

## Provider Notice

**To:** All Network Providers  
**From:** Jessica Yasher, MBA, MSN, RN, Director of Operations  
**Date:** November 4, 2025  
**Subject:** AD 25 119 NaviNet® Administrative Appeal Submission

---

PerformCare and NantHealth|NaviNet are excited to announce that we have added a new functionality which allows for the submission of Administrative Appeals and supporting documentation via the NaviNet provider portal.

Providers can now submit this information by accessing *Forms and Dashboards* and completing the applicable form. Once the form has been submitted, a document ID number will be provided. This document ID number will need to be included in any follow-up inquiries. Please refer to page 2 for more details on how to submit the Administrative Appeals in NaviNet.

While this enhancement is designed to streamline your workflow by eliminating the need to mail hardcopy requests, providers are still permitted to mail Administrative Appeals to the appropriate mailing address. For providers submitting Multiple Administrative Appeal spreadsheets that impact 10 or more claims, this process will take the place of emailing these submissions by **December 4, 2025**.

There is no limit on the number of supporting documents that can be uploaded when submitting a request. However, each supporting document must be 32 MB or smaller and in one of the following file formats:

- .docx, .doc
- .pdf
- .png
- .jpg
- .xls, .xlsx

### New to NaviNet?

If you do not have access to the NaviNet provider portal, please visit: <https://register.navinet.net/> to sign up. User guides specific to PerformCare capabilities can be found on the PerformCare website here, <https://pa.performcare.org/providers/self-service-tools/navinet>.

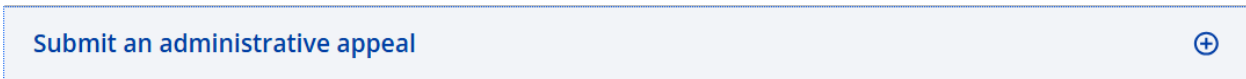
If you have questions or need further assistance, please contact your Account Executive.

cc: Lisa Hanzel, PerformCare  
Scott Suhring, Capital Area Behavioral Health Collaborative  
Missy Wileman, Tuscarora Managed Care Alliance  
PerformCare Account Executives

## Administrative Appeal Submission

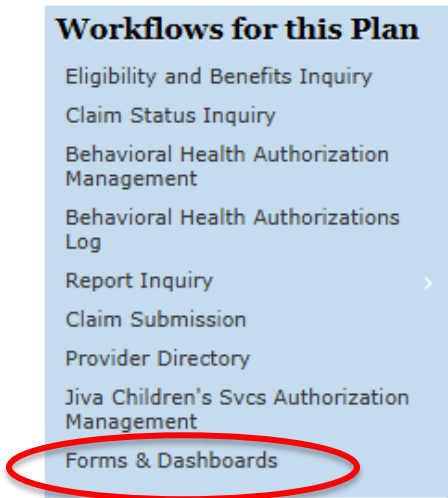
PerformCare providers can now submit an Administrative Appeal and attach supporting documents via the NaviNet Provider Portal. Each document must be 32MB or smaller and in the following file types: .docx, .gif, .pdf, and .png.

Providers should refer to our [Claims and Billing Page](#) for full instructions on Administrative Appeals,



To submit Administrative Appeal through NaviNet, follow these steps:

1. From the NaviNet Plan Central Page, click **Forms & Dashboards** under Workflows for this Plan.



2. In the drop-down, select the provider in which the Administrative Appeal applies to.



### Provider Selection

- NaviNet will then take the user to the Forms page. User should scroll down to the **Provider Appeals** menu. Click **Submit Provider Appeals**,

Provider Appeals

Administrative appeals are the process by which claims denials that are not approved because they do not meet contractual or administrative requirements are reviewed. Administrative denials are not denied based on medical necessity guidelines.

- [Submit Provider Appeals](#)

- Provider will be taken to the Provider Appeals form. All fields with a \* must be completed. When finished with the form and required documents, click **Complete**.

Providers are reminded that the Administrative Appeal process is **not** intended for the situations highlighted in the yellow box below and further explained here,

- The request is related to a pre-service denial. If providers need to appeal an Medical Necessity Criteria (MNC) denial, providers should follow the [Grievance process](#).
- The request is related to an Overpayment/Recovery dispute. Providers receive a letter in the mail and should follow the instructions outlined in the letter.
- The request is related to a Vendor-related dispute. Providers should work with the vendor on any disputes.
- A corrected claim is needed. Providers should refer to [PerformCare’s Claim Submission Instructions](#) on how to complete a corrected claim.



