PROVIDER Bulletin

March 27, 2018

This Provider Bulletin applies to the lines of business and provider types checked below:

☒ **PHP (Medicare)**	☒ **Primary Care Physicians**	☒ **Specialists**
☒ **PHC (Medicaid)**	☐ **Ancillary**	☐ **Hospitals**

Direct Referral

An "authorization" is not required for a participating Primary Care Practitioner (PCP) to refer a Plan Member to a participating specialist for consultation and related treatment. A Direct Referral may be written for up to three (3) visits and is valid up 90 days. ***Diagnostic procedures, tests and treatment requiring "authorization" must be requested by the specialist/treating provider and not the PCP.***

To locate a participating network specialist of PHP (Medicare Advantage Part D plan) or PHC (Medicaid Reform HMO) please access the Plan's on-line **Network Provider/Facility/Pharmacy Search** tool located on our website: www.positivehealthcare.org.

Participating PCPs, we ask that you use the below Director Referral Form to communicate referrals to participating network specialists. If you need to refer to a specialist who is not in our network, please fax your request to 877-243-3536.

The below Direct Referral Form may be downloaded from our website www.positivehealthcare.org under the Publication and Forms tab.

PHP HMO SNP | PHC FLORIDA

DIRECT REFERRAL

No authorization number is required for payment.
Paper Claims Department, PHP & PHC, P.O. Box 7490, La Verne, CA 91750
Electronic Claims: Clearinghouse: Emdeon; Submitter I.D.: 95411

Patient Name: ____________________ **DOB:** ____________

Current Address: ____________________ **Phone Number:** (   ) ____________

Member ID: ____________________

Diagnosis: ____________________ **Diagnosis Code:** ____________

Provider/Specialist	Address & Telephone Number	Appointment Date & Time

PCP Name: ____________ **Signature:** ____________ **Date:** ____________

The specialty consult services listed below can be referred directly to the specialist ***without a prior authorization number.*** Your patients must see ***in-network*** providers/physicians and utilize contracted facilities shown on your current provider roster. Please give this direct referral form to your patient to make the appointment, and ask that he or she bring this form to the requested specialist/facility. **Procedures such as, but not limited to, surgeries, colonoscopies, imaging guided procedures and device placements will require prior authorization.**

Cardiology
- ☐ Office Evaluation ☐ Follow-Up Visit(s) x
- ☐ EKG ☐ Treadmill Stress Test
- ☐ Nuclear Stress Test

Dermatology
- ☐ Office Evaluation ☐ Follow-up Visit(s) x
- ☐ Biopsy

Gastroenterology
- ☐ Office Evaluation ☐ Follow-up Visit(s) x

General Surgery
- ☐ Office Evaluation, including X-rays in office, if required
- ☐ Follow-Up Visit(s), including X-rays in office, if required x

Hematology/Oncology
- ☐ Office Evaluation ☐ Follow-Up Visit(s) x

Neurology
- ☐ Office Evaluation ☐ Follow-Up Visit(s) x

Ob/Gyn
- In Network, **no referral required**
- **Out of Network, prior auth required**

Ophthalmology
- ☐ Office Evaluation, Yearly Diabetic Eye Exam
- ☐ Follow-Up Visit(s) x

Other ____________
- ☐ Office Evaluation ☐ Follow-up Visit(s) x

NOTE: All lab work must be referred to LabCorp.

Optometry (verify benefits)
- ☐ Office Evaluation
- ☐ Routine Eye Exam – one per year or change in Rx (verify benefits)
- ☐ Glasses/Frames/Lens (verify benefits)
- ☐ 92015 Refraction (verify benefits)
- ☐ Z2930 Dispensing (verify benefits)

Orthopedic
- ☐ Office Evaluation, including X-rays in office, if required
- ☐ Follow-Up Visit(s), including X-rays in office, if required x

Pain Management
- ☐ Office Evaluation
- **Follow-up Care Requires Prior Authorization**

Podiatry
- ☐ Office Evaluation, including X-rays in office, if required
- ☐ Follow-Up Visit(s), including X-rays in office, if required x

Psychiatry/Psychology
- ☐ Office Evaluation ☐ O/P Follow-Up Visit(s) x

Urology
- ☐ Office Evaluation ☐ Follow-Up Visit(s) x

Radiology* – *Must use contracted facilities only.*
- ☐ X-Ray of: ____________
- ☐ Ultrasound of: ____________
- ☐ Mammogram
- ☐ Bone Density
- * CT scans, MRI, PET scans and nuclear imaging **require prior authorization.**

Eligibility: Member must be eligible at the time of visit. To verify eligibility for PHP (HMO SNP) (Medicare Advantage and Prescription Drug Plan) or PHC Florida (Medicaid HMO plan), **call (866) 990-9322 or fax to (888) 972-5340.**
Benefits: Member must have appropriate benefit level at the time of visit. Provider of service must verify benefits.
Signature: Direct Referral Form must be signed by the referring primary care provider.
Provider: The provider to whom member is referred must be an in-network provider and **utilize contracted facilities.**
Time: This referral is effective for ninety (90) days from the date issued for initial and two (2) follow-up visits. **Additional visits, or visits after**

This Provider Bulletin is not intended to replace or conflict with any requirements outlined in your signed agreement with AHF, PHP or PHC. If you have any questions or suggestions contact the Provider Relations Department at 954.522.3132 or email to Remon.Walker@phcplans.org

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Electronic Claims: Clearinghouse: Emdeon; Submitter I.D.: 95411

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Diagnosis: ______________________ **Diagnosis Code:** ______________________

Provider/Specialist	Address & Telephone Number	Appointment Date & Time

PCP Name: ______________________ **Signature:** ______________________ **Date:** ______________________

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Benefits: Member must have appropriate benefit level at the time of visit. Provider of service must verify benefits.

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