

## District Cares Program Provider Workshop May 14, 2019

Health Care District of Palm Beach County  
1515 N. Flagler Drive, Suite 101  
West Palm Beach, FL 33401

9:00 am – 9:20 am 1:00 pm – 1:20 pm	<b>Registration</b> <ul style="list-style-type: none"> <li>• Provider check-in / Workshop Packet</li> </ul>
9:25 am – 9:45 am 1:25 pm – 1:45 pm	<b>Welcome – Amy Walker, Director of Patient Access</b> <ul style="list-style-type: none"> <li>• District Cares Program               <ul style="list-style-type: none"> <li>➢ New ID Cards</li> <li>➢ C.L. Brumback Primary Care Clinics</li> </ul> </li> <li>• Members Eligibility Changes</li> <li>• Call Center – Member Inquiries</li> </ul> <b>Sarah Gonzalez, Director of Credentialing &amp; Provider Services</b> <ul style="list-style-type: none"> <li>• District Cares Community Providers               <ul style="list-style-type: none"> <li>➢ Specialty Network</li> <li>➢ Provider Services functions – Credentialing /Contracting</li> </ul> </li> </ul> <b>Eileen Perry, Director of Care Coordination</b> <ul style="list-style-type: none"> <li>• District Cares Case Management and Care Coordination</li> </ul>
9:45 am – 9:50 am 1:45 pm – 1:50 pm	<b>CCP Administrative Services – Ken Walters, Chief Operating Officer</b> <ul style="list-style-type: none"> <li>• CCP – Mission/Vision</li> <li>• Administrative Services for HCD               <ul style="list-style-type: none"> <li>➢ Utilization Management</li> <li>➢ Claims Processing</li> </ul> </li> <li>• Benefits               <ul style="list-style-type: none"> <li>➢ Online Provider Portal</li> <li>➢ EFT Payments / Weekly Check Runs</li> </ul> </li> </ul>
9:50 am – 10:00 am 1:50 pm – 2:00 pm	<b>CCP Provider Operations – Jackie Hernandez, Contract Negotiator</b> <ul style="list-style-type: none"> <li>• PlanLink               <ul style="list-style-type: none"> <li>➢ Instructions for completing Access Request Form</li> <li>➢ Turn-around time for granting user access</li> <li>➢ Provider Hotline for PlanLink Access (855) 819-9506</li> <li>➢ PlanLink features</li> </ul> </li> <li>• Clearinghouse: Availity               <ul style="list-style-type: none"> <li>Payer Name: Community Care Plan (Palm Beach Health District)</li> <li>Payer ID: PBHD1</li> </ul> </li> </ul>

	<p>Paper claims that require attachments or claims appeals should be mailed to:</p> <p><b>CCP / HCDPBC Claims Department</b>  <b>P.O. Box 841109</b>  <b>Pembroke Pines, FL 33084</b></p>
<p>10:00 am – 10:15 am</p> <p>2:00 pm – 2:15 pm</p>	<p><b>CCP Utilization Management – Maria Jam-Crease, Director of Medical Management / Shannon Gonzalez, Manager of Medical Management</b></p> <ul style="list-style-type: none"> <li>• PlanLink Authorization Request</li> <li>• Services Requiring Authorization</li> <li>• Facility Authorization Requests</li> <li>• Required Documentation</li> </ul>
<p>10:15 am – 11:00 am</p> <p>2:15 pm – 3:00 pm</p>	<p><b>Provider Questions</b></p>

## Provider Bulletin

<b>Attention:</b>	<b>Participating Providers</b>		
<b>Subject:</b>	Administrative Program Changes		
<b>Program:</b>	District Cares (Option 1)	<b>Bulletin Date:</b>	March 6, 2019
<b>Bulletin Number:</b>	19-001	<b>Effective Date:</b>	April 1, 2019

### Purpose:

This bulletin serves to notify participating providers of important changes to the eligibility, authorization and claims processing for the District Cares Program.

### Change:

**Effective April 1, 2019** – Community Care Plan (CCP) will serve as the District Cares Program third-party administrator (TPA) to administer the following delegated services:

- ✓ ***Enrollee Eligibility Status Verification***
  - Online verification of enrollee eligibility available <http://planlink.ccpcares.org/>
- ✓ ***Authorizations***
  - Submit online authorization requests <http://planlink.ccpcares.org/>
- ✓ ***Claims Processing***
  - Electronic claims submission (see attached)
    - Clearinghouse: Availity
    - Payer Name: Community Care Plan (Palm Beach Health District)
    - Payer ID: PBHD1
  - Obtain online claim status <http://planlink.ccpcares.org/>
  - Paper claims that require attachments or claims appeals should be mailed to:  
CCP/HCDPBC Claims Department  
P.O. Box 841109  
Pembroke Pines, FL 33084  
  
Appeals must be submitted using the CCP Request for Reconsideration Form available at [www.ccpcares.org](http://www.ccpcares.org)

**Providers MUST register for the Provider Portal prior to 4/1/2019 to request prior authorizations, to check eligibility and to check claims status. Registration information is available at: <https://www.hcdpbc.org/for-providers/provider-portal-planlink-registration>**

For Customer and Provider Services, please continue to contact the District at (866) 930-0035.

