Provider Bulletin

Attention: Participating Providers
Subject: Benefit Changes
Program: District Cares (Option 1)  Bulletin Date: April 18, 2019
Bulletin Number: 19-004  Effective Date: May 1, 2019

Purpose:

This bulletin serves to notify participating providers of benefit changes for District Cares members.

Change:

Effective May 1, 2019 – Benefits for the following services are as follows:

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>AUTHORIZATION</th>
<th>BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient – Acute Care</td>
<td>Yes / Required</td>
<td>Ten (10) days per calendar year (combined with Rehab)</td>
</tr>
<tr>
<td>Inpatient – Rehabilitation (hospital setting)</td>
<td>Yes / Required</td>
<td>Ten (10) days per calendar year (combined with Acute Care)</td>
</tr>
<tr>
<td>Outpatient - Cardiac Rehabilitation</td>
<td>Yes / Required</td>
<td>One (1) 12-week (24 visits) occurrence per year</td>
</tr>
<tr>
<td>Observation Stay</td>
<td>No / Not required</td>
<td>(2) 23-hour stays per calendar year</td>
</tr>
<tr>
<td>Optometry</td>
<td>N/A</td>
<td>Not covered</td>
</tr>
<tr>
<td>Home Care / Home Infusion</td>
<td>Yes / Required</td>
<td>Combined 45 days per calendar year (skilled nursing care and home infusion)</td>
</tr>
<tr>
<td>Hospice</td>
<td>N/A</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

The CCP Prior Authorization Request Form is available for submitting authorization requests through April 30, 2019.

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

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

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) 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.
Each person requesting access to Plan Link/Epic Link must complete this form including the office Site Managers.

All PlanLink users complete this Form. Complete this top section with information pertaining to the person requesting the access to PlanLink.

Enter the last 4 of SS# or a 4-digit PIN. NOTE: you must remember the 4 digit PIN. You will not be able to reinstate your access without this PIN and you will need to submit new forms for access.

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

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

If the person requesting access is a physician on staff at Memorial Healthcare, complete this section. Otherwise, leave blank.
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 the 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 my password where another individual may find it. I will log out or secure my workstation whenever I leave the workstation, including closing windows and placing user 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 gained by my password will be treated as confidential and never be released to any person or released 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 on 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 that I 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 Director of Privacy. I can also call the Privacy Reporting Number 954-205-1153 or email mhsprivacy@fhr.net. I understand that if I have been given remote access to the Healthcare System's computer system, I will abide by all of the above conditions.

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 unlicensed 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 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.

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”.

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