Managed Care Organization

Reports Companion Guide

10/10/2012
Microsoft

Contents

Disclaimer

The report formats and reporting timeframe contained herein were accurate at the time of publishing. It is the responsibility of the MCO to ensure they are using the correct format listed in this companion guide. The MCO should contact the Program Area to verify that no changes have been made prior to submitting reports.

Model Attestation Letter

To be attached to all reports upon every submission

(Company Letter Head)
Attestation for Reports

Date_____

I, _____, as an Officer (Title) for (Name of Company), and I have signature authority for (Name Company) do hereby attest the data provided in the _____ Report(s) is accurate, true, and complete.

I understand that should SCDHHS determine the submitted information is inaccurate, untrue, or incomplete, (Name of company) may be subject to liquidated damages as outlined in Section 13.3 of the contract or sanctions and/or fines as outlined in Section 13.5 of the contract.

_____ _____

Signature/Title Date

Network Provider and MCO Listing Spreadsheet Requirements

Frequency – Monthly

Provide the following information regarding all network providers:

1. Practitioner Last Name, First Name and Title - For types of service such as primary care providers and specialist, list the practitioner's name and practitioner title such as MD, NP (Nurse Practitioner), PA (Physician Assistant), etc.

2. Practice Name/Provider Name - Indicate the name of the provider. For practitioners indicate the professional association/group name, if applicable.

3. Street Address, City, County, State, Zip Code, Telephone Number of Practice/Provider

4. Office hours- the hours the physician is actually available to see the MCO Member (i.e. 8-5)

5. Days of Operation-state what day the physician is actually in the office. (i.e. Monday through –Friday or Tuesday and Thursday , or any variations etc)

6. License Number - Indicate the provider/practitioner license number, if appropriate.

7. Medicaid Provider Number – Indicated the provider/practitioner's Medicaid provider number, if they are a Medicaid provider.

8. Specialty Code - Indicate the practitioner's specialty using the Medicaid Specialty Codes .

9. New Patient - Indicate whether or not the provider is accepting new patients.

10. Practice Limitation - Indicate any restrictions or limitations of a provider's scope of service.. For instance, for a physician who only sees patients up to age 18, indicate < 18; Should an OB/GYN not accept high risk patients, indicate this clearly in a short descriptive narrative.

11. Contract Name/Number – Indicate which MCO subcontract the physician is associated with. Example: If the contract is for a group practice, all physicians within the group will have the same contract name/number.

12. Contract Begin Date – Indicate the date the contract became effective.

13. Contract Termination Date – Indicate the date the contract ended.

14. County Served – Indicate which county or counties the provider serves. Do so by listing all 46 counties in alphabetical order (one column per county) and placing an "X" in each appropriate column, indicating that the provider serves that county. For example, if the provider has offices in 3 counties, but is used by the MCO to provide services in 6 counties, place an "X" in the columns of each of the 6 counties served.

On separate tabs to the spreadsheet, please provide listings of all 1) new and 2) terminated providers for the month. For these tabs, please provide the information requested in items 1-14 above.

Grievance Log with Summary Information

Collected Monthly, Reported Quarterly

For each grievance, utilize the following to report information:

Month/Year: Indicate reporting month and year.

Date Filed: Enter the exact month, day and year the grievance was received by the MCO.

Member Name and Number: Indicate the member's name and the member's Medicaid number. These should be listed exactly as they appear on the member listing report supplied to the MCO by SCDHHS.

Summary of Grievance: Give a brief description of the member's grievance. Include enough information to provide SCDHHS with an understanding of the member's grievance.

Current Status: Indicate the current status of the grievance at the time of reporting; i.e., number of contacts with the member, what actions have been taken to resolve the matter, etc..

Resolution/Response Given: Indicate the resolution/ the response given to the member. Include enough information to provide SCDHHS with an understanding of how the grievance was resolved. If the grievance is pharmaceutical in nature, please provide the name of the medication and the date the prescription was filled by the member.

Resulting Corrective Action: Specify any corrective actions being taken by the MCO as a result of the grievance.

Date of Resolution: The date the resolution was achieved.

Plan Name (Medicaid Number)
Grievance Log
Month/Year: _____

Date Filed	Member Name	Member Number	Summary of Grievance	Current Status	Resolution/ Response Given	Resulting Corrective Action	Date of Resolution

Appeals Log with Summary Information
Collected Monthly, Reported Quarterly

For each appeal, utilize the following to report information:

Month/Year: Indicate reporting month and year.

