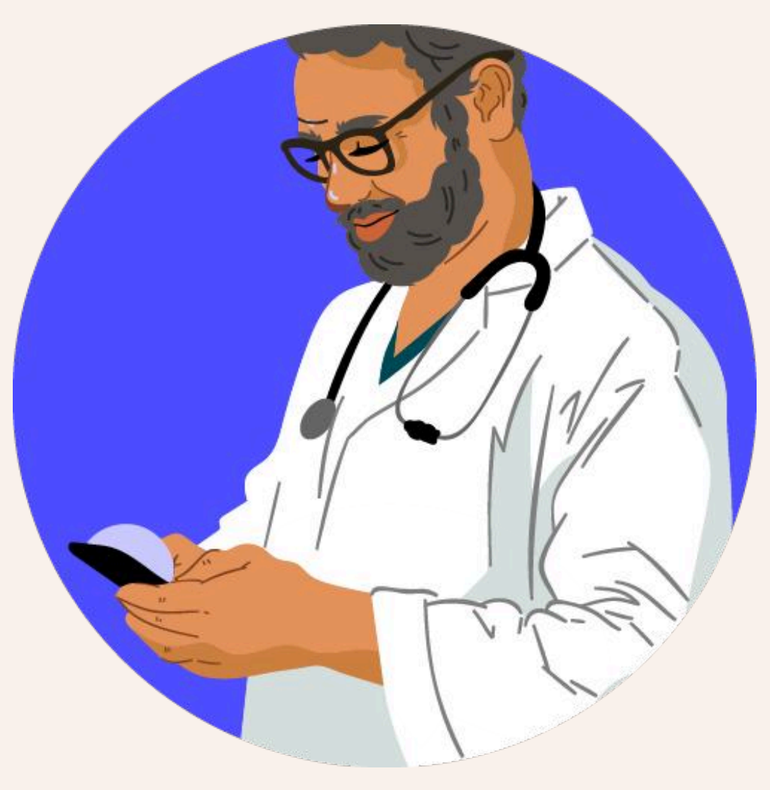
Check out the Provider Manual for more comprehensive guidelines.

Provider Manual

FAQ/Resources

You have questions, we have answers

We know that getting you the information you need, when you need it, is essential to getting patients the care they need. That’s why we’ve developed online provider resources that you can access 24/7.



Provider Resource hub

Access a variety of tools like videos and how-to guides for common tasks

Learn more

Provider Manual

View policy and procedure information by state

Learn more

FAQ’s

Check out answers to some of our most commonly asked questions

Learn more

Want to talk to us directly? Reach out to our Provider Services team at (855) 672-2755, then press 4.

Got a minute?

Share your thoughts so we can make this newsletter work better for you.

Take Survey

Questions?
Our Oscar Business team is here to help at
855-672-2755 or business@hioscar.com.

Oscar Health 75 Varick Street, 5th Floor, New York, NY, 10013, US

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