Provider Bulletin

<table>
<thead>
<tr>
<th>Attention:</th>
<th>Participating Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subject:</td>
<td>CCP Prior Authorization Request Form</td>
</tr>
<tr>
<td>Program:</td>
<td>District Cares (Option 1)</td>
</tr>
<tr>
<td>Bulletin Number:</td>
<td>19-003</td>
</tr>
</tbody>
</table>

**Purpose:**
This bulletin serves to notify participating providers of the CCP Prior Authorization Request Form available for requesting authorizations for services rendered to District Cares members on or after 4/1/2019.

**Change:**

Effective April 1, 2019 – District Cares authorization requirements are changing. All services with the exception of emergency room visits and observation days will require an approved prior authorization including but not limited to all provider office visits, inpatient stays, outpatient services, surgery, and diagnostic services.

The Prior Authorization Request Form can be utilized for submitting authorization requests to CCP for the next thirty (30) days.

Effective May 1, 2019 – all authorization requests must be requested through CCP’s PlanLink portal.

PlanLink Registration information is available at:
https://www.hcdpbc.org/for-providers/provider-portal-planlink-registration

The table below highlights the District Cares service authorization requirements:

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>AUTHORIZATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient – Acute Care</td>
<td>Yes / Required</td>
</tr>
<tr>
<td>Inpatient – Rehabilitation (hospital setting)</td>
<td>Yes / Required</td>
</tr>
<tr>
<td>Outpatient - Cardiac Rehabilitation</td>
<td>Yes / Required</td>
</tr>
<tr>
<td>Observation Stay</td>
<td>No / Not required</td>
</tr>
<tr>
<td>Durable Medical Equipment / Supplies</td>
<td>Yes / Required</td>
</tr>
<tr>
<td>SERVICE</td>
<td>AUTHORIZATION</td>
</tr>
<tr>
<td>------------------------------------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Home Care / Home Infusion</td>
<td>Yes / Required</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>No / Not required</td>
</tr>
<tr>
<td>Orthotics</td>
<td>Yes / Required</td>
</tr>
<tr>
<td>Prosthetics</td>
<td>Yes / Required</td>
</tr>
<tr>
<td>Outpatient – Diagnostic (MRI/CT/PET/SPECT)</td>
<td>Yes / Required</td>
</tr>
<tr>
<td>Outpatient - Surgery</td>
<td>Yes / Required</td>
</tr>
<tr>
<td>Outpatient - Therapy</td>
<td>Yes / Required</td>
</tr>
<tr>
<td>Specialty Care</td>
<td>Yes / Required</td>
</tr>
</tbody>
</table>

Questions:
If you have any questions pertaining to this bulletin, please contact the Provider Services Department at (866) 930-1002.

Please insert the bulletin into your Provider Handbook. The policies and procedures in this bulletin supersede any related policies and procedures in the handbook.
Health Care District Palm Beach County (HCDPBC)
PRIOR AUTHORIZATION REQUEST FORM
Fax #: 954-699-0741

***CONFIDENTIAL HEALTH INFORMATION***

The information contained in this telecopy transmission contains confidential information, belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you received this telecopy in error, please notify the Requesting Provider immediately to arrange for return or destruction of these documents.

Prior to visit, check Plan Link or call HCDPBC Customer Service at 866-930-0035 to verify eligibility
To register for Plan Link visit:
https://www.hcdpbc.org/for-providers/provider-portal-planlink-registration

Include supporting clinical documentation with every request | INCOMPLETE REQUESTS WILL NOT BE PROCESSED

Mbr Name: ______________________________________
Mbr ID#: ___________________________ Phone #: ____________________ DOB: ________________
Mbr Address: ____________________________________________________________________________________

Requesting Provider Name: ____________________________ NPI# ____________________________
Requesting Provider Address: ____________________________________________________________________________
Phone #: ____________________________ Fax #: ____________________________
Office contact person name: ____________________________ Date: ____________________________

Service Request: ________________________________________      □ Inpatient      □ Outpatient
Provider Name: ___________________________________ (Required) NPI# ____________________________ Phone # ____________________________
Provider Address: __________________________________ Fax #: ____________________________
Diagnosis/ ICD-10 Code(s): __________________________________
Procedure/ CPT/ HCPCS Code(s): __________________________________

Submit claims for DOS 4/1/19 forward through Availity, Payer ID PBHD1/Community Care Plan (Palm Beach Health District)

Authorization DOES NOT GUARANTEE PAYMENT. Payment is subject to member’s eligibility on the date of the service is rendered, contractual provision of the plan, and standard industry billing guidelines. Prior Authorization Request Forms received after 5:00PM, will be considered received the next business day.