### Questions:

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

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**Please insert the bulletin into your Provider Handbook. The policies and procedures in this bulletin supersede any related policies and procedures in the handbook.**



## HCDPBC Claims Submission Information

Community Care Plan (CCP) understands that the use of electronic healthcare transactions is of great value to the provider community. CCP and its strategic clearinghouse partner Availity are working together to promote the adoption and use of electronic health care transactions including claim transactions and electronic remittance advice, so that your organization can take better advantage of the savings available.

If you are currently submitting paper claims to CCP or using a clearinghouse that is unable or unwilling to submit claims electronically to CCP's clearinghouse, you have options available to you that will allow you to send electronic claims and start saving time and money today!

CCP and Availity partnered to offer free claim and Electronic Remittance Advice (ERA) options. We are excited to offer an enhanced free claim direct data entry option and ERA portal for your use. This option enables providers to conduct business with CCP using the following methods. These are entirely sponsored by CCP, at no cost to you:

- Enter and submit claims, receive ERA, and exchange other electronic transactions using a browser-based application over the Internet.
- Directly transmit HIPAA compliant ANSI transactions over a secure direct connection.
- If you are currently registered with Availity, [click here](#) to access the Availity Portal for CCP.
- If you are not currently registered with Availity, [click here](#) to get registered to use the Availity Portal for CCP.
- For assistance with registration to the Availity portal, please [click here](#) to access an on-demand training video.
- To learn more about these options, visit [www.availity.com](http://www.availity.com) or contact Availity at [1-800-282-4548](tel:1-800-282-4548). We know you will enjoy industry leading products and services that will bring value to your organization!

Paper claims that require attachments or claim appeals should be mailed to CCP/HCDPBC Claims Department, P.O. Box 841109, Pembroke Pines, FL 33084. Claim Appeals must be submitted using the CCP Request for Reconsideration Form along with a copy of the claim form.

## Provider Bulletin

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

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

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.**

## Provider Bulletin

<b>Attention:</b>	<b>Participating Providers</b>		
<b>Subject:</b>	CCP Electronic Funds Transfer (EFT) Request Form		
<b>Program:</b>	District Cares (Option 1)	<b>Bulletin Date:</b>	April 26, 2019
<b>Bulletin Number:</b>	19-005	<b>Effective Date:</b>	April 26, 2019

### **Purpose:**

This bulletin serves to notify participating providers of the Electronic Funds Transfer (EFT) Request Form available through CCP, the Third Party Administrator (TPA) for the District Cares Program.

### **Notice:**

Electronic Funds Transfer (EFT) payments are available for participating providers submitting claims for services rendered to District Cares members.

Please submit the completed EFT Request Form to [eftforms@ccpcares.org](mailto:eftforms@ccpcares.org) and allow an estimated forty-five (45) days for processing.

For any questions regarding the status of a submitted EFT Request Form, please email your inquiry to [eftforms@ccpcares.org](mailto:eftforms@ccpcares.org).

### **Questions:**

Please contact the Provider Services Department at (866) 930-1002.

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**Please insert the bulletin into your Provider Handbook. The policies and procedures in this bulletin supersede any related policies and procedures in the handbook.**



## Electronic Funds Transfer Request Form

### Payee (Vendor) Information

\*Name: \_\_\_\_\_ \*Tax ID/SSN #: \_\_\_\_\_

\*Address: \_\_\_\_\_

*\* Required Field*

\*City/ST/  
Zip: \_\_\_\_\_

\*Contact: \_\_\_\_\_ \*Phone: (     ) \_\_\_\_\_

\*E-mail: \_\_\_\_\_ Fax: (     ) \_\_\_\_\_

### Financial Institution Information

(All submissions must include this form, filled out in its entirety, AND a voided check in order to be processed. Estimated turnaround time for completed submissions is 45 calendar days. Please submit via email to: [EFTforms@ccpcares.org](mailto:EFTforms@ccpcares.org))

**\*\* Please notify the Finance Department via the above email if this information changes \*\***

\*Bank Name: \_\_\_\_\_

\*Bank Address: \_\_\_\_\_

\*City/ST/Zip: \_\_\_\_\_

ABA/ROUTING NUMBER

ACCOUNT NUMBER

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--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

### **\*Company Authorization for EFT/Wire Transfer**

\_\_\_\_\_  
*Authorized Signature*

\_\_\_\_\_  
*Printed Name*

\_\_\_\_\_  
*Title*

\_\_\_\_\_  
*Date*

### Internal Use Only

Verified by Finance: \_\_\_\_\_ Date: \_\_\_\_\_

Initiated by: \_\_\_\_\_ Date: \_\_\_\_\_

Vendor updated by: \_\_\_\_\_ Date: \_\_\_\_\_

# Memorial Healthcare System ENTERPRISE SYSTEM ACCESS REQUEST FORM

You have the right to not provide the personal information on this form. If you choose not to complete this form in its entirety, you will be required to present yourself in person to the Department leader/MHS sponsor approving the access so that we can confirm your identity.