Date Filed: Enter the exact month, day and year the appeal was received by the MCO.

Member Name and Number: Indicate the member's name and the member's Medicaid number. These should be listed exactly as they appear on the member listing report supplied to the MCO by SCDHHS.

Summary of Appeal: Give a brief description of the member's appeal. Include enough information to provide SCDHHS with an understanding of the member's appeal.

Current Status: Indicate the current status of the appeal at the time of reporting; i.e., number of contacts with the member, what actions have been taken to resolve the matter, etc..

Resolution/Response Given: Indicate the resolution, the response given to the member., Include enough information to provide SCDHHS with an understanding of how the appeal was resolved. . If the grievance is pharmaceutical in nature, please provide the name of the medication and the date the prescription was filled by the member.

Resulting Corrective Action: Specify any corrective actions being taken by the MCO as a result of the appeal.

Date of Resolution: The date the resolution was achieved.

Plan Name (Medicaid Number)
Appeals Log
Month/Year: _

Date Filed	Member Name	Member Number	Summary of Appeal	Current Status	Resolution/ Response Given	Resulting Corrective Action	Date of Resolution

Adjustment Maternity Kicker Notification Payment Log Definitions

SCDHHS automated the maternity kicker process in 2010. If the MCO finds that a maternity kicker or stillborn has not been processed through automated adjustments within the fourth month after the birth then the MCO must submit the form below to their program manager. The MCO shall submit any maternity kickers that they are seeking manual adjustments for within six months of the child's birth. SCDHHS at its discretion may consider circumstances beyond this timeframe.

Indicate with an "X" for multiple births. Otherwise, do not fill in this column.

Count: Numerical count of lines reported - 1, 2, 3….

Newborns Date of Birth: date of birth of newborn format – 00/00/00

Mother's Last Name: Add the mothers last name

Mother's First Name: Add the mother first name

Mother's Medicaid ID Number: Mother's Medicaid ID number – 10 digits

Newborn's Last Name: Add the newborn's last name. If name is not known, use "Baby Boy" or "Baby Girl"

Newborn's First Name: Add the newborn's first name. Not applicable if name is not known

Newborn's Sex: Use M for male, F for female

Multiple Births: Please place an "X" in this column for any multiple birth situations. Regardless of how many births you will only be reimbursed for one maternity kicker.

* These columns reserved for SCDHHS use

Adjustment Maternity Kicker Payment Notification Log

Frequency – Monthly

MCO Name (MCO Number)											
Maternity Kicker Payment Notification Log											
Date (Unpaid Through Date)											
		Mother's Information			Newborn's Information					Reserved for SCDHHS use	
Count	Newborn's DOB (mm/dd/yy)	Last Name	First Name	Mother's Medicaid ID	Last Name	First Name	Child's Medicaid ID	NB Sex (M/F)	Multiple Birth? (X=Yes)	Y/N	$ amt
									Total		$0.00
Stillborn Deliveries Below This Line											

Capitation Rate Calculation Sheet – Data Element Summary

MCO Name: Plan Name

Quarterly Reporting Period: Identify the beginning and ending period for the submitted report. The reporting period is on an incurred date of service basis without adjustment for completion factors.

Region: Statewide

Rate Category: Separate Reports for each Capitation Rate Category

Member Months or Deliveries: This field represents the number of member months or deliveries for the reporting period.

# of Units (Column A): This field represents the total number of units allowed from the health plan paid claim experience. The definition of units has been defined in the "Units" Column.

Amount Paid (Column B): This field represents the net amount paid for the service.

Annual Utilization per 1,000 (Column C): This is a calculated field using the following formula:

(Column A ÷ Member Months) x 12 x 1,000

Utilization per Delivery (Column C): This is a calculated field using the following formula:

(Column A ÷ Deliveries) x 1,000

Cost per Unit (Column D): This is a calculated field using the formula: (Column B ÷ Column A)

Service Cost PMPM or Per Delivery (Column E): This is a calculated field using one of the following formulas:

If Non-Maternity = Column B ÷ Member Months, or,
If Maternity = Column B ÷ Number of Deliveries

