meridianhealth

MICHIGAN PROVIDER ORIENTATION

MISSION

Our members are our reason for being. We help those eligible for government-sponsored healthcare plans live better, healthier lives.

VISION

WellCare's vision is to be a leader in government-sponsored healthcare programs in collaboration with our members, providers, and government partners. We foster a rewarding and enriching culture to inspire our associates to do well for others and themselves.

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WHO WE ARE

MeridianHealth (Meridian) has been operating government-sponsored health plans throughout the United States as a licensed HMO since 2000 and has organically become the largest Medicaid HMO in the State of Michigan with the most comprehensive provider network. In 2008, our Medicaid line of business, MeridianHealth, expanded our presence into the State of Illinois, growing to be the largest Medicaid health plan in the state participating in all managed care programs by 2016.

Today, Meridian affiliates provide administrative services to over 1 million beneficiaries. Collectively, our affiliated organizations administer Medicare, Medicaid, Health Insurance Marketplace health plans (MeridianChoice), and Medicare-Medicaid Plans (MeridianComplete).

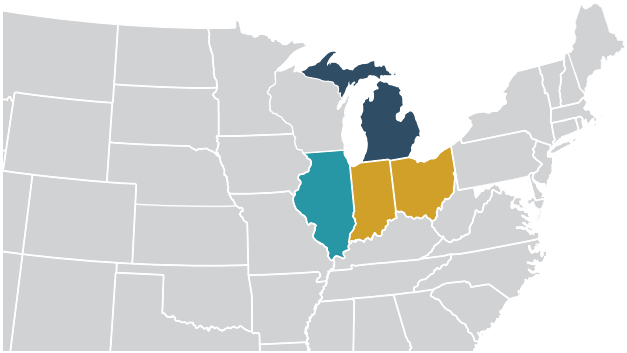
Meridian Programs by State

	MEDICARE	MEDICAID	MEDICAID EXPANSION	EXCHANGE
MI	✓	✓	✓	✓
IL	✓	✓	✓	
OH	✓			
IN	✓			

MEDICAID	
POPULATION	**DESCRIPTION**
Medicaid	Members that need temporary assistance
ABD/ICP	Aged, Blind and Disabled/Integrated Care Program
Aging	Aged Member in Medicaid
AIDS/HIV	AIDS/HIV Member
CCN	Children with Complex Needs
CD	Consent Decree
CSHCS	Children's Special Health Care Services
Dual	Medicare & Medicaid Covered Member
PD/DD	Physically Disabled/Developmentally Disabled
MH	Mental Health
SNF/LTC	Skilled Nursing Facility/Long Term Care
TBI	Traumatic Brain Injury

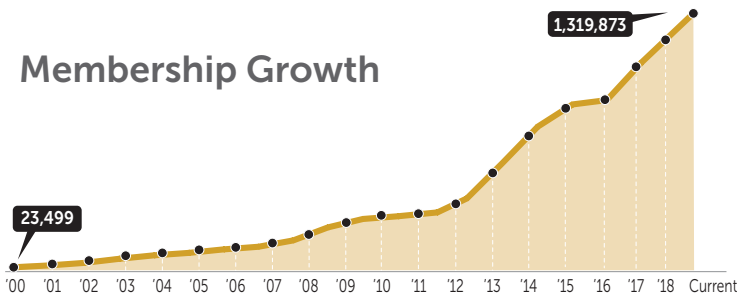
MEDICARE	
POPULATION	**DESCRIPTION**
D-SNP	Dual Eligible Special Needs Plans
MAPD	Medicare Advantage Prescription Drug
MMP	Medicare Medicaid Program
PDP	Prescription Drug Plan

Meridian Service Area



- Medicare, Medicaid, MMP and Exchange Plans
- Medicare Only
- Medicare, Medicaid, MMP Plans

Membership Growth



WHAT WE DO

Meridian offers several products in the State of Michigan, including:

MeridianHealth

Provides healthcare services to Medicaid and MIChild Program beneficiaries in all counties in Michigan's Lower Peninsula based on the State of Michigan Medicaid benefit guidelines.

MeridianHealth - Healthy Michigan Plan

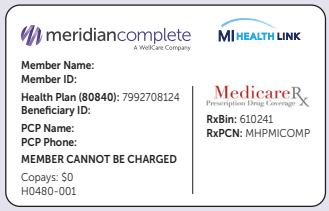
Part of Medicaid expansion, provides care to eligible Michigan residents who have an income at or below 133% of the federal poverty level.

MeridianChoice