*Please fill out this form entirely. Incomplete forms can delay your account setup process.*  
**NON-MHS EMPLOYEES: ALL REQUIRED NOTICES MUST BE SENT TO MHS IT SYSTEM ACCESS TEAM VIA FAX (954-276-5397) OR EMAIL (MHSAccessRequestformONLY@mhs.net)**  
**MHS EMPLOYEES: PLEASE SUBMIT AN ONLINE REQUEST AND ATTACH COMPLETED FORM**

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

- \*\*All Users are required to read the following Policies. Initial by each Policy to confirm that you have received it.**
- System Access Establishment, Modification and Termination Policy and Procedure
  - Risk Analysis and Risk Management Policy
  - Information System Activity Review Policy and Procedure

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

Person requesting access must sign and date the form.

USER INFORMATION (TO BE FILLED OUT BY THE PERSON REQUIRING ACCESS)			
*Today's Date:	*Legal Last Name:	*Legal First Name:	MI:
Note: As part of the user ID creation process, all users will automatically be setup with MHS network login IDs as well as an MHS email account (if requested). User IDs are normally established with the first initial of the first name and complete last name, depending on availability. Please write legibly. You will be notified by MHS when the user ID is established. If an MHS email account is set up, we will use the email address to send periodic updates and other important system-related notifications, so please be sure to check this email account often.			
*Birth Date (MM/DD/YY):	*Office Phone:	*Last 4 digits Social Security #:	
*Office street address:		*Mobile Phone:	
*City:	*State:	*Zip Code:	*Your Email Address:
The above information is true to the best of my knowledge. I understand my obligations under MHS policies and applicable law, including HIPAA and related rules and regulations, and agree to utilize information only as needed to perform my job as part of the workforce of a Covered Entity or as a Business Associate of a Covered Entity (each as defined in HIPAA). I agree to comply with all MHS policies and procedures, and the terms of the Confidentiality and Data Security Agreement attached to this 3 page form and incorporated by reference. I agree that I am responsible for maintaining the custody and security of any MHS data I access, view, print, download or otherwise obtain from MHS. It is my sole responsibility to report any suspected breach of security or loss of custody of any MHS confidential information to the Privacy Reporting Number (954) 265-1165 or I can also send an email to mhsprivacy@mhs.net.			
*Requestor's Signature:		*Date:	
MHS SPONSOR VERIFICATION SECTION (TO BE FILLED OUT BY MHS SPONSOR ONLY FOR CONTRACTOR/STUDENT/VENDOR REQUESTS)			
User Title:	Company/School:		
Start Date:	End Date:	Sponsor's Employee ID #:	
Name of MHS Sponsor approving this request:			
Sponsor's Department:		Sponsor's Email Address:	
Sponsor's Title (Supervisor or above):		Sponsor's Office Phone:	
***Applications/Access Requested:			
The above information is true to the best of my knowledge. I understand my obligations under MHS policies and applicable law, including HIPAA and related rules and regulations, and certify that the above named user has a legitimate need to access MHS systems to perform duties for my department. I authorize this user to be setup with access to the systems as indicated on this form. I agree to notify MHS IT System Access Team via fax (954) 276-5397 or email MHSAccessRequestformONLY@mhs.net of any changes to this user's status under my Department. All user IDs that are not used within a 3 month period will be disabled as a security precaution. I agree to comply with all MHS policies and procedures and will ensure that this user complies by those policies. Remote access to any MHS system may require the use of a type of security device such as a token. Upon termination of the user's assignment or duties in my department, I agree to immediately return all devices that have been provided to this user. I will immediately notify MHS IT System Access Team via fax (954) 276-5397 or email MHSAccessRequestformONLY@mhs.net to delete the user IDs that have been setup for this user.			
Sponsor's Signature:		Date:	

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.

DO NOT COMPLETE THIS SECTION

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

To send applications via email, send to:  
[ccp.provider@ccpcare.org](mailto:ccp.provider@ccpcare.org).



RL 14244



If the person requesting access is a physician on staff at Memorial Healthcare, complete this section. Otherwise, leave blank.