Capitation Rate Calculation Sheet (CRCS) – Composite
Frequency – Quarterly

MCO Name: MCO						
Quarterly Reporting Period: MM/DD/YYYY-MM/DD/YYYY						
Region: Statewide						
Rate Category: Composite						
Member Months In The Reporting Quarter: XXXX						
		A	**B**	**C**	**D**	**E**
Category of Service	**Units**	**# of Units**	**Amount Paid**	**Annual Utilization per 1,000**	**Cost per Unit**	**Service Cost PMPM**
Inpatient Hospital						
I/P Medical/Surgical/Non-Delivery Maternity	Days	-	$ -	-	$ -	$ -
I/P Well Newborn	Days	-	$ -	-	$ -	$ -
Mental Health / Substance Abuse	Days	-	$ -	-	$ -	$ -
Other Inpatient	Days	-	$ -	-	$ -	$ -
Outpatient Hospital						

Surgical (Type 1)	Encounters	-	$ -	-	$ -	$ -
Non-Surgical Emergency Room (Type 5)	Encounters	-	$ -	-	$ -	$ -
Non-Surgical-All Other (Type 5)	Encounters	-	$ -	-	$ -	$ -
Observation Room (Type 1 and Type 5)	Encounters	-	$ -	-	$ -	$ -
Treatment/Therapy/Testing (Type 4)	Encounters	-	$ -	-	$ -	$ -
All Other Outpatient	Encounters	-	$ -	-	$ -	$ -
Pharmacy						
Prescription Drugs	Scripts	-	$ -	-	$ -	$ -
Ancillaries						
Ambulance	Runs	-	$ -	-	$ -	$ -
Prosthetic/DME	Units	-	$ -	-	$ -	$ -
Other Ancillaries	Units	-	$ -	-	$ -	$ -
Physician						
Surgery - I/P and O/P	Procedures	-	$ -	-	$ -	$ -
Surgery - I/P and O/P - Anesthesia	Procedures	-	$ -	-	$ -	$ -
Maternity – Non-Delivery	Cases	-	$ -	-	$ -	$ -
Hospital Visits	Visits	-	$ -	-	$ -	$ -
Office Visits	Visits		$ -		$ -	$ -

		-		-		
Hospital Inpatient Visits	Visits	-	$ -	-	$ -	$ -
Immunizations	Services	-	$ -	-	$ -	$ -
Radiology	Procedures	-	$ -	-	$ -	$ -
Pathology	Procedures	-	$ -	-	$ -	$ -
Mental Health / Substance Abuse	Visits	-	$ -	-	$ -	$ -
Other Professional	Procedures	-	$ -	-	$ -	$ -
SUM OF COVERED SERVICES		-	$ -	-	$ -	$ -

Capitation Rate Calculation Sheet (CRCS) – Maternity

Frequency – Quarterly

MCO Name: MCO						
Quarterly Reporting Period: MM/DD/YYYY - MM/DD/YYYY						
Region: Statewide						
Rate Category: Maternity						
Number of Deliveries for the Reporting Quarter:	**0**					
		A	**B**	**C**	**D**	**E**
Category of Service	**Units**	**# of Units**	**Amount Paid**	**Annual Utilization per Delivery**	**Cost per Unit**	**Service Cost per Delivery**
Inpatient Hospital						
Inpatient Maternity Delivery	Days	-	$ -	-	$ -	$ -
Outpatient Hospital						
Outpatient Hospital - Maternity	Cases	-	$ -	-	$ -	$ -
Physician						
Maternity – Delivery	Cases	-	$ -	-	$ -	$ -
Maternity – Delivery - Anesthesia	Procedures	-	$ -	-	$ -	$ -
SUM OF COVERED SERVICES		-	$ -	-	$ -	$ -

CRCS Capitation Rate Calculation Sheet

Category of Service	Medicare DRGs	Other Information	Unit Measure
Inpatient Hospital			
IP Medical/Surgical/Non‐Delivery Maternity	0001-0003, 0006-0019, 0021-0023, 0026-0106, 0108, 0110-0111, 0113-0114, 0117-0147, 0149-0153, 0155-0208, 0210-0213, 0216-0220, 0223-0230, 0232-0369, 0376-0377, 0385-0390, 0392-0399, 0401-0414, 0417-0424, 0439-0455, 0461-0468, 0471, 0473, 0476-0477, 0479-0482, 0484-0513, 0515, 0518-0520, 0524-0525, 0528-0579		Days
IP Well Newborn	0391		Days
Mental Health / Substance Abuse	0425 – 0433, 0521-0523		Days
Other Inpatient	0004-0005, 0020, 0024-0025, 0107, 0109, 0112, 0115-0116, 0148, 0154, 0209, 0214-0215, 0221-0222, 0231, 0400, 0415-0416, 0434-0438, 0456-0460, 0469-0470, 0472, 0474-0475, 0478, 0483, 0514, 0516-0517, 0526-0527	Any services provided by Inpatient Hospital Providers and not assigned by DRG methodology.	Days

