

# Managed Care Organization

## Reports Companion Guide

10/10/2012  
Microsoft

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## **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
<b>Stillborn Deliveries Below This Line</b>											

## 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:

$$(\text{Column A} \div \text{Member Months}) \times 12 \times 1,000$$

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

$$(\text{Column A} \div \text{Deliveries}) \times 1,000$$

**Cost per Unit (Column D):** This is a calculated field using the formula:  $(\text{Column B} \div \text{Column A})$

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

If Non-Maternity =  $\text{Column B} \div \text{Member Months}$ , or,  
If Maternity =  $\text{Column B} \div \text{Number of Deliveries}$

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

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

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	-	\$	-	-	\$	-	\$	-
<b>Pharmacy</b>									
Prescription Drugs	Scripts	-	\$	-	-	\$	-	\$	-
<b>Ancillaries</b>									
Ambulance	Runs	-	\$	-	-	\$	-	\$	-
Prosthetic/DME	Units	-	\$	-	-	\$	-	\$	-
Other Ancillaries	Units	-	\$	-	-	\$	-	\$	-
<b>Physician</b>									
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	-	\$ -	-	\$ -	\$ -
<b>SUM OF COVERED SERVICES</b>		-	\$ -	-	\$ -	\$ -

**Capitation Rate Calculation Sheet (CRCS) – Maternity**

*Frequency – Quarterly*

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

### CRCS Capitation Rate Calculation Sheet

Category of Service	Medicare DRGs	Other Information	Unit Measure
<b><i>Inpatient Hospital</i></b>			
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
<b><i>Outpatient Hospital</i></b>			
			Claims
			Claims
			Units
			Units
			Units

Type of Service	FFS Methodology and Revenue Codes		Unit Measure
<b><i>Outpatient Hospital</i></b>			
-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- <a href="http://www.scdhhs.gov/internet/pdf/manuals/Hospital/SECTION%204.pdf">http://www.scdhhs.gov/internet/pdf/manuals/Hospital/SECTION%204.pdf</a> Pages 4-1 to 4-18. For this section, Encounter = Visit		Encounters Encounters Encounters Encounters
<b>Type of Service</b>	<b>CPT – 4 / HCPCS Code</b>	<b>Other Information</b>	<b>Unit Measure</b>
<b>Pharmacy</b>			
Prescription Drugs	All Prescription Drugs Dispensed		Line Items
<b>Ancillaries</b>			
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
<i>Physician</i>			
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
<b>Physician</b>			
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
<b>Inpatient Hospital</b>			
Inpatient Maternity Delivery	0370-0375, 0378-0384		Days

Type of Service	Revenue Code	Other Information	Unit Measure
<b>Outpatient Hospital</b>			
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
<b>Physician</b>			
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		II. MEMBER INFORMATION		
Prescriber name	NPI#	Member name	Today's date	
Prescriber specialty	Phone	Member plan ID #	Date of birth	
Office contact name	Fax	Drug allergies		
Pharmacy name	Pharmacy phone	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	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? <input type="checkbox"/> office <input type="checkbox"/> home				
B. Is the member currently treated on this drug? <input type="checkbox"/> Yes: how long? _____ [go to item C] <input type="checkbox"/> No [skip items C and D; go to item E]				
C. Is this request for continuation of a previous approval? <input type="checkbox"/> Yes [go to item D] <input type="checkbox"/> No [skip item D; go to item E]				
D. Has strength, dosage or quantity required per day increased or decreased? <input type="checkbox"/> Yes [go to item H] <input type="checkbox"/> 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 17-P Authorization Form

**Universal 17-P Authorization Form**

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

<input type="checkbox"/> Absolute Total Care	<input type="checkbox"/> BlueChoice HealthPlan	<input type="checkbox"/> First Choice by Select Health	<input type="checkbox"/> 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.

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### 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.

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**PCMH1 Form**

<b>Provider Name:</b>		<b>Provider Address:</b>		<b>Provider Phone Number:</b>
Medicaid Member ID number	Member First Name	Member Last Name		
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<b>Provider Name:</b>		<b>Provider Address:</b>		<b>Provider Phone Number:</b>
Medicaid Member ID number	Member First Name	Member Last Name		
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**PCMH2 Form**

<b>Provider Name:</b>		<b>Provider Address:</b>		<b>Provider Phone Number:</b>
Medicaid Member ID number	Member First Name	Member Last Name		
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<b>Provider Name:</b>		<b>Provider Address:</b>		<b>Provider Phone Number:</b>
Medicaid Member ID number	Member First Name	Member Last Name		
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**PCMH3 Form**

<b>Provider Name:</b>		<b>Provider Address:</b>		<b>Provider Phone Number:</b>
Medicaid Member ID number	Member First Name	Member Last Name		
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<b>Provider Name:</b>		<b>Provider Address:</b>		<b>Provider Phone Number:</b>
Medicaid Member ID number	Member First Name	Member Last Name		
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**Managed Care Organizations Policy and Procedure Guide**

**PCMH Application Form**

<b>Provider Name:</b>		<b>Provider Address:</b>		<b>Provider Phone Number:</b>
Medicaid Member ID number	Member First Name	Member Last Name		
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<b>Provider Name:</b>		<b>Provider Address:</b>		<b>Provider Phone Number:</b>
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.

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**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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