VENDOR/CONTRACTOR VERIFICATION SECTION (TO BE FILLED OUT BY VENDOR/CONTRACTOR LEADER APPROVING THIS REQUEST)	
Name of Vendor/Contractor approving this request:	
Name/Title of Person Signing for Contractor/Vendor#:	
Office Phone:	Email Address:
<p>The above information is true to the best of my knowledge. I certify that the above named user is the agent or subcontractor of the above named vendor/contractor. Company authorizes this user to be setup with access to the systems as indicated on this form. Company will immediately notify MHS IT System Access Team via fax (954) 276-5397 or email <a href="mailto:MHSAccessRequestFormONLY@mhs.net">MHSAccessRequestFormONLY@mhs.net</a> of any changes to this individual's status as the agent or subcontractor of the above named vendor/contractor such as extended leave or termination of employment or affiliation. All user IDs that are not used within a 3 month period will be disabled as a security precaution. Vendor/Contractor agrees to comply with all MHS policies and procedures and will ensure that this user complies by those policies. Upon termination of the user's employment or status agent or subcontractor, Company will immediately return all devices that have been provided to this user and will immediately notify MHS IT System Access Team via fax (954) 276-5397 or email <a href="mailto:MHSAccessRequestFormONLY@mhs.net">MHSAccessRequestFormONLY@mhs.net</a> to delete the user access. Vendor/Company agrees to hold harmless and indemnify MHS, its employees and agents from and against any and all claims damages, expenses and causes of action, including, without limitation, attorney fees at all levels, arising out of, related to, or by reason of any misconduct, negligence, or breach of the terms and conditions of this Enterprise Access Form.</p>	
Signature:	Date:
PHYSICIAN OFFICE STAFF VERIFICATION SECTION (TO BE FILLED OUT BY PHYSICIAN APPROVING THIS REQUEST)	
Name of Physician approving this request:	Physician ID#:
Office Phone:	Email Address:
<p>The above information is true to the best of my knowledge. I understand my obligations as a Covered Entity under MHS policies and applicable law, including HIPAA and related rules and regulations, and certify that the above named user is part of my workforce. I authorize this user to be setup with access to the systems as indicated on this form. I agree to immediately notify MHS of any changes to this individual's status as part of my workforce such as extended leave or termination of employment. All user IDs that are not used within a 3 month period will be disabled as a security precaution. I agree to comply with all MHS policies and procedures and will ensure that this user complies by those policies. Remote access to any MHS system may require the use of a type of security device such as a token. Upon termination of the user's employment or status as part of my workforce, I agree to immediately return all devices that have been provided to this user and will immediately notify MHS IT System Access Team via fax (954) 276-5397 or email <a href="mailto:MHSAccessRequestFormONLY@mhs.net">MHSAccessRequestFormONLY@mhs.net</a> to delete the user IDs that have been setup for this user.</p>	
***Physician Signature:	Date:

\*\*\* All Physicians are required to comply with applicable law and MHS System policies, including but not limited to the MHS HIPAA Compliance Program, regarding access, use, and disclosure of medical information. Physicians who fail to comply with MHS policies shall be subject to corrective action.

All information gathered on this form is confidential in accordance with applicable law, as part of the MHS Security Program and is only used to verify identity. All requests will be logged via the MHS Service Now ticketing system for record keeping purposes. If you have any questions about this form please call 954-276-4848 (MHS IT Service desk).

**MEMORIAL HEALTHCARE SYSTEM**

Memorial Regional Hospital	Joe DiMaggio Children's Hospital	Memorial Hospital West
Memorial Hospital Pembroke	Memorial Hospital Miramar	Memorial Regional Hospital South
Memorial Manor	Memorial Home Health	

#### CONFIDENTIALITY AND DATA SECURITY AGREEMENT

Patient Care Services provided by the Memorial Healthcare System (further referred to as Healthcare System or MHS) for its patients are privileged and confidential under the law, as is other information used by the Healthcare System in its operations. Other confidential and privileged information includes, without limitation, medical review/peer review committee information, risk management information, quality improvement information, and trade secrets. I will not make any illegal copies of material subject to the copyright laws. To enable the Healthcare System to perform those services, patients furnish information with the understanding that it will be kept confidential and used only by authorized persons as necessary in providing those services. The goodwill of the Healthcare System depends upon keeping such services and information confidential, that certain legal obligations attach to this information, and that by reason of your duties you may receive or have access to verbal, written or electronic media information concerning patients and services performed by the Healthcare System. *If you have any questions, please ask for clarification.*



Where there is any question as to the privileged or confidential nature of any information, or the right of any party to obtain information, the Healthcare System attorney should be consulted.  
RL 14244

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](mailto:ccp.provider@ccpcares.org).

YOUR SIGNATURE ON PAGE THREE INDICATES ACCEPTANCE OF THE FOLLOWING:

User agrees to hold harmless and indemnify MHS, its employees and agents from and against any and all claims damages, expenses and causes of action, including, without limitation, attorney fees at all levels, arising out of, related to, or by reason of any misconduct, negligence, or breach of the terms and conditions of this Enterprise Access Form.

- 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 misuse 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 me, 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 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 gained by my password will be treated as confidential and never be released to any person or misused 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 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 call the Privacy Reporting Number (954) 265-1165 or email [mhsprivacy@mhs.net](mailto:mhsprivacy@mhs.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.