			Unit Measure
Outpatient Hospital			
			Claims
			Claims
			Units
			Units
			Units

Type of Service	FFS Methodology and Revenue Codes		Unit Measure
Outpatient Hospital			
-Surgical (Type 1) -Non-Surgical Emergency Room	The Fee for Service methodology and revenue codes for the types of service can be found in the SCDHHS Hospital Provider Manual, Section		Encounters Encounters

(Type 5) -Non-Surgical – All Other (Type 5) -Observation Room (Type 1 and Type 5) -Treatment/Therapy/Testing (Type 4) -All Other Outpatient	4, Billing Codes- http://www.scdhhs.gov/internet/pdf/manuals/Hospital/SECTION%204.pdf Pages 4-1 to 4-18. For this section, Encounter = Visit		Encounters Encounters Encounters Encounters

Type of Service	CPT – 4 / HCPCS Code	Other Information	Unit Measure
Pharmacy			
Prescription Drugs	All Prescription Drugs Dispensed		Line Items
Ancillaries			
Ambulance	A0001-A0999, Q3019-Q3020, S0207-S0215	*Note: Removed provider logic	Line Items
Prosthetic/DME	A4206-A4265, A4270-A4640, A4648-A8004, A9155, A9274-A9284, A9900-A9999, B4000-B9999, D5985-D5988, E0100-E9999, J7602-J7799, K0000-K0899, L0100-L9999, Q0480-Q0505, Q1001-Q1005, Q4001-Q4051, Q4093-Q4094, S0142-S0143, S0515, S1015-S1016, S1030-S1031, S1040, S5560-S5571, S8095-S8101, S8120-S8490, S8999-S9007, S9061, V2600-V2632, V2788, V5335-V5336 *Note: moved S8004 to Other Professional	*Note: Removed provider logic	Units
Other Ancillaries	92325-92326, 92340-92342, 92370, 92390-92392, 92396, 99500-99602, G0151-G0156, Q5001, S0270-S0274, S0345-S0347, S0500-S0514, S0516-S0590, S0595, S5035-S5036, S5108-S5116, S5180-S5181, S5497-S5523, S9097-S9098, S9122-S9131, S9208-S9590, S9810, V2020-V2599, V2700-V2787, V5011-V5298	*Note: Removed provider logic	Units

Type of Service	CPT – 4 / HCPCS Code	Other Information	Unit Measure
Physician			
Surgery - I/P and O/P	10000-36410, 36420-58999, 59525, 60000-69999, 92973-92974, 92980-92998, 93501-93533, 93561-93581	Excludes anesthesiologist services.	Units
Surgery - I/P and O/P - Anesthesia	00100-00849, 00851-00856, 00858-00945, 00947-00954, 00956-01959, 01962-01966, 01969-01999, 99100, 99116, 99135, 99140, 99143-99145, 99148-99150	Or surgery services provided by an anesthesiologist as identified by a modifier. *Note: Removed provider logic	Line Items
ER Visits	99281-99288		Units
Hospital Visits	90816-90829, 99217-99239, 99289-99316, 99356-99357, 99431, 99433-99440, 99460, 99462-99480, G0263-G0264, G0390, S0310		Units
Office Visits	98966-98969, 99050-99060, 99201-99215, 99321-99355, 99358-99359, 99361-99380, 99441-99444, 99499, G0179-G0182, G0337, S0220-S0260, S9083, S9088 *Note: moved 99024 to Other Professional, 99281-99288 to ER		Units
Immunizations	90465-90749, G0008-G0010, J3530, S0195		Units
Radiology	70000-79999, R0070-R0076		Units
Pathology	80000-89999, P2028-P2038, P3000-P3001, P7001		Units
Mental Health/ Substance Abuse	90801-90815, 90845-90899		Units
Other Professional Services		Any services provided by Professional Providers and not assigned by CPT-4 HCPCS methodology. *Note: Removed provider logic	Units

