



Table of Contents

The power of vaccination: a vital tool for providers.....	2	Pharmacy overview	14
Provider credentialing rights.....	4	Provider Data Intake Form (PDIF)	15
Timely filing of claims.....	4	NaviNet.....	15
Provider web pages.....	5	Medical records requirements.....	16
Clinical practice guidelines.....	5	Fraud, waste, and abuse.....	16
Participating provider office standards for access and availability.....	6	Enhancing cultural competency in health care settings.....	17
Billing the member	7	Help us improve member and provider relationships by sharing your demographic and language data.....	18
Population Health program.....	8	Electronic claims submission (EDI).....	20
Population Health program participation.....	9	Use the correct payer ID when filing claims.....	20
Collaborating to enhance Population Health.....	10	Social determinants of health and low birth weight: What providers need to know	21
Member rights and responsibilities.....	11	Building trust to strengthen well-child visits.....	22
Prior authorization guidelines	12	The importance of syphilis screenings during pregnancy	24
Pharmacy benefit management transition to OptumRx	13		

You are receiving this newsletter because you participate in AmeriHealth Caritas Next or First Choice Next, collectively referred to as “the Plan” throughout this newsletter.



The power of vaccination: a vital tool for providers

As frontline advocates for preventive care, providers play a critical role in promoting vaccine confidence and uptake among their patients. Immunizations not only protect individual patients but also help build healthier communities and reduce the burden on the health care system.

Why vaccines matter — clinical and public health benefits

1. Proven efficacy in preventing disease

Vaccines prevent millions of deaths globally each year. Routine immunizations have virtually eliminated diseases like polio, measles, and rubella in many regions — showcasing the long-term success of coordinated public health efforts.

2. Herd immunity safeguards vulnerable populations

By achieving high vaccination coverage, providers help limit disease spread, protecting immunocompromised individuals, infants, and those who cannot be vaccinated for medical reasons.

3. Economic and system-level benefits

Vaccination reduces avoidable health care utilization,

including emergency visits and hospitalizations.

According to the Centers for Disease Control and Prevention (CDC), U.S. childhood vaccines administered from 1994 to 2023 will prevent over 508 million lifetime illnesses and save nearly \$2.7 trillion in societal costs.¹

4. Reducing disparities in care

Equitable access to vaccines helps close health gaps in underserved populations. Routine immunizations are a powerful tool to prevent complications and improve quality of life across all socioeconomic groups.

5. Readiness for emerging diseases

The rapid development and deployment of COVID-19 vaccines demonstrated the importance of immunization infrastructure and public-private partnerships in managing future health threats.



Measles resurgence: A call to action

Despite being declared eliminated in the United States 25 years ago, the number of confirmed measles cases has risen in recent years. On May 23, 2025, the CDC, reported a total of 1,046 confirmed cases across 31 states. One of the highest concentrations is in West Texas, where 728 cases were reported and confirmed since January. These resulted in 94 hospitalizations and two deaths of unvaccinated children without any prior conditions. Nationwide, there have been 14 measles outbreaks so far in 2025. This number is trending up from 2024, when there were 16 outbreaks reported throughout the entire year.²

Measles is one of the most highly contagious viruses, which led to 3 to 4 million cases worldwide prior to the development of the Measles, Mumps, and Rubella (MMR) vaccine in 1963. After the disease was declared eliminated in 2000, hesitation and vaccine safety and misinformation led to many parents declining vaccination for their children in the United States.³ This, combined with increasing global measles activity, has led to the recent increase in measles outbreaks.

Experts state that the best way to stop measles outbreaks is through administration of the MMR vaccine to at least 95% of the people in a given community. While access to the vaccine may be an issue in certain global communities, the biggest challenge in the United States is communicating with patients and dispelling misinformation about the safety and effectiveness of the vaccine.⁴

Key points:

- **High contagiousness:** About 90% of unvaccinated people who come in close contact with an infected person will contract the disease.⁵
- **Vaccination status:** Of the 1,046 measles cases reported so far in the U.S. in 2025, 96% either were unvaccinated or their vaccination status was unknown.³
- **Global trends:** The World Health Organization reports that measles cases across North and South America went up 11 times from 2024. Most of these cases were among unvaccinated people from ages 1 – 29.⁶

Coverage through AmeriHealth Caritas Next and First Choice Next

AmeriHealth Caritas Next and First Choice Next cover all ACIP-recommended vaccines for **children and adults at a \$0 copay**. Please refer to our formulary for the most up-to-date list of covered vaccines and billing guidance.

Support patient conversations

As trusted health care professionals, providers are uniquely positioned to address vaccine hesitancy, correct misinformation, and guide patients through vaccine schedules. Use each patient encounter to review vaccination history and make strong, personalized recommendations.

Let's continue working together to protect our communities, prevent disease, and promote a culture of proactive health through immunization.

Sources:

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2. "Measles Cases and Outbreaks," Centers for Disease Control, May 23, 2025, <https://www.cdc.gov/measles/data-research/index.html>
3. Bridget Balch, "Measles Cases Are on the Rise. Here's What You Need to Know." AAMCNews, April 30, 2025, <https://www.aamc.org/news/measles-cases-are-rise-here-s-what-you-need-know>
4. Public Health on Call, "Controlling the Measles Outbreak in the Southwest," Johns Hopkins Bloomberg School of Public Health, March 12, 2025, <https://publichealth.jhu.edu/2025/the-measles-outbreak-in-west-texas-and-beyond>
5. Chelsea Backler, "An Overview of Measles for Oncology Nurses," ONS Voice, March 6, 2025, <https://www.ons.org/publications-research/voice/news-views/03-2025/overview-measles-oncology-nurses>
6. "Disease Outbreak News: Measles – Region of the Americas," World Health Organization, April 28, 2025, <https://www.who.int/emergencies/disease-outbreak-news/item/2025-DON565>

Provider credentialing rights

The criteria, verification methodology, and processes used by the Plan are designed to credential and recredential providers in a nondiscriminatory manner, regardless of race, ethnic or national identity, gender, age, sexual orientation, specialty, or procedures performed.

During the review of the credentialing application, applicants are entitled to certain rights. Every applicant has the right to:

- Review the information submitted to support their credentialing application, except for recommendations and peer-protected information obtained by the Plan.
- Correct erroneous information. When the Provider Services department receives information that varies substantially from the information the provider gave, the Provider Services department will notify the health care provider to correct the discrepancy.
- Make corrections in writing to the Provider Services department within 10 business days of identification. If the change is not reflected in 10 business days, please contact your Provider Network Management Account Executive. Please refer to the provider manual to learn more.
- Be updated on the status of their credentialing or recredentialing application by requesting this update from the Provider Services department. The Provider Services department will share all information with the provider, except for references, recommendations, or peer-review protected information (e.g., information received from the National Practitioner Data Bank). Applicants can ask for updates by phone, email, or writing. The Provider Services department will respond to all requests within 24 business hours of receipt. We will respond by email or phone call to the provider.
- Be notified within 60 calendar days of the Credentialing Committee or Medical Director review decision.
- Review all credentialing application and primary source verification policies and procedures by requesting them from the Provider Services department.