Provider Appeals Form

The Administrative Appeal process is **NOT** intended for any of the following scenarios. Please do not use this form if:

- Your request is related to a pre-service denial, for services that haven't been provided and/or a claim hasn't been submitted.
- Your request is related to an Overpayment/Recovery dispute. Please reference the Recovery findings letter for appeal/dispute submission guidelines.
- Your request is related to a Vendor-related dispute. Please reference the findings letter for appeal/dispute submission guidelines.
- You are submitting a corrected claim.

Provider Info

Group

Provider \*

Phone

Tax ID \*

Medicaid ID

Email ID

Contact \*

Fax

NPI \*

Mailing Address

Address Line1

Address Line2

City  Select State  Zip

Member Info

Member Name \*

MAID \*

Member DOB \*

County of Residence \*

**Claim Info**

Date of Service From *	<input type="text"/>	Date of Service To *	<input type="text"/>
Payment Notification Date	<input type="text"/>	Type *	<input type="text"/>
Diagnosis Code	<input type="text"/>	Reason *	Select Reason ▼
Claim ID *	<input type="text"/>	Type of Service *	Select Type of Service ▼
CPT/HCPCS Codes *	<input type="text"/>	Total Dollar Amount Requested *	<input type="text"/>
		Supporting Documents	Choose Files   No file chosen

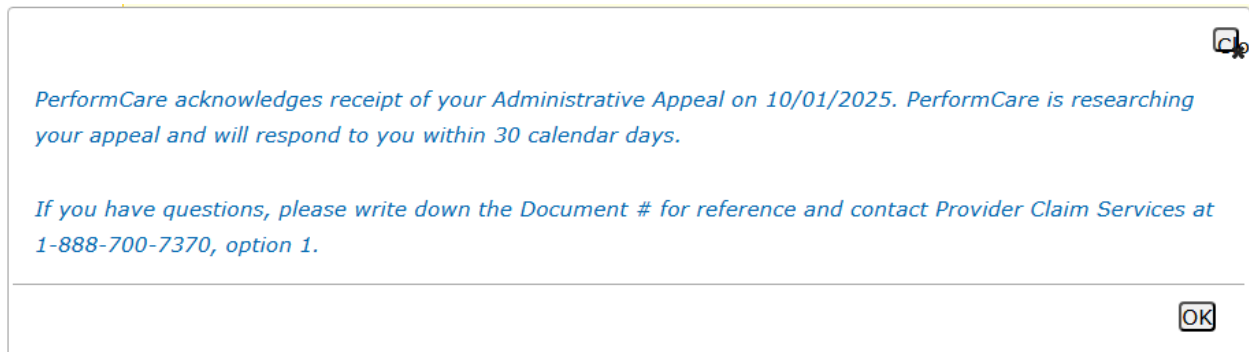
eg: pdf, doc, docx, jpg, png, xls, xlsx  
Note: XLS documents are limited to 100 columns of data

State your rationale for the appeal and expected outcome. Steps taken to correct and prevent future occurrences (if applicable). Please attach any supporting documentation that will assist with resolution. \*

Providers should complete the fields above completely. Additional instructions for each field are as follows,

- Group-** This would only need to be completed if the Payee name is different than the provider who the claim was billed under.
- Provider-** This should match the provider that the claim was billed under.
- Tax ID-** This should match the provider that the claim was billed under.
- Contact-** This is the person that PerformCare would contact should there be any questions on the appeal. Contact’s phone number and email address should also be included.
- NPI-** This should match the provider that the claim was billed under.
- Mailing address-** Providers should list the billing provider’s address listed in PerformCare’s system.
- Member Info-** All information must be completed and match what is in PerformCare’s system.
- Date of Service From/Date of Service To-** These dates must match what was billed on the claim. If the dates do not match, the appeal could be rejected.
- Payment Notification Date-** The date of the EOB from PerformCare should be listed.
- Type-** Providers should enter Provider Appeal.
- Diagnosis Code-** Must match what was billed on the claim.
- Reason-** Provider must choose the reason for the appeal from the dropdown box.
- Claim ID-** Provider must bill the claim and receive the denial before submitting the appeal.
- Type of Service-** Provider should choose the level of care that the claim is in relation to.
- CPT/HCPCS Codes-** Provider should list the code billed on the claim that is reimbursable by PerformCare.
- Total \$ Amount Requested-** Provider should list the dollar amount that is expected from PerformCare.
- Supporting Documents-** Provider should attach any documents that support the appeal. Providers are reminded that if the service requires prior authorization, providers should include the member’s record. Each document must be 32MB or smaller and in the following file types: .docx, .gif, .pdf, and .png.
- State your rationale for the appeal and expected outcome-** Providers should outline why the appeal is being submitted, and what outcome the provider is seeking.

5. Provider will then see a confirmation pop-up box.



6. Once a decision has been rendered on the Administrative Appeal a response letter will be mailed out within 30 days. Providers should allow some time for mailing time.