Type of Service	CPT – 4 / HCPCS Code	Other Information	Unit Measure
Physician			
Maternity – Non-Delivery	59000-59399, 59425-59426, 59428, 59430, 59812-59899 *Note: moved 59412, 59414 to delivery		Units

Category of Service	Medicare DRGs	Other Information	Unit Measure
Inpatient Hospital			
Inpatient Maternity Delivery	0370-0375, 0378-0384		Days

Type of Service	Revenue Code	Other Information	Unit Measure
Outpatient Hospital			
Outpatient Hospital Maternity	Hospital Outpatient providers with a primary diagnosis code of v27.0 – v27.9, 650, and 651.01 - 669.92 (with the 5th digit being 1 or 2)		Claims

Type of Service	CPT – 4 / HCPCS Code	Other Information	Unit Measure
Physician			
Maternity – Delivery	59400, 59409-59410, 59412, 59414, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 59622	*Note: Removed provider logic	Claims
Maternity – Delivery - Anesthesia	00850, 00857, 00946, 00955, 01960-01961, 01967-01968	Or delivery services provided by an anesthesiologist as identified by a modifier. *Note: Removed provider logic	Line Items

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Forms

Universal Medication Prior Authorization Form

I. Provider Information

Prescriber name	NPI #
Prescriber specialty	Phone
Office contact name	Fax
Pharmacy name	Pharmacy phone

II. Member Information

Member name	Today's date
Member plan ID #	Date of birth
Drug allergies	
Plan name and fax for form submission: Use the drop down to select the appropriate health plan.	

III. Drug Information (one drug per request form)

Drug name	Drug strength	Dosage form	Dosage interval	Quantity per day
Diagnosis relevant to this request				ICD-9 code
Expected length of therapy				Number of refills

IV. Drug History for this Diagnosis

A. Is the prescription for a drug to be administered in the office or for the member to take at home? ☐ office ☐ home

B. Is the member currently treated on this drug? ☐ Yes: how long? _____ [go to item C] ☐ No [skip items C and D; go to item E]

C. Is this request for continuation of a previous approval? ☐ Yes [go to item D] ☐ No [skip item D; go to item E]

D. Has strength, dosage or quantity required per day increased or decreased?

☐ Yes [go to item H] ☐ No [skip item H; indicate rationale in Section V and submit form]

E. Please indicate previous treatments and outcomes with other medications below.

Drug name	Strength	Directions	Dates of therapy	Reason for failure or discontinuation

V. Rationale for Request and Pertinent Clinical Information (attach additional sheets if more space is needed)

Appropriate clinical information to support the request on the basis of medical necessity must be submitted.	
Prescriber/Authorized Representative signature	Date

Universal Newborn Prior Authorization Form

Universal Newborn Prior Authorization Form – Pediatric Offices

Out-of-network pediatric providers must provide this information to obtain an authorization for services rendered in the office during the first 60 days after discharge. Authorization should be requested by close of the next business day. For questions, contact the plan at the associated phone number.

***Fax the COMPLETED form OR call the plan with the requested information.**

☐ **Absolute Total Care**
P: 866-433-6041
F: 866-918-4451
www.absolutetotalcare.com

☐ **BlueChoice HealthPlan**
P: 866-902-1689
F: 800-823-5520
www.bluechoicescmedicaid.com

☐ **First Choice by Select Health**
P: 888-559-1010
F: 866-368-4562
www.selecthealthofsc.com

☐ **Unison Health Plan**
P: 800-366-7304
F: 866-841-9336
www.unisonhealthplan.com

Patient's Name _____ (First / Middle / Last) DOB _____

Address (Street, Apt.#) _____ City/State/Zip _____

Phone(s) _____ Medicaid Number _____ MCO ID Number _____

Mom's Name _____ (First / Middle / Last) Mom's Medicaid Number _____

Mom's SSN _____

Secondary Coverage:

Plan _____ ID# _____ Group # _____

Policy Holder _____ DOB _____ Relationship to patient _____ Employer _____

☐ ***EPSDT and Immunization***

☐ 99381 (EPSDT New) ☐ 99391 (EPSDT Est.) ☐ 1 Visit ☐ 2 Visits

☐ 90471 DOS: _____ Immunization Administered: _____
☐ 90472 DOS: _____ Immunization Administered: _____
☐ 90473 DOS: _____ Immunization Administered: _____