To ask for any of the above, please contact the Provider Services department.

Timely filing of claims

Providers must submit all original paper and electronic claims to the Plan within 180 calendar days from the date services were rendered (or the date of discharge for inpatient admissions). This applies to both capitated and fee-for-service claims. Please allow for normal processing time before resubmitting a claim either through the electronic data interchange (EDI) or paper process. This will reduce the possibility of your claim being rejected as a duplicate claim. Claims are not considered as received under timely filing guidelines if rejected for missing or invalid provider or member data.

Note: The EDI vendor must receive a claim by 9 p.m. for it to be sent to the Plan the next business day.

Type of claim	Description and time frame
Original claim	Must be submitted to the Plan within 180 calendar days from the date services were rendered or compensable items were provided.
Rejected claim	Is not registered in the claims processing system and can be resubmitted as a new claim. They may be corrected and resubmitted within 180 calendar days from the date of services.
Denied claim	Has been processed in the claims system. It may have a payment attached (partial denial) or may have been denied. A corrected claim can be reprocessed if submitted within 365 calendar days of the original date of service. Note: A corrected claim is not the same as a claim dispute. If your claim did not have all elements listed correctly, that claim may be corrected. If you disagree with the outcome of your adjudicated claim, you may file a claim dispute.
Out-of-network provider claim	Must be submitted to the Plan within 180 calendar days from the date services were rendered or compensable items were provided.

Provider web pages

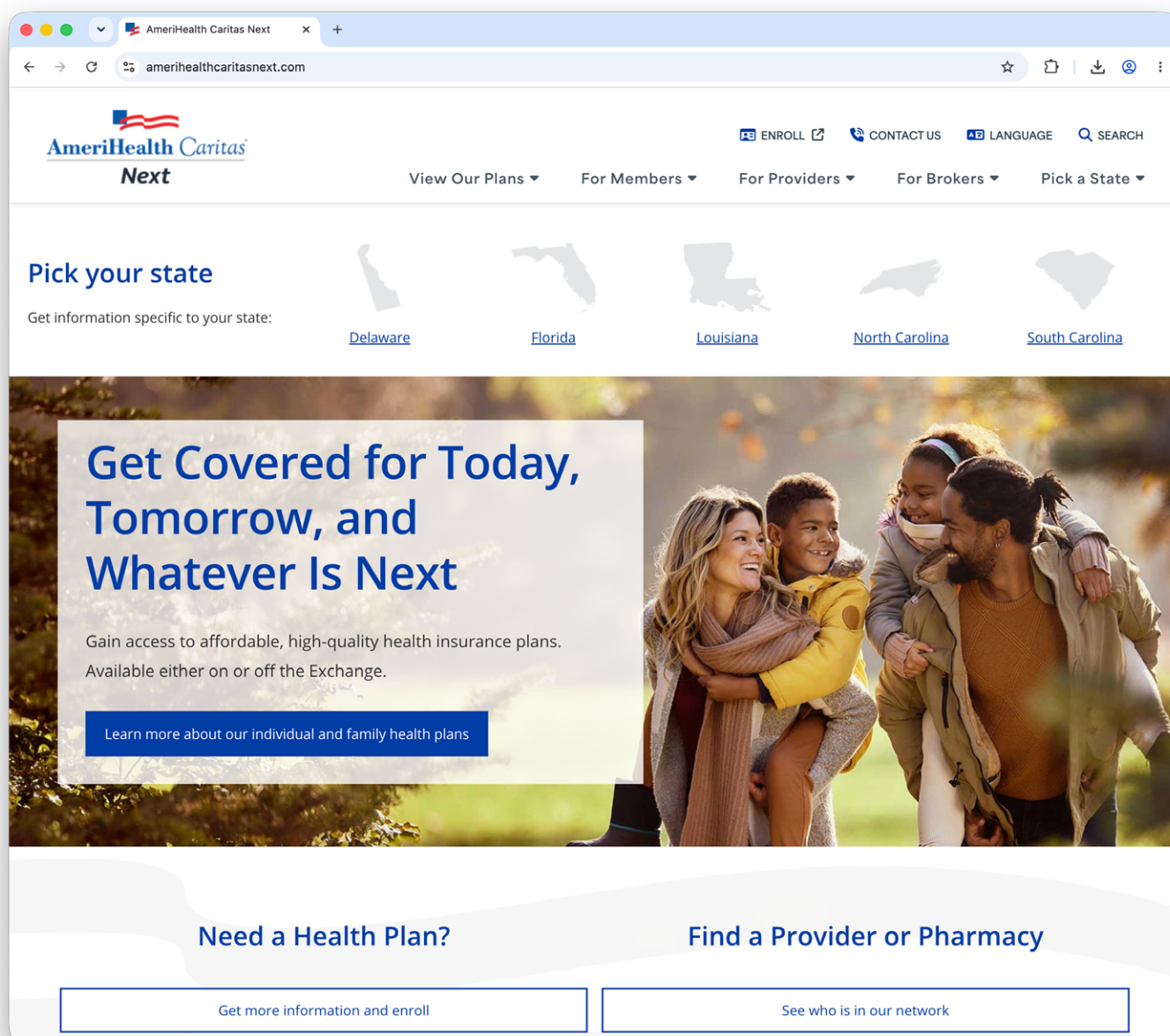
Our provider-dedicated web pages feature up-to-date news and information of interest to providers and the health care community. The site has a user-friendly interface that allows you to easily navigate the latest news and information of interest to you and your office. Additionally, you can easily access resources including forms, NaviNet, and provider publications. Provider pages can be found at www.amerihhealthcaritasnext.com. Select your state and then select **For Providers**.

Clinical practice guidelines

AmeriHealth Caritas Next and First Choice Next are dedicated to providing the most comprehensive, outcomes-driven health solutions for our members. Part of this approach means making it a priority to reduce unnecessary variations in care. We've used the latest scientific evidence and research to create our clinical practice guidelines, which represent the latest in current professional standards.

While these clinical practice guidelines are intended to inform, they aren't intended to replace a physician's clinical judgment. The physician remains responsible for determining the applicable treatment for each individual.

Providers can learn more about clinical practice guidelines by visiting the Clinical Resources page of the Plan's website.





Participating provider office standards for access and availability

The Quality Management (QM) department, in collaboration with Provider Network Management, establishes an annual access and availability plan to address the sufficiency of the Plan's provider network in number, type, and geographic location of practitioners who practice primary and specialty care, in accordance with relevant regulatory and accreditation standards. The cultural needs of the Plan members are taken into consideration, and mechanisms are implemented to provide adequate access to primary and specialty care practitioners. Availability of practitioners is assessed annually by the Provider Network Management department.

Through the QHP Member Experience survey, the QM department also establishes and measures the accessibility of services, such as regular and routine appointments, urgent care appointments, after-hours care, emergent care, and access to customer service.

We collect and analyze this data to identify opportunities for improvement. Interventions are implemented to improve performance.