NOTICE: This message is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is prohibited. If you have received this message in error, please notify us immediately and destroy the related message.

4/1/19
Initial here once you read all policies (Page 4-22 of package)

Person requesting access must sign and date the form.

To send applications via fax, send to:
Fax number 954-251-4044.

To send applications via email, send to:
ccp.provider@ccpcs.org.
If the person requesting access is a physician on staff at Memorial Healthcare, complete this section. Otherwise, leave blank.

This section is to be completed by the PlanLink Site Manager.

The PlanLink Site Manager is the person in charge of maintaining and updating the access to PlanLink for all users within the office/site/group.

To send applications via fax, send to: Fax number 954-251-4044.

To send applications via email, send to: ccp.provider@ccpcares.org.
The person requesting the access to PlanLink must complete this section.

1) I hereby agree. I will not access any computer or electronic data, except as required to perform my duties and subject to the above limitations. I further agree that, except as directed by the Healthcare System, or as required by law, I will not at any time disclose or release any confidential or privileged information to any unauthorized person, or permit any such person to examine or make copies of any reports or other documents prepared by or coming into my possession or control, or to which I have access, that concerns in any way the privileged or confidential information of the Healthcare System.

2) Work Station Security. Under no circumstances will I give my password to any other individual. I will choose quality passwords, which I will remember. I will not write down the password where another individual may find it. I will log out or secure my workstation whenever I leave the workstation, including closing blinds and placing patient identifiable information in a secure area out of plain view. I will not use a workstation that has been logged onto by another user unless I log them out. All information passed by my password will be treated as confidential and never be released to any person or disclosed, unless they have a need to know and I have been authorized to release that information by my supervisor. I understand that I will be held responsible for all computer transactions that occur under my sign-on. I understand that all data from, or MHS computers and computer systems is legally owned by the Healthcare System. I will not electronically copy or transmit MHS information (patient, financial, etc.) not directly related to my authorized duties without written consent from the authorized source. I understand the need to protect the Healthcare System’s assets (its data), and that every individual is responsible for data security. I will report any and all suspected security breaches to the Chief Information Security Officer / Corporate Directory of Privacy. I can also all the Privacy Reporting Number 954-251-1885 or email mhsprivacy@fhe.com. I understand that if I have been given access to the Healthcare Systems computer system, I will abide by all of the above conditions.

I recognize that the unauthorized access and/or disclosure of information by me may violate state or federal laws, and that the unauthorized access and/or release of information may result in criminal and/or civil liability, dismissal or other disciplinary action being taken against me.

3) Security of Healthcare System Information/Equipment. I agree that I will comply with all security regulations in effect at the Healthcare System. I understand that all software used on a computer owned by the Healthcare System must be properly licensed and approved by the Healthcare System Administration for use on that computer. The use of unlicensed or unapproved software constitutes a serious risk to Healthcare System operations. If I use or allow to be used any unauthorized or unapproved software on a Healthcare System computer, I may be subject to criminal and/or civil liability, dismissal or other disciplinary action.

I acknowledge that an IT Security presentation is available on the MHS intranet site under IT Security. Under the section marked IT Security Presentations. I agree to access and completely review this presentation prior to any other use of MHS computer systems.

Print Requestor's Full Name: ________________________________

Requestor's Signature: __________________________ Date: ________

The Enterprise System Access form must be submitted to CCP by the designated PlanLink Site Manager and not by individual users.

ID/Login is emailed to the applicant from "MHS IT Service Desk".

To send applications via fax, send to: Fax number 954-251-4044.

To send applications via email, send to: ccp.provider@ccpcares.org.