☐ ***EIM Non-EPSDT***

☐ CPT: _____ Dx: _____ DOS: _____ ☐ CPT: _____ Dx: _____ DOS: _____

☐ ***Labs*** ***CLIA Certificate Number*** _____

☐ CPT: _____ DOS: _____ ☐ CPT: _____ DOS: _____
☐ CPT: _____ DOS: _____ ☐ CPT: _____ DOS: _____
☐ CPT: _____ DOS: _____ ☐ CPT: _____ DOS: _____

☐ ***Other***

☐ 17250 DOS: _____ ☐ 54160 DOS: _____ ☐ 96150 DOS: _____
☐ 51701 DOS: _____ ☐ 94640 DOS: _____ ☐ 96152 DOS: _____
☐ 54150 DOS: _____ ☐ 94760 DOS: _____ ☐ 97802 DOS: _____
☐ CPT: _____ DOS: _____ ☐ CPT: _____ DOS: _____

Practice Name: _____ Practice NPI: _____
Attending Physician (last name, first name): _____ NPI: _____
Contact Person: _____ Phone: _____ Fax: _____

Plan Point of Contact: _____ Date Plan Called: _____ Time of Call: _____
Plan Reference/Confirmation Number: _____

FOR MCO USE ONLY:

☐ Approved ☐ Denied Authorization # _____ Date of Notification to Pediatric Office: _____
Reviewer(s) name & title: _____

Please note that our review applies only to the authorization of medical necessity and benefit coverage. This authorization is not a guarantee of payment unless the member is eligible at the time the services are rendered.

Universal 17-P Authorization Form

Universal 17-P Authorization Form

*Fax the COMPLETED form OR call the plan with the requested information.

☐ Absolute Total Care	☐ BlueChoice HealthPlan	☐ First Choice by Select Health	☐ UnitedHealthcare CommunityPlan
P: 803-933-3689	P: 866-902-1689	P: 888-559-1010 x55251	P: 800-366-7304
F: 866-918-4451	F: 800-823-5520	F: 866-533-5493	F: 866-841-9336

Date of Request for Authorization _____

Patient/Member Name _____ DOB _____
First Middle Last

Address (Street, Apt.#) _____ City/State/Zip _____

Phone _____ Medicaid Number _____ MCO ID Number _____

☐ Pregnancy Information and History

G___ T___ P___ A___ L___ (Note: A= abortion (spontaneous and medically induced) EDC _____

Last menstrual period _____ EDD _____ Current Gestational age _____ weeks

Bed Rest ☐ Yes ☐ No Experiencing Preterm Labor ☐ Yes ☐ No
(Home administration available if on bed rest)

☐ Singleton Pregnancy ☐ Multiple Pregnancy

At least 16 weeks gestation ☐ Yes ☐ No Major Fetal or Uterine Anomaly ☐ Yes ☐ No

Patient has a history of prior spontaneous singleton preterm birth between 20-36.6 weeks ☐ Yes ☐ No

Delivery was due to preterm labor or PPROM even if it resulted in C-section ☐ Yes ☐ No

Delivery was not due to medical indication, e.g. preeclampsia, abruption, etc. ☐ Yes ☐ No

Medication Allergies _____ ☐ No known drug allergies

Other Pertinent Clinical Information: _____

☐ Pharmacy Information

☐ Ship to patient's home address End Date of Service _____

☐ Ship to provider's address End Date of Service _____

Shipping Preference: ☐ Regular Mail ☐ Ground ☐ Overnight

Ordering Physician's Signature: _____

☐ Provider Information

Ordering Provider Name _____
(Please Print)

Ordering Provider NPI _____ Tax ID _____

Address _____ City/State/Zip _____

Phone _____ Fax _____

Provider Type: ☐ OB/GYN ☐ Family Medicine ☐ MFM/Perinatology ☐ Other _____

Practice Name: _____ Practice NPI: _____

Contact Person: _____ Phone: _____ Fax: _____

FOR MCO USE ONLY:

☐ Approved ☐ Denied Authorization # _____ Number of Injections _____

Date of Notification to Provider: _____ Reviewer(s) name & title: _____

Please note that our review applies only to the authorization of medical necessity and benefit coverage. This authorization is not a guarantee of payment unless the member is eligible at the time the services are rendered.

Patient Centered Medical Home (PCMH) Form

Completing the PCMH Form:

There are 5 worksheet tabs to this form. Worksheet 1 are the instructions, worksheet two is the spreadsheet utilized for the level 1 PCMH providers, worksheet three is for the level 2 PCMH providers, worksheet 4 is for the level 3 PCMH providers and the final worksheet is for providers in the application phase.