Access standards for PCPs and specialists are as follows:

Appointment availability

PCPs

- Emergent/immediate — Twenty-four (24) hours per day, seven (7) days per week
- Urgent — One (1) business day
- Routine and regular (well or preventive) care — Fifteen (15) business days

Specialists/chiropractors/podiatrists

- Emergent/immediate — Members should call 911 or go to the nearest emergency room
- Urgent — One (1) business day
- Routine appointment — Thirty (30) business days
- OB/GYN routine appointment — Thirty (30) business days

Mental health providers (non-medication prescribers and medication prescribers)

- Emergency — Within fifteen (15) minutes of presentation at a service delivery site
- Urgent, nonemergency — Within one (1) hour of presentation at a service delivery site or within twenty-four (24) hours of telephone contact with provider or the Contractor.
- Non-life-threatening emergency — Within 6 hours
- Routine mental health services (in follow-up to intake assessment and upon determination) — Twenty-one (21) calendar days of the request for an appointment.
- Initial visit for routine care — Ten (10) business days

Internal waiting time

Patients should be seen within 30 minutes of the time of the scheduled appointment.

Availability

Coverage must be provided 24 hours per day, seven days per week, for our members. Covering practitioner must be a participating provider. Providers who use answering machines for after-hours services are required to include the following in the outgoing message:

- Urgent/emergent instructions as the first point of instruction
- Information on contacting a covering provider
- Telephone number for after-hours provider access

After-hours phone response

For an urgent/emergent problem, the provider should respond within 30 minutes. Auto-response messages should direct callers with emergent needs to dial 911 or go to their nearest emergency room.



Billing the member

Providers may collect copayments, coinsurance, and any unpaid portion of the deductible at the time of service. In-network providers may not bill members for any amounts other than such copayments, coinsurance, or deductibles.

Balance or surprise billing

Members are protected from balance billing for the following services:

Emergency services

If a member has an emergency medical condition and gets emergency services from an out-of-network provider or facility, the most the provider or facility may bill the member is the Plan's in-network cost-sharing amount (such as copayments and coinsurance). A provider cannot balance bill a member for these emergency services. This includes services the member may get after they are in a stable condition, unless they give written consent and give up their protections not to be balance billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When a member gets services from an in-network hospital or ambulatory surgical center, certain providers within such facilities may be out of network. In these cases, the most those providers may bill the member is the Plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. Providers can't balance bill the member and may not ask the member to give up their protections not to be balance billed.

Out-of-network providers

Out-of-network providers may need to bill the member for an unpaid balance after the time of service. It is the out-of-network provider's responsibility to advise the member and obtain the member's acknowledgment in writing if products or services extend beyond the Plan's coverage so that the member understands that they are liable for any costs beyond what the Plan will pay.

Population Health program

The Plan's Population Health program is a holistic solution to provide comprehensive care management services. This fully integrated model allows members to transition seamlessly from one level of care to another for their unique needs. From this integrated solution, the Plan delivers and coordinates care across all programs. We offer this program to all plan members.

The Population Health program includes:

- Assessment
- Screening for social determinants of health
- Care planning
- Health and wellness education to encourage self-management
- Service coordination
- Treatment
- Reassessing and adjusting the person-centered care plan and its goals as needed

The Population Health program uses evidence-based practice guidelines and is structured around a member-based decision support system that drives both communication and person-centered care plan development through a multidisciplinary approach to management.

The Plan's Population Health team works proactively to meet our members' needs at all levels to maximize health outcomes. The team includes:

- Nurses
- Licensed mental health and substance use disorder professionals
- Care Connectors
- Clinical pharmacists
- Plan medical directors
- PCPs
- Specialists
- Community agencies
- Members and their caregivers, parents, or guardians





Population Health program participation

We offer all plan members the chance to participate in Population Health programs. Members can opt out on request. Providers may also contact the Plan to enroll members in a program, and members may contact the Plan to self-refer into a program.

For specific Population Health-related needs, members are identified when they enroll in the Plan through systematic risk stratification. We include a new member assessment in the member's welcome packet to help identify current health conditions and health care services. Based on their responses to this initial health assessment, we identify members for participation in the appropriate care management program. We also identify members for participation through telephonic outreach.

The Plan systematically restratifies members quarterly. Members are encouraged to let the Plan know if they have a chronic health condition or special health need, or if they are receiving ongoing care.

Let Us Know program

We encourage providers to refer members to Population Health Management as needs arise or are identified. If you recognize a member with a special, chronic, or complex health condition who may need the support of one of our programs, including Complex Care Management, Care Coordination, or the Bright Start® program, please contact our Rapid Response and Outreach Team. Providers can also complete our Let Us Know member intervention request form and fax it to our Rapid Response and Outreach Team for members who have missed appointments or who may need transportation services or further education on their treatment plan or chronic condition. You can download this form from our website at: www.amerihhealthcaritasnext.com.

Members are also referred to the Population Health programs through internal plan processes. Identified issues and diagnoses that result in a referral to the Population Health program may include:

- Multiple diagnoses (three or more actual or potential major diagnoses)
- Risk score indicating over- or under-utilization of care and services
- Infants receiving care in the NICU
- Members with dual medical and behavioral health needs
- Members with substance use disorder-related conditions
- Members who are developmentally or cognitively disabled
- Members with a special health care needs
- Members with polypharmacy use
- Pregnant members
- Members with high trauma exposure
- Members who need long-term services and supports to avoid hospital or institutional admission

Collaborating to enhance Population Health

Providing care for our shared members requires teamwork, communication, and a unified dedication to improving outcomes. Population health management aims to address care gaps, support those at highest risk, and promote comprehensive well-being across our communities. We strive to supply your practice with valuable tools and resources that complement the exceptional care you already offer.

Defined roles and shared accountability

Successful population health management relies on clear role definitions and aligned responsibilities. Together, we are accountable for achieving measurable health results.

Your practice:

- Guides clinical decisions and oversees patient care.
- Determines care needs during appointments and coordinates treatment plans.
- Involves patients in recommended preventive and follow-up care as part of our health plan.

Our health plan:

- Supplies actionable data and quality performance reports.
- Identifies members who could benefit from extra support.
- Reaches out to engage members and reinforce care plans.
- Offers care management services for members who are high-risk or have complex needs.
- Connects members to community and social support services.

By aligning responsibilities and maintaining open communication, we can coordinate outreach efforts and connect members to the appropriate care management and support programs, such as Let Us Know. We encourage providers to collaborate with us to refer eligible members and to reinforce engagement in available support services and programs.

You lead your practice's care; we provide support through data, coordination, and engagement. When we work together around shared goals and maintain clear communication, we can:

- Address care gaps.
- Enhance quality performance.
- Minimize unnecessary utilization.
- Improve the member experience.



Advancing population health through value-based collaboration

In addition to defining roles in coordinated care activities, we support providers through alternative payment model (APM) arrangements designed to align incentives with shared population health goals. These value-based strategies promote accountability for quality outcomes and care coordination, and facilitate overall member well-being by aligning performance expectations, data insights, and financial incentives. APM opportunities further strengthen collaboration and support measurable improvements in health outcomes throughout our communities.