**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 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 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".

The person requesting the access to PlanLink must complete this section.



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

To send applications via email, send to:  
[ccp.provider@ccpcares.org](mailto:ccp.provider@ccpcares.org).

# Memorial Healthcare System

## ENTERPRISE SYSTEM ACCESS REQUEST FORM

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**Please fill out this form entirely. Incomplete forms can delay your account setup process.**  
**NON-MHS EMPLOYEES: ALL REQUIRED NOTICES MUST BE SENT TO MHS IT SYSTEM ACCESS TEAM VIA FAX**  
**(954-276-5397) OR EMAIL (MHSAccessRequestformONLY@mhs.net)**  
**MHS EMPLOYEES: PLEASE SUBMIT AN ONLINE REQUEST AND ATTACH COMPLETED FORM**

**\*\*All Users are required to read the following Policies. Initial by each Policy to confirm that you have received it.**

- **System Access Establishment. Modification and Termination Policy and Procedure** \_\_\_\_\_
- **Risk Analysis and Risk Management Policy** \_\_\_\_\_
- **Information System Activity Review Policy and Procedure** \_\_\_\_\_

USER INFORMATION (TO BE FILLED OUT BY THE PERSON REQUIRING ACCESS)				
*Today's Date:	* Legal Last Name:	*Legal First Name:		MI:
Note: As part of the user ID creation process, all users will automatically be setup with MHS network login IDs as well as an MHS email account (if requested). User IDs are normally established with the first initial of the first name and complete last name, depending on availability. Please write legibly. You will be notified by MHS when the user ID is established. If an MHS email account is set up, we will use the email address to send periodic updates and other important system-related notifications, so please be sure to check this email account often.				
*Birth Date (MM/DD/YY):	*Office Phone:	* Last 4 digits Social Security #:		
*Office street address:			*Mobile Phone:	
*City:	*State:	*Zip Code:	* Your Email Address:	
The above information is true to the best of my knowledge. I understand my obligations under MHS policies and applicable law, including <b>HIPAA</b> and related rules and regulations, and agree to utilize information only as needed to perform my job as part of the workforce of a Covered Entity or as a Business Associate of a Covered Entity (each as defined in HIPAA). <b>I agree to comply with all MHS policies and procedures, and the terms of the Confidentiality and Data Security Agreement attached to this 3 page form and incorporated by reference. I agree that I am responsible for maintaining the custody and security of any MHS data I access, view, print, download or otherwise obtain from MHS. It is my sole responsibility to report any suspected breach of security or loss of custody of any MHS confidential information to the Privacy Reporting Number (954) 265-1165 or I can also send an email to mhsprivacy@mhs.net.</b>				
*Requestor's Signature:			*Date:	
MHS SPONSOR VERIFICATION SECTION (TO BE FILLED OUT BY MHS SPONSOR ONLY FOR CONTRACTOR/STUDENT/VENDOR REQUESTS)				
User Title:		Company/School:		
Start Date:	End Date:	Sponsor's Employee ID #:		
Name of MHS Sponsor approving this request:				
Sponsor's Department:			Sponsor's Email Address:	
Sponsor's Title (Supervisor or above):			Sponsor's Office Phone:	
***Applications/Access Requested:				
The above information is true to the best of my knowledge. I understand my obligations under MHS policies and applicable law, including <b>HIPAA</b> and related rules and regulations, and certify that the above named user has a legitimate need to access MHS systems to perform duties for my department. I authorize this user to be setup with access to the systems as indicated on this form. I agree to notify MHS IT System Access Team via fax (954) 276-5397 or email <a href="mailto:MHSAccessRequestformONLY@mhs.net">MHSAccessRequestformONLY@mhs.net</a> of any changes to this user's status under my Department. All user IDs that are not used within a 3 month period will be disabled as a security precaution. I agree to comply with all MHS policies and procedures and will ensure that this user complies by those policies. Remote access to any MHS system may require the use of a type of security device such as a token. Upon termination of the user's assignment or duties in my department, I agree to immediately return all devices that have been provided to this user. I will immediately notify MHS IT System Access Team via fax (954) 276-5397 or email <a href="mailto:MHSAccessRequestformONLY@mhs.net">MHSAccessRequestformONLY@mhs.net</a> to delete the user IDs that have been setup for this user.				
Sponsor's Signature:			Date:	