PCMH1 Worksheet:

a. At the top of the worksheet you will need to add the provider name, the providers full address and the providers phone number designated as PCMH1 providers.
b. Directly underneath the provider information please add the members that the this provider currently sees as a part of their PCMH. Please include the members Medicaid ID number and their first and last names.
c. Space has been provided for 75 members on the excel file, if there are more members than this please insert a row or rows for the extra members
d. You will see underneath the first 75 members another space for your second PCMH1 provider entry and room for 75 more members. Please add the second provider entry in this space.

PCMH2 Worksheet:

a. At the top of the worksheet you will need to add the provider name, the providers full address and the providers phone number designated as PCMH2 providers.
b. Directly underneath the provider information please add the members that the this provider currently sees as a part of their PCMH. Please include the members Medicaid ID number and their first and last names.
c. Space has been provided for 75 members on the excel file, if there are more members than this please insert a row or rows for the extra members
d. You will see underneath the first 75 members another space for your second PCMH2 provider entry and room for 75 more members. Please add the second provider entry in this space.

PCMH3 Worksheet:

a. At the top of the worksheet you will need to add the provider name, the providers full address and the providers phone number designated as PCMH3 providers.
b. Directly underneath the provider information please add the members that the this provider currently sees as a part of their PCMH. Please include the members Medicaid ID number and their first and last names.
c. Space has been provided for 75 members on the excel file, if there are more members than this please insert a row or rows for the extra members.
d. You will see underneath the first 75 members another space for your second PCMH3 provider entry and room for 75 more members. Please add the second provider entry in this space.

PCMH Application:

a. Please add those providers and their members that are still under application to the worksheet tab labeled App.

b. Directly underneath the provider information please add the members that the this provider currently sees as a part of their PCMH. Please include the members Medicaid ID number and their first and last names.

c. Space has been provided for 75 members on the excel file, if there are more members than this please insert a row or rows for the extra members.

d. You will see underneath the first 75 members another space for your second PCMH provider under application and room for 75 more members. Please add the second provider entry in this space.

e. For anyone still in the application process you will need to include with their contracts a copy of the application and a defined timeline with an update provider quarterly. See appendix 5 of the P&P for more details.

PCMH1 Form

Provider Name:			Provider Address:		Provider Phone Number:
	Medicaid Member ID number	Member First Name	Member Last Name		
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Provider Name:			Provider Address:		Provider Phone Number:
	Medicaid Member ID number	Member First Name	Member Last Name		
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PCMH2 Form

Provider Name:			Provider Address:		Provider Phone Number:
	Medicaid Member ID number	Member First Name	Member Last Name		
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Provider Name:			Provider Address:		Provider Phone Number:
	Medicaid Member ID number	Member First Name	Member Last Name		
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PCMH3 Form

Provider Name:			Provider Address:		Provider Phone Number:
	Medicaid Member ID number	Member First Name	Member Last Name		
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Provider Name:			Provider Address:		Provider Phone Number:
	Medicaid Member ID number	Member First Name	Member Last Name		
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PCMH Application Form

Provider Name:			Provider Address:		Provider Phone Number:
	Medicaid Member ID number	Member First Name	Member Last Name		
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Provider Name:			Provider Address:		Provider Phone Number:
	Medicaid Member ID number	Member First Name	Member Last Name		
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Centering Program Form

There are two worksheets within this form. Worksheet 1 contains the instructions and the second worksheet is available for adding Centering Program providers.

a. For each provider you will need to add the centering provider name, the centering providers full address and the centering providers phone number
b. Underneath the provider information please add the members this provider currently sees as part of their centering program. The information required includes their Medicaid ID number and their first and last names.
c. Space has been provided for 25 members. Please only include those members that have had more than five visits.
d. You will see underneath the first 25 members another space for your second Centering provider entry and room for 25 more members. Please add the second provider entry in this space.
e. The MCO will need to provide a copy of the contract that includes a certificate from the Centering Healthcare Institute. In addition the MCO must attach a copy of the signed logs showing their members has attended at least five (5) session.

Centering Program Form

Provider Name:			Provider Address:		Provider Phone Number:	
	Medicaid Member ID number	Member First Name	Member Last Name			
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Provider Name:			Provider Address:		Provider Phone Number:	
	Medicaid Member ID number	Member First Name	Member Last Name			
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