Member rights and responsibilities

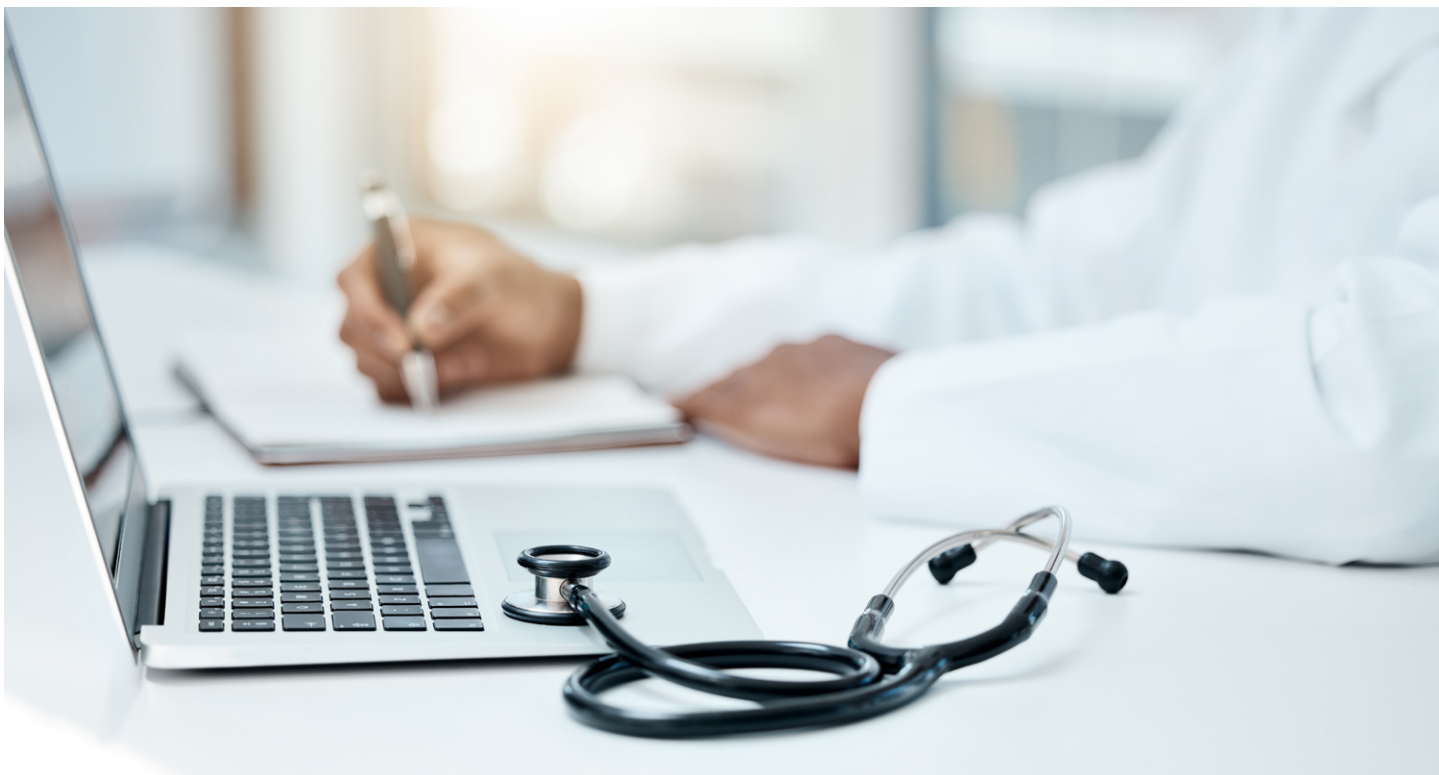
Providers are responsible for honoring and supporting member rights. Members receive information about their rights and responsibilities through the member handbook.

Examples of member rights include the right to:

- Receive the full range of services offered by the health plan.
- Be treated in a respectful and dignified manner.
- Have medical records protected in accordance with applicable state and federal laws and health plan policies.
- Review their medical records.
- Request information in an alternate format, consistent with the Americans with Disabilities Act.
- Receive language assistance at no cost during all points of contact and throughout all hours of operation.

Member responsibilities include:

- Learn about their health conditions and notify their health care providers when they do not understand their treatment plan or care expectations.
- Attend scheduled appointments and, when possible, contact the physician's office if they need to cancel or will be late.
- Present their member ID card at appointments.
- Follow the care instructions and treatment plans agreed upon with their health care practitioner.
- For a complete list of Member Rights and Responsibilities, please refer to the Provider Manual or refer to the member's Evidence of Coverage located at www.amerihealthcaritasnext.com > Pick your State > For Members > Forms and Documents > Evidence of Coverage.



Prior authorization guidelines

Prior authorization is required to evaluate the medical necessity of certain health care products and services. When referring members to a hospital, the PCP only needs to refer to the admitting/performing physician, who is then responsible for obtaining prior authorization for the hospital admission.

Responsibilities of the admitting/performing physician for hospital admissions:

- Make hospital admission arrangements.
- Acquire the following required information:
 - Member name and date of birth
 - Member ID number
 - Admission date
 - Place of admission
 - Diagnosis
 - Planned procedure
- Provide medical information to support the prior authorization review request.
- Notify the member's PCP of the diagnosis, planned procedure, and hospital arrangements.
- Contact the hospital with the prior authorization code.

Criteria used for utilization management determinations are available on request to all AmeriHealth Caritas Next and First Choice Next providers and members free of charge. Members and providers can learn more about the availability of review criteria and how to obtain clinical criteria used for a utilization management determination through the provider manual, Member Handbook, and written utilization management determination letters.

Pharmacy benefit management transition to Optum Rx

What is changing

Effective January 1, 2027, AmeriHealth Caritas Next/First Choice Next will transition pharmacy benefit management services from PerformRxSM to Optum Rx.

AmeriHealth Caritas Next/First Choice Next will continue to manage formulary oversight, clinical programs, prior authorizations, and Member Services. Optum Rx will support claims processing, rebates, and all pharmacy network contracting.

Formulary and prior authorization

The transition will not affect the formulary and/or covered drug list. Providers should continue to use the formulary for covered drugs and prior authorization requirements found on our website: www.amerhealthcaritasnext.com > Pick your State > For Providers > Find a Provider, Pharmacy, or Drug.

The prior authorization process and phone number will not change. The Pharmacy Prior Authorization contact and process information can be found at: www.amerhealthcaritasnext.com > Pick your State > For Providers > Prior Authorizations.

Pharmacy network access

AmeriHealth Caritas Next/First Choice Next is working to maintain access to current network pharmacies. If changes occur, impacted members will be notified.

Questions

- Providers may call the Pharmacy Clinical Prior Authorization phone number found on our website: www.amerhealthcaritasnext.com > Pick your State > For Providers > Prior Authorizations.
- Members may call the Pharmacy General Assistance phone number found on our website: www.amerhealthcaritasnext.com > Pick your State > For Providers > Prior Authorizations.