**VENDOR/CONTRACTOR VERIFICATION SECTION**  
**(TO BE FILLED OUT BY VENDOR/CONTRACTOR LEADER APPROVING THIS REQUEST)**

**Name of Vendor/Contractor approving this request:**

**Name/Title of Person Signing for Contractor/Vendor#:**

**Office Phone:**

**Email Address:**

The above information is true to the best of my knowledge. I certify that the above named user is the agent or subcontractor of the above named vendor/contractor. Company authorizes this user to be setup with access to the systems as indicated on this form. Company will immediately notify MHS IT System Access Team via fax (954) 276-5397 or email [MHSAccessRequestformONLY@mhs.net](mailto:MHSAccessRequestformONLY@mhs.net) of any changes to this individual's status as the agent or subcontractor of the above named vendor/contractor such as extended leave or termination of employment or affiliation. All user IDs that are not used within a 3 month period will be disabled as a security precaution. Vendor/Contractor agrees to comply with all MHS policies and procedures and will ensure that this user complies by those policies. Upon termination of the user's employment or status agent or subcontractor, Company will immediately return all devices that have been provided to this user and will immediately notify MHS IT System Access Team via fax (954) 276-5397 or email [MHSAccessRequestformONLY@mhs.net](mailto:MHSAccessRequestformONLY@mhs.net) to delete the user access. **Vendor/Company agrees to hold harmless and indemnify MHS, its employees and agents from and against any and all claims damages, expenses and causes of action, including, without limitation, attorney fees at all levels, arising out of, related to, or by reason of any misconduct, negligence, or breach of the terms and conditions of this Enterprise Access Form.**

**Signature:**

**Date:**

**PHYSICIAN OFFICE STAFF VERIFICATION SECTION**  
**(TO BE FILLED OUT BY PHYSICIAN APPROVING THIS REQUEST)**

**Name of Physician approving this request:**

**Physician ID#:**

**Office Phone:**

**Email Address:**

The above information is true to the best of my knowledge. I understand my obligations as a Covered Entity under MHS policies and applicable law, including HIPAA and related rules and regulations, and certify that the above named user is part of my workforce. I authorize this user to be setup with access to the systems as indicated on this form. I agree to immediately notify MHS of any changes to this individual's status as part of my workforce such as extended leave or termination of employment. All user IDs that are not used within a 3 month period will be disabled as a security precaution. I agree to comply with all MHS policies and procedures and will ensure that this user complies by those policies. Remote access to any MHS system may require the use of a type of security device such as a token. Upon termination of the user's employment or status as part of my workforce, I agree to immediately return all devices that have been provided to this user and will immediately notify MHS IT System Access Team via fax (954) 276-5397 or email [MHSAccessRequestformONLY@mhs.net](mailto:MHSAccessRequestformONLY@mhs.net) to delete the user IDs that have been setup for this user.

**\*\*\*Physician Signature:**

**Date:**

**\*\*\* All Physicians are required to comply with applicable law and MHS System policies, including but not limited to the MHS HIPAA Compliance Program, regarding access, use, and disclosure of medical information. Physicians who fail to comply with MHS policies shall be subject to corrective action.**

All information gathered on this form is confidential in accordance with applicable law, as part of the MHS Security Program and is only used to verify identity. All requests will be logged via the MHS Service Now ticketing system for record keeping purposes. If you have any questions about this form please call 954-276-4848 (MHS IT Service desk).

**MEMORIAL HEALTHCARE SYSTEM**

Memorial Regional Hospital  
Memorial Hospital Pembroke  
Memorial Manor

Joe DiMaggio Children's Hospital  
Memorial Hospital Miramar  
Memorial Home Health

Memorial Hospital West  
Memorial Regional Hospital South

**CONFIDENTIALITY AND DATA SECURITY AGREEMENT**

Patient Care Services provided by the Memorial Healthcare System (further referred to as Healthcare System or MHS) for its patients are privileged and confidential under the law, as is other information used by the Healthcare System in its operations. Other confidential and privileged information includes, without limitation, medical review/peer review committee information, risk management information, quality improvement information, and trade secrets. I will not make any illegal copies of material subject to the copyright laws. To enable the Healthcare System to perform those services, patients furnish information with the understanding that it will be kept confidential and used only by authorized persons as necessary in providing those services. The goodwill of the Healthcare System depends upon keeping such services and information confidential, that certain legal obligations attach to this information, and that by reason of your duties you may receive or have access to verbal, written or electronic media information concerning patients and services performed by the Healthcare System. **If you have any questions, please ask for clarification.**

Where there is any question as to the privileged or confidential nature of any information, or the right of any party to obtain information, the Healthcare System attorney should be consulted.  
RL 14244



**YOUR SIGNATURE ON PAGE THREE INDICATES ACCEPTANCE OF THE FOLLOWING:**

User agrees to hold harmless and indemnify MHS, its employees and agents from and against any and all claims damages, expenses and causes of action, including, without limitation, attorney fees at all levels, arising out of, related to, or by reason of any misconduct, negligence, or breach of the terms and conditions of this Enterprise Access Form.

- 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 misuse 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 me, 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 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 gained by my password will be treated as confidential and never be released to any person or misused 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 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 call the Privacy Reporting Number (954) 265-1165 or email mhsprivacy@mhs.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.

**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 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 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: \_\_\_\_\_





## PlanLink Site Manager Designation for a sponsored Referred Group or CCP Participating Provider

This Section is to be completed by the Medical Director or main physician within the office/site.

**SPONSOR Designation**

- **Designated Sponsor Representative for Credentialed/Referring Physician Practice:**

Your signature below signifies that you understand the responsibilities associated with designating the Site Manager(s) for your practice, and adhering to the designated sponsor responsibilities delineated above (refer to page 1 – section titled “Responsibility of the designated sponsoring representative for the Credentialed / Referring Physician or Referred Group”).

Physician's Name: \_\_\_\_\_ CCP Participating Provider ID: \_\_\_\_\_

Practice Name: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

- **Designated Sponsor for Sponsored/Referred Group:**

Your signature below signifies that you understand the responsibilities associated with designating the Site Manager(s) for your group, and adhering to the designated sponsor responsibilities delineated above (refer to page 1 – section titled “Responsibility of the designated sponsoring representative for the Credentialed / Referring Physician or Referred Group”).

CCP Sponsor's Name (Please PRINT): \_\_\_\_\_

CCP Sponsoring Department: \_\_\_\_\_

CCP Sponsor's Signature: \_\_\_\_\_

**Lead Site Manager and 2<sup>nd</sup> Site Manager must also complete the Enterprise System Access Request Form (one per person).**

**DO NOT COMPLETE THIS SECTION**

This Section is to be completed by designated PlanLink Site Manager.

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

**SITE MANAGER(S) Designation (for both Physician Practice and Sponsored/Referred Group)**

Your signature below signifies that you understand the responsibilities associated with your role as the Site Manager for your Practice / Sponsored/Referred Group, and that you will comply with timely site verification every 30 days.

**IMPORTANT:** Non-compliance with monthly site-verification by the Site Manager will result in termination of MHS Epic/EpicLink access for each member of your practice / group.

- **Lead Site Manager is REQUIRED** (must be the Medical Director, Agency Director or Office Manager of the Sponsored/Referred Group or Physician Practice):

Medical Director, Agency Director or Office Manager Name (Please PRINT): \_\_\_\_\_

Medical Director, Agency Director or Office Manager Signature: \_\_\_\_\_

E-mail address (required): \_\_\_\_\_

- **2<sup>nd</sup> Site Manager is OPTIONAL** (if Lead Site Manager requires assistance to comply with monthly Site Verification)

2<sup>nd</sup> Site Manager's Name (Please PRINT): \_\_\_\_\_

2<sup>nd</sup> Site Manager's Signature: \_\_\_\_\_

E-mail address (required if 2<sup>nd</sup> Site Manager is designated above): \_\_\_\_\_

**IF CLAIMS / REFERRALS ACCESS REQUESTED:**

Tax ID Number(s) (required): \_\_\_\_\_

Please return this form via fax to 954-276-5397

This Section is to be completed by the site managers backup or 2<sup>nd</sup> site manager.

CCP strongly recommends designating a second site manager although this is not a requirement.

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

To send applications via email, send to:  
[ccp.provider@ccpcares.org](mailto:ccp.provider@ccpcares.org).



### **Epic Link Site Manager Designation for a Sponsored Referred Group or CCP Participating Provider Practice**

#### **Responsibility of the designated sponsor representative for the Credentialed/Referring Physician or Referred Group:**

When a Credentialed/Referring Physician Practice or Referred Group (herein referred to as the “Sponsored/Referred Group”), requires access to Memorial Healthcare Systems (MHS) Epic Link system, Community Care Plan (CCP) requires the designation of a sponsor. The designated sponsor representative must be a CCP Participating Provider/Referring Physician or CCP Provider Operations Representative working with the “Sponsored/Referred Group” who agrees to the following responsibilities:

- Sponsor the Group/Physician Practice and the assigned Epic Link Site Manager(s) by signing the Epic Link Site Manager Designation Form below.
- Communicate to the MHS IT Department if the Site Manager(s) assigned on this form leaves the Sponsored/Referred Group/Physician Practice.
- Communicate to the MHS IT Department immediately if the Sponsored/Referred Group ceases to provide referring services to their patients (i.e., if the relationship between the referring provider/agency and CCP is terminated).

#### **Responsibility of Epic Link Site Manager(s)**

Each Sponsored/Referred Group/Physician Practice must have at least one Lead Site Manager. The Lead Site Manager must be the Medical Director, Agency Director, or Office Manager for the group requesting access.

The Lead Site Manager for each Sponsored/Referred Group/Physician Practice will be responsible for:

- Signing each **MHS Access Request Form** for each member of the Sponsored/Referred Group/Physician Practice requesting access.
- Inactivating users who have left the group/practice, immediately upon termination.
- Completing a monthly Site Verification in Epic Link. Site Verification is a function in Epic Link that allows the Site Manager(s) to validate the Epic/Epic Link access for all of its employees. Site Verification ensures that access to Epic/Epic Link is terminated for any staff that has left the group/practice.

If the Lead Site Manager is not able to perform the Site Verification task, a second Site Manager can be designated to complete this task.

**IMPORTANT:** if this monthly Site Verification is not completed in a timely manner, MHS will be alerted, which will result in termination of MHS Epic/Epic Link access for each member of the non-compliant Sponsored/Referred Group or Referring Physician Practice.

## Plan Link Site Manager Designation for a Sponsored Referred Group or CCP Participating Provider

**SPONSOR Designation**

- **Designated Sponsor Representative for Credentialed/Referring Physician Practice:**

Your signature below signifies that you understand the responsibilities associated with designating the Site Manager(s) for your practice and adhering to the designated sponsor responsibilities delineated above (refer to page 1 – section titled “**Responsibility of the designated sponsor representative for the Credentialed/Referring Physician or Referred Group”**).

Physician’s Name: \_\_\_\_\_ CCP Participating Provider ID: \_\_\_\_\_

Practice Name: \_\_\_\_\_

Physician’s Signature: \_\_\_\_\_

- **Designated Sponsor for Sponsored/Referred Group:**

Your signature below signifies that you understand the responsibilities associated with designating the Site Manager(s) for your group and adhering to the designated sponsor responsibilities delineated above (refer to page 1 – section titled “**Responsibility of the designated sponsor representative for the Credentialed/Referring Physician or Referred Group”**).

CCP Sponsor’s Name (Please PRINT): \_\_\_\_\_

CCP Sponsoring Department: \_\_\_\_\_

CCP Sponsor’s Signature: \_\_\_\_\_

**SITE MANAGER(S) Designation (for both Physician Practice and Sponsored/Referred Group)**

Your signature below signifies that you understand the responsibilities associated with your role as the Site Manager for your Sponsored/Referred Group/Practice and that you will comply with site verification every 30 days. **IMPORTANT:** Non-compliance with monthly site-verification by the Site Manager will result in termination of MHS Epic/Epic Link access for each member of your practice/group.

- **Lead Site Manager is REQUIRED** (must be the Medical Director, Agency Director, or Office Manager of the Sponsored/Referred Group or Physician Practice):

Medical Director, Agency Director, or Office Manager Name (Please PRINT): \_\_\_\_\_

Medical Director, Agency Director, or Office Manager Signature: \_\_\_\_\_

E-mail address (*required*): \_\_\_\_\_

- **2<sup>nd</sup> Site Manager is OPTIONAL (if Lead Site Manager requires assistance to comply with monthly Site Verification)**

2<sup>nd</sup> Site Manager’s Name (Please PRINT): \_\_\_\_\_

2<sup>nd</sup> Site Manager’s Signature: \_\_\_\_\_

E-mail address (*required if 2<sup>nd</sup> Site Manager is designated above*): \_\_\_\_\_

**IF CLAIMS/REFERRALS ACCESS REQUESTED:**

Tax ID Number(s) (*required*): \_\_\_\_\_

Please return this form via fax to 954-276-5397



# Authorization Requirements 2019

SERVICE	AUTHORIZATION INDICATOR	LIMITATIONS
<b>Any Inpatient – Acute Care (including Behavioral Health)</b>	Yes / Required	Ten (10) Inpatient days per year for medical/rehab/behavioral (combined).
<b>Any Inpatient – Rehabilitation (hospital setting)</b>	Yes / Required	Ten (10) Inpatient days per year for medical/rehab/behavioral (combined).
<b>Any Outpatient - Cardiac Rehabilitation</b>	Yes / Required	One 12-week (24 visits) occurrence
<b>Durable Medical Equipment / Supplies</b>	Yes / Required	Must be medically necessary and a covered benefit. Accumulated cost of the rental of DME is not to exceed the purchase price.
<b>Home Care / Home Infusion</b>	Yes / Required	Combined forty-five (45) day limit skilled nursing care and home infusion.
<b>Orthotics</b>	Yes / Required	Restricted to joint immobilization as medically necessary.
<b>Prosthetics</b>	Yes / Required	One (1) prosthetic per limb per lifetime  One (1) prosthetic eye per lifetime
<b>Outpatient – Diagnostic (only MRI/CT/PET/SPECT)</b>	Yes / Required	Must meet medical necessity protocols
<b>Outpatient - Surgery</b>	Yes / Required	Must meet medical necessity protocols
<b>Outpatient - Therapy</b>	Yes / Required	Combined modality limits of 30 treatments per calendar year.
<b>Colonoscopy / EGD (any type / any location)</b>	Yes / Required	Must meet medical necessity protocols
<b>Specialty Care Gatekeeper Model</b>	Yes / Required	All specialty care visits must be ordered by a CL Brumback PCP. Specialty care must be provided by a participating physician and meet medical necessity protocols. Benefit limit is six (6) visits per specialty per calendar year (excluding Oncology).