Thank you for your continued partnership in supporting our members during this transition.



Pharmacy overview

The Plan strives to provide members with high-quality and cost-effective drug coverage. PerformRxSM, our pharmacy benefits manager and AmeriHealth Caritas Next or First Choice Next delegated entity, handles the administration and claims processing of the Plan prescription drug benefit. As part of our commitment to comprehensive coverage, we offer a range of plans covering prescription drugs approved by the U.S. Food and Drug Administration (FDA).

The Pharmacy and Therapeutics (P&T) Committee oversees our pharmacy policies and procedures and promotes the selection of clinically appropriate, safe, effective, and economically advantageous medications for our members. The P&T Committee objectively appraises, evaluates, and selects drugs and/or drug classes for the formulary; evaluates, analyzes, and reviews policies and procedures to ultimately educate and inform health care providers about drug products, usage, and committee decisions; and evaluates, analyzes, and reviews protocols and procedures for the use of, and access to, non-formulary drug products. The committee is comprised of internal and external clinical pharmacists and physicians in a variety of specialties.

The P&T Committee meets on at least a quarterly basis to review and update the formulary.

Prescription drug programs

Members with an AmeriHealth Caritas Next or First Choice Next prescription drug benefit may have coverage through one of the programs listed in this section. Coverage for drugs is based on the member’s health benefit plan. The formulary is reviewed over the course of the year for value, quality, effectiveness, and consideration of new generic and brand drugs that are introduced into the Health Insurance Marketplace[®]. As a result, the formulary is updated throughout the year. Some drugs may be subject to utilization management programs to ensure appropriate clinical use and cost efficiency.

- Prior authorization program
- Step therapy protocol
- Quantity limit program
- Generic drug program
- Brand drug program
- New-to-market drugs
- Non-formulary drug program
- Specialty drug program

2026 Formulary tiers

- Tier 1 — Generics
- Tier 2 — Preferred Brands
- Tier 3 — Non-Preferred Brands
- Tier 4 — Specialty

Before you prescribe drugs to members, we recommend that you become familiar with the Pharmacy section in the provider manual. In it you will find information about our prescription drug programs, formulary, and prior authorization process. The formulary is also available on our website.

Health Insurance Marketplace[®] is a registered trademark of the U.S. Department of Health & Human Services.

Provider Data Intake Form (PDIF)

Updating your provider information

Whether submitting claims, reporting changes in your practice, or completing recredentialing applications, it is essential that the information you transmit is timely and accurate. When changing key provider demographic information, you are contractually required to notify us in writing with at least 30 days' advance notice.

Every 90 days, before the due date, you will be sent a reminder to verify that your provider data is accurate. You will have 30 days to attest to the accuracy of information or submit any corrections through the **Provider Data Intake Form** on NaviNet. Providers who do not respond in this time frame may be removed from our provider directory until they validate their data. This validation process is only used for our AmeriHealth Caritas Next and First Choice Next products. It does not apply to our Medicaid plans.

To review or update your provider information, follow these steps:

1. Log in to NaviNet.
2. Select the appropriate health plan.
3. Click the **Provider Data Information Form** link (in the upper left corner of the Plan homepage).
4. On the **Provider Selection** screen, click the **Please Select a Provider** option. Select a provider and then submit.
5. You will be taken to the **Provider Self-Service** screen. In the bottom right portion of the page, click the box titled **Proceed to Provider Updates**.
6. Click the box titled **PDIF Update**.
7. Click **Location Selection**.
8. Click the box for the provider(s) for whom you want to attest and/or make changes. Click the **Next** box in the bottom right corner of the page.
9. Review and make changes to the provider summaries, if applicable.
10. Provide required documentation, if applicable.
11. Attest and click the **Next** box in the bottom right corner of the page.

Provider directory data changes will be reflected within the online provider directory within 14 business days. If the change is not shown in 14 business days, please contact your Provider Network Management Account Executive.



NaviNet

The NaviNet Provider Portal is an easy-to-use, secure platform that links providers to health plan members. Our Provider Portal at www.navinet.net allows you to share critical administrative, financial, and clinical information with AmeriHealth Caritas Next or First Choice Next, all in one place.

This tool can help you manage patient care through quick access to:

- Member eligibility and benefits information, including information for members in pending status
- Panel roster reports
- Care gap reports to identify needed services
- Member clinical summaries
- Social determinants of health information
- Admission and discharge reports
- Medical and pharmacy claims data
- Electronic submission of prior authorization requests

If you do not already use NaviNet to keep informed of your member accounts, you can register at www.navinet.net. All you need is a federal taxpayer ID number.

Medical records requirements

Participating providers must maintain medical records in a manner that is current and detailed and allows for effective and confidential patient care and quality review. Provider office medical record filing systems should facilitate access, availability, confidentiality, and organization of records at all times.

Providers must retain all medical records, whether electronic or paper, for a period of no less than 10 years after the rendering of covered services to the member.

Providers are required to make medical records accessible to all appropriate government agencies, including but not limited to the Department of Insurance and their respective designees for quality assurance, investigation of complaints or grievances, enforcement, or other activities related to compliance with applicable laws.

Providers must follow the medical record standards outlined in the provider manual for each member's medical record, as appropriate.



Fraud, waste, and abuse

The Plan has an established enterprise-wide Program Integrity department with a proven record in preventing, detecting, investigating, and mitigating fraud, waste, and abuse. Local AmeriHealth Caritas Next and First Choice Next staff, including a Special Investigation Unit Manager and Investigator, will be supported by the Program Integrity department.

As a network provider, you are responsible for reporting suspected fraud, waste, and abuse.

Reporting issues to AmeriHealth Caritas Next or First Choice Next

If you are aware of potential or actual fraud, waste, or abuse, we encourage you to report the issue to the Special Investigations Unit by:

- Calling the toll-free Fraud, Waste, and Abuse Hotline at **1-866-833-9718**. The hotline is available 24/7 and allows anonymous reporting of issues.
- Emailing fraudtip@amerihealthcaritas.com
- Completing the anonymous online fraud intake form found at www.amerihealthcaritasnext.com.
- Mailing a written statement to:
Special Investigations Unit
AmeriHealth Caritas Next/First Choice Next
P.O. Box 7318
London, KY 40742





Enhancing cultural competency in health care settings

The Plan encourages providers and their staff to report their race and ethnicity, the languages they speak, and the language services available through their practice. This information can be reported when providers do their attestation through the Council for Affordable Quality Healthcare (CAQH).

The languages reported by providers are published in the provider directory so members can easily find providers who speak their language.

The provision of culturally appropriate care requires an understanding of the social and cultural differences of the patient population served and the impact culturally appropriate care during a medical encounter can have on patient satisfaction and adherence. Cultural awareness and ongoing education are important when it comes to improving the quality of care and health outcomes and addressing racial and ethnic disparities in culturally diverse patient populations.

Cultural competency training

Providers are encouraged to complete the free eLearning cultural competency training offered by the Health & Human Services Department (HHS) Office of Minority Health titled “A Physician's Practical Guide to Culturally Competent Care.” This training offers up to nine continuing education units (CEUs) and can be accessed from the [Think Cultural Health website](#).

For additional cultural competency resources and training, including continuing medical education (CME) offerings, please visit the Provider Training page found in the provider section of your Next plan website.

Additional resources

- [Health Resources and Services Administration: Culture, Language, Health Literacy](#)
- [National Institutes of Health: Clear Communication](#)
- [The Health Literacy & Plain Language Resource Guide \(PDF\)](#)
- [The Fenway Institute, National LGBTQIA+ Health Education Center](#)
- [Do Ask, Do Tell: LGBT People: An Overview](#)
- [Health Literacy Universal Precautions Toolkit](#)
- [Office of Minority Health – Cultural and Linguistic Competency](#)
- [National Center for Cultural Competence](#)

Help us improve member and provider relationships by sharing your demographic and language data

At AmeriHealth Caritas Next and First Choice Next, we believe quality care starts with informed choice and culturally responsive connections between members and providers. AmeriHealth Caritas Next and First Choice Next collect, store, and report race, ethnicity, and language (REL) data from providers and their offices that is made available to members upon request.

By sharing your demographic information, including but not limited to race, ethnicity, and/or language, you help empower our members to make informed decisions about their care, improve health equity, and support stronger health outcomes for the communities we serve.

This data allows us to:

- Provide members with meaningful, choice-based information when selecting a provider.
- Tailor resources and services to meet the cultural and linguistic needs of our diverse member population.
- Monitor and address health disparities across our network.

What is race and ethnicity data?

Race is a term used to describe a category of people who share certain physical traits, such as skin color, hair color and texture, or eye color. Race, as popularly understood, divides human populations into groups based on physical factors. Although the National Human Genome Research Institute and other researchers confirm that race is a political and social construct,¹ the federal government asks people to self-identify into one of six racial categories, so that data can help ensure federal programs address the needs of all groups.² The groups are:

- | | |
|-------------------------------------|-------------------------------------|
| • American Indian* or Alaska Native | • Pacific Islander/ Native Hawaiian |
| • Asian | • White |
| • Black/African American | • Middle Eastern/ North African |

*Please be aware that some people consider “American Indian” outdated. While it may be necessary to use when collecting data, when speaking to an individual, refer to them using the terms they use to identify themselves.²

1. “Race,” National Human Genome Research Institute, January 14, 2025, <https://web.archive.org/web/20250114154121/https://www.genome.gov/genetics-glossary/Race>, accessed August 5, 2025.
2. U.S. Census Bureau, “Why We Ask Questions About Race,” <https://www.census.gov/acs/www/about/why-we-ask-each-question/race/>



Ethnicity is a classification of humans based on historical connection by a common national origin or language. Ethnicity could also be defined as a person’s roots, ancestry, heritage, country of origin, or cultural background. The two ethnicity categories as defined by the federal government are:

- Hispanic
- Non-Hispanic

Why is language data necessary?

The first step to strong patient-centered care is direct communication. Language is more than a communication tool; we express emotions, retain critical information, and make decisions in the language that we most prefer. Providing data on the language(s) spoken by the provider and their staff is the first step in strong communication between patients and providers.

Spoken language refers to the language in which a member prefers to speak about their health care.

Written language refers to the language in which a member prefers to read or write about their health care.

Several laws, like the 1964 Civil Rights Act, Title III of the Americans with Disabilities Act (ADA) and Section 1557 of the Affordable Care Act (ACA), require medical facilities, doctors, and other health care providers to implement a language access program. Independent of this, patient satisfaction, care adherence and other positive benefits result when patients can access services in their preferred language.

How do we collect this information?

- AmeriHealth Caritas Next and First Choice Next request that our contracted provider network voluntarily share their REL data, as well as their office support staff's languages.
- AmeriHealth Caritas Next and First Choice Next requests and collects network provider REL data using the same Office of Management and Budget (OMB) categories used to collect members' REL.

How do we store and share this information?

REL data is housed in a database that is made available to members.

- Gender data is available through AmeriHealth Caritas Next and First Choice Next provider directory.
- Provider's language, staff's language, and additional language services are also available through the provider directory.
- Information on race and ethnicity is only made available to members upon request.

Demystifying common provider concerns

"My race and ethnicity have no impact on the care I give."

Being grounded in cultural responsiveness is critical to building rapport, comfort, and trust with patients from various cultures.³ REL data is one essential tool that health plans use to establish, enhance, and promote cultural competence.⁴

"My practice is equipped to support language services, so how does what language I or my staff speak matter?" When the health plan shares other languages spoken by the provider

network, members have the autonomy to select a provider that matches their cultural and linguistic preferences.

Sharing your race, ethnicity, and language with AmeriHealth Caritas Next and First Choice Next may feel uncomfortable at first. However, this is an important piece of provider-patient shared decision-making. Racial or ethnic concordance has been shown to have a positive impact on health outcomes⁵ and reduce health expenditures.⁶

Additional resources

Marcella Alsan et al., "Does Diversity Matter for Health? Experimental Evidence from Oakland," Working Paper 24787, National Bureau of Economic Research, June 2018.

Erin Dehon et al., "A Systematic Review of the Impact of Physician Implicit Racial Bias on Clinical Decision Making," *Academic Emergency Medicine: Official Journal of the Society for Academic Emergency Medicine*, Vol. 24, No. 8, August 2017, pp. 895 – 904.

Sherman James, "The Strangest of All Encounters: Racial and Ethnic Discrimination in US Health Care." *Cadernos De Saude Publica*, Vol. 33, No. Suppl 1, May 8, 2017,

Rachel Johnson et al., "Patient Race/Ethnicity and Quality of Patient-Physician Communication During Medical Visits," *American Journal of Public Health*, Vol. 94, No.12, December 2004, pp. 2084 – 2090.

Ivy Maina et al., "A Decade of Studying Implicit Racial/Ethnic Bias in Healthcare Providers Using the Implicit Association Test," *Social Science & Medicine*, Vol. 199, February 2018, pp. 219 – 229.

Salimah Meghani et al., "Patient-Provider Race-Concordance: Does It Matter in Improving Minority Patients' Health Outcomes?" *Ethnicity & Health* Vol. 14, No. 1, February 2009, pp.107 – 130.

Richard Street et al., "Understanding Concordance in Patient-Physician Relationships: Personal and Ethnic Dimensions of Shared Identity," *The Annals of Family Medicine*, Vol. 6, No. 3, May 1, 2008, pp. 198 – 205.

3. Carrington Moore et al., "It's Important to Work with People that Look Like Me': Black Patients' Preferences for Patient-Provider Race Concordance," *J Racial Ethn Health Disparities*, Vol. 10, No. 5, December 19, 2022, <https://web.archive.org/web/20250114092031/https://pmc.ncbi.nlm.nih.gov/articles/PMC9640880/>, accessed July 31, 2025.

4. Megan Johnson Shen et al., "The Effects of Race and Racial Concordance on Patient-Physician Communication: A Systematic Review of the Literature," *J Racial Ethn Health Disparities*, Vol. 5, No. 1, 2018, pp. 117 – 140, <https://web.archive.org/web/20241228034235/https://pmc.ncbi.nlm.nih.gov/articles/PMC5591056/pdf/nihms858748.pdf>, accessed May 16, 2025.

5. "Do Black Patients Fare Better With Black Doctors?" American Association of Medical Colleges, June 6, 2023, <https://web.archive.org/web/20250119013744/https://www.aamc.org/news/do-black-patients-fare-better-black-doctors>, accessed January 19, 2025.

6. Timothy T. Brown et al., "Shared Decision-Making & Racial or Ethnic Concordance Reduces Health Expenditures," National Institute for Health Care Management Foundation, August 2023, https://nihcm.org/assets/articles/FINAL_RI-PDF-Tim-Brown_2023-07-12-032727.pdf, accessed July 22, 2025.



Use the correct payer ID when filing claims

To ensure prompt payment of claims, please use the correct payer ID for AmeriHealth Caritas Next and First Choice Next.

Table: AmeriHealth Caritas Next and First Choice Next plan payer IDs*

State	Plan payer ID
Delaware	47073
Florida	45408
Louisiana	75066
North Carolina	83148
South Carolina (First Choice Next)	57103

*Improper claim submission could result in rejected claims, denied claims, and payment delays.

Electronic claims submission (EDI)

The Plan encourages all providers to submit claims electronically using electronic data interchange (EDI). For those interested in electronic claim filing, please contact your EDI software vendor or Change Healthcare. Providers who wish to submit electronic claims through ConnectCenter, Change Healthcare's claims management system, may call Change Healthcare at **1-800-527-8133, option 2**, for assistance on how to enroll in ConnectCenter.

Electronic claims that are submitted through Change Healthcare's Connect Center use a four-digit ConnectCenter Payer identifier (CPID).

There are many different products that may be used to bill electronically. If you have the capability to send EDI claims to Change Healthcare, whether through direct submission via ConnectCenter or through another clearinghouse/vendor, you may submit claims electronically.

Providers interested in sending claims electronically may also contact EDI Technical Support by calling Provider Services to arrange transmission and for assistance in beginning electronic submissions. When ready to proceed:

- Contact your EDI software vendor or Change Healthcare's ConnectCenter at **1-800-527-8133, option 2**, to inform them you wish to initiate electronic claim submissions to AmeriHealth Caritas Next or First Choice Next, depending on your Next plan.
- Be prepared to inform the vendor of the Plan's electronic payer identification number.



Social determinants of health and low birth weight: What providers need to know

Low birth weight is a significant health concern

Low birth weight (LBW), defined as a neonatal weight of less than 5 pounds, 8 ounces, affects 1 in 12 infants (8.5%) in the United States and is widely recognized as a public health concern.¹ Infants with LBW are considered to be at elevated risk for infant mortality, developmental delays, and long-term health complications. Common medical concerns associated with LBW include the need for specialized intensive care due to conditions such as respiratory distress syndrome, intraventricular hemorrhage (IVH), patent ductus arteriosus, necrotizing enterocolitis, retinopathy of prematurity, jaundice, and infections. These babies may also face other health conditions later in life which may include diabetes, heart disease, high blood pressure, intellectual and/or developmental disabilities, metabolic syndrome, or obesity.

How SDOH can affect birth weight

While the clinical complications of LBW are well understood, what is often less recognized is the critical role that social determinants of health (SDOH) play in driving these outcomes. Providers are uniquely positioned to identify and address these factors during pregnancy.

Social determinants of health, as defined by the World Health Organization, comprise the circumstances in which individuals “are born, grow, live, work, and age.”² Pregnant

individuals are especially vulnerable to adverse outcomes related to unmet basic needs within these domains. When basic social, economic, and environmental needs remain unfulfilled, the likelihood of LBW increases:³

- **Access to basic needs:** Lack of stable housing, nutritious food, safe water, and reliable transportation impacts maternal health and prenatal care.
- **Stress and mental health:** Maternal stress, domestic violence, language barriers, and limited social support increase biological and behavioral risks.
- **Environmental exposures:** Pollution, unsafe neighborhoods, and poor working conditions contribute to adverse birth outcomes.
- **Structural inequities:** Limited access to high-quality, culturally responsive care prolongs disparities, especially among minority and underserved populations.

Ways that providers can intervene

Clinical interventions alone cannot address the multifactorial origins of low birth weight. However, through comprehensive prenatal care, providers can play a pivotal role in mitigating the impact of SDOH on birth weight:⁴

- **Screening:** Systematically incorporate SDOH screening into prenatal visits to identify needs related to housing, nutrition, transportation, and mental health at an early stage.

- **Connection:** Establish partnerships with community organizations to link patients to resources (e.g., food assistance, housing support, transportation services, counseling).
- **Education:** Offer targeted education on nutrition, stress management, and health literacy to empower patients through pregnancy,
- **Advocacy:** Champion policy and program changes that expand access to maternal health services, reduce inequities, and improve long-term outcomes.

Benefits of addressing SDOH

Delivering culturally competent care — including language access, respectful communication, and awareness of systemic barriers — empowers pregnant individuals to be more open about their actual needs and stay on top of getting the care they need throughout their pregnancy. Building trust encourages pregnant individuals to be proactive with their conversations about risks and supports better care coordination.

Low birth weight is not only a clinical complexity, but it also has roots in the social, economic, and environmental conditions that are affecting pregnant individuals. Through collaboration and integrating SDOH into clinical care, health care providers and community partners can help reduce disparities in birth outcomes, improve maternal health and infant survival, and strengthen families and communities in the long term.

1. “Low Birthweight,” March of Dimes, June 2021, <https://www.marchofdimes.org/find-support/topics/birth/low-birthweight>, accessed February 13, 2026.
2. “Social determinants of health,” World Health Organization, https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1, accessed February 13, 2026.
3. Guillermina Girardi, et al., “Social determinants of health in pregnant individuals from underrepresented, understudied, and underreported populations in the United States,” *Int J Equity Health*, Vol. 22, No. 186, September 6, 2023, <https://doi.org/10.1186/s12939-023-01963-x>, accessed February 13, 2026.
4. “Social Determinants of Health: Improving Maternal and Infant Health requires more than clinical care,” Progeny Health, <https://info.progenyhealth.com/sdoh>, accessed February 13, 2026.
5. “Why Cultural Competence is Essential to Delivering Patient-Centered Care,” Jon-Michial Carter, <https://www.chartspan.com/blog/why-cultural-competence-is-essential-to-delivering-patient-centered-care/#:~:text=Embedding%20cultural%20competence%20into%20everyday,informed%20by%20understanding%20and%20respect.>



Building trust to strengthen well-child visits

The importance of well-child visits in pediatric care

Well-child visits serve as a fundamental component of pediatric care, providing health care providers with essential opportunities to monitor children’s growth and development, deliver preventive services, and foster trusted relationships with families.

These visits are particularly significant for addressing disparities in preventive care. For example, a 2020 study within a large health care system found that 71% of white children were up to date with their well-child visits, compared to only 64% of Hispanic/Latino children and 59% of Black children.¹ For Black/African American children, well-child visits also present critical moments to address disparities in timely immunizations and other preventive screenings. By prioritizing culturally responsive communication and patient-centered care, providers can help improve adherence to recommended visits, reduce health inequities, and support healthier futures.²

Challenges and barriers to preventive care

Preventive care in childhood is essential for encouraging healthy growth, facilitating early screenings, and ensuring children receive timely immunizations consistent with national recommendations.³ Yet, racial and ethnic disparities in preventive care persist. Black/African American children are less likely to be fully immunized by age two, compared with their white and Latino peers.^{4,5} This gap may be caused by mistrust of the health care system, transportation issues, and scheduling problems, which can lead not only to vaccine delays but also to missed well-child visits.⁶ Each visit becomes more than just a routine checkup. It is an opportunity for providers to build trust, address family concerns, and equip parents with the information needed to support their child’s health.⁷



Five strategies for building trust and strengthening well-child visits

1. **Review care gaps by race and ethnicity.** Examine your practice data by race and ethnicity to identify missed visits, incomplete vaccinations, or other disparities. Pay particular attention to vaccines, such as DTaP and flu, as these often reflect broader gaps in preventive care.⁵
2. **Acknowledge mistrust.** Recognize that families may have concerns rooted in historical and ongoing inequalities. Responding with empathy and clear explanations can help build trust.⁸
3. **Connect preventive care to family priorities.** Go beyond simply saying vaccines are “safe and effective.” Frame the benefits in ways that resonate with parents. For example, “This helps keep your child healthy, in school, and protected from serious illnesses.”⁷
4. **Address practical barriers.** Engage families in conversations about challenges they encounter with transportation, time off work, or scheduling. Providing solutions such as flexible hours, reminders, and connections to ride assistance programs can make a significant impact.⁶
5. **Create space for open dialogue.** Encourage questions and listen closely to family concerns about vaccines, nutrition, or development. Dialogue, instead of one-way information, helps build confidence and makes guidance more meaningful.⁷

Well-child visits provide essential opportunities to build trust, overcome barriers, and fill care gaps. By communicating clearly and remaining attentive to the unique challenges faced by Black/African American families, providers can help ensure every child has the chance to grow up healthy and supported.

1. Amanda Luff, et al., “Attendance patterns in well-child visits across diverse pediatric populations, Midwestern United States,” *Preventive Medicine Reports*, Vol. 54, Article 103082, June 2025, <https://doi.org/10.1016/j.pmedr.2025.103082>, accessed February 13, 2026.
2. Joseph F. Hagan, Jr., et al. (Eds.), *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* (4th ed.), American Academy of Pediatrics, 2017.
3. Centers for Disease Control and Prevention. (2026). *Child and Adolescent Immunization Schedules*. <https://www.cdc.gov/vaccines/hcp/imz-schedules/child-adolescent-age.html> [cdc.gov], accessed February 16, 2026.
4. Cierra Buckman, et al., “The influence of local political trends on childhood vaccine completion in North Carolina,” *Social Science & Medicine*, Vol. 260, Article 113187, September 2020, <https://doi.org/10.1016/j.socscimed.2020.113187> [doi.org], accessed February 13, 2026.
5. Trisha C. Parker, et al., “Rotavirus vaccination rate disparities seen among infants with acute gastroenteritis in Georgia,” *Ethnicity & Health*, Vol. 22, No. 6, pp. 585–595, October 14, 2016, <https://www.tandfonline.com/doi/full/10.1080/13557858.2016.1244744>, accessed February 13, 2026.
6. Lavanya Vasudevan, et al., “Vaccine hesitancy in North Carolina: The elephant in the room?” *North Carolina Medical Journal*, Vol. 82, No. 2, pp. 130–137, March 1, 2021, <https://doi.org/10.18043/ncm.82.2.130> [doi.org].
7. Monica Schoch-Spana, et al., “The public’s role in COVID-19 vaccination: Human-centered recommendations to enhance vaccine acceptance, uptake, and equity,” *Vaccine*, Vol. 39; No. 40, pp. 6004–6012, September 24, 2021, <https://doi.org/10.1016/j.vaccine.2021.09.012> [doi.org], accessed February 13, 2026.
8. Giselle Corbie-Smith, “Vaccine hesitancy is a scapegoat for structural racism,” *JAMA Health Forum*, Vol. 2; No. 3, Article e210434, March 25, 2021, <https://doi.org/10.1001/jamahealthforum.2021.0434> [doi.org], accessed February 13, 2026.



The importance of syphilis screenings during pregnancy

In 2024, The American College of Obstetricians and Gynecologists (ACOG) underscored a report from the Centers for Disease Control and Prevention (CDC) that revealed a 755% increase in cases of congenital syphilis had occurred between 2012 and 2021.^{1,2} As the rates of congenital syphilis in the U.S. continue to rise, it is imperative that birthing people are tested regularly throughout their pregnancy journey. ACOG's latest advisory updated their syphilis testing advisory, recommending "all pregnant individuals [be tested] serologically for syphilis at the first prenatal care visit, followed by universal rescreening during the third trimester and at birth, rather than use a risk-based approach to testing."³

Additionally, The American Academy of Pediatrics (AAP) has updated its guidance as well. Despite varying testing mandates across the country, the AAP Red Book states, "No newborn infant should be discharged from the hospital without confirmation of the birthing parent's serologic status for syphilis."^{4,5}

A 2024 report from the CDC found significant disparities in congenital syphilis rates across different racial and ethnic groups. For example, "Infants born to American Indian/Alaska Native parents had a rate of about 681 cases per 100,000 live births, while rates were lowest for Asian families at nine cases per 100,000 births. Data also showed Black infants represented 30% of all cases while making up just 14% of live births."⁶ The same report revealed that "about 43% of birth parents had no documented timely test, and about 23% had no documented treatment."⁶

As gatekeepers of health, providers have a vital role in reducing congenital syphilis rates and mitigating its risks and effects. Providers also have the task of educating patients on the risks associated with congenital syphilis and stressing the importance of regular testing. Adverse pregnancy outcomes occur in 50% to 80% of pregnancies affected by syphilis.⁷

Serious complications of congenital syphilis may include:

- Miscarriage or stillbirth
- Severe anemia
- Premature birth
- Blindness or deafness
- Low birth weight

Many factors can influence pregnancy and birth outcomes, but consistent syphilis screening offers a practical step toward prevention. It remains vital for all professionals involved in obstetric care to prioritize frequent patient testing throughout the birthing journey.

1. "Screening for syphilis in pregnancy," American College of Obstetricians and Gynecologists (ACOG) Practice Advisory, April 2024, <https://www.acog.org/clinical/clinical-guidance/practice-advisory/articles/2024/04/screening-for-syphilis-in-pregnancy#:~:text=endorse%20this%20document>, accessed February 13, 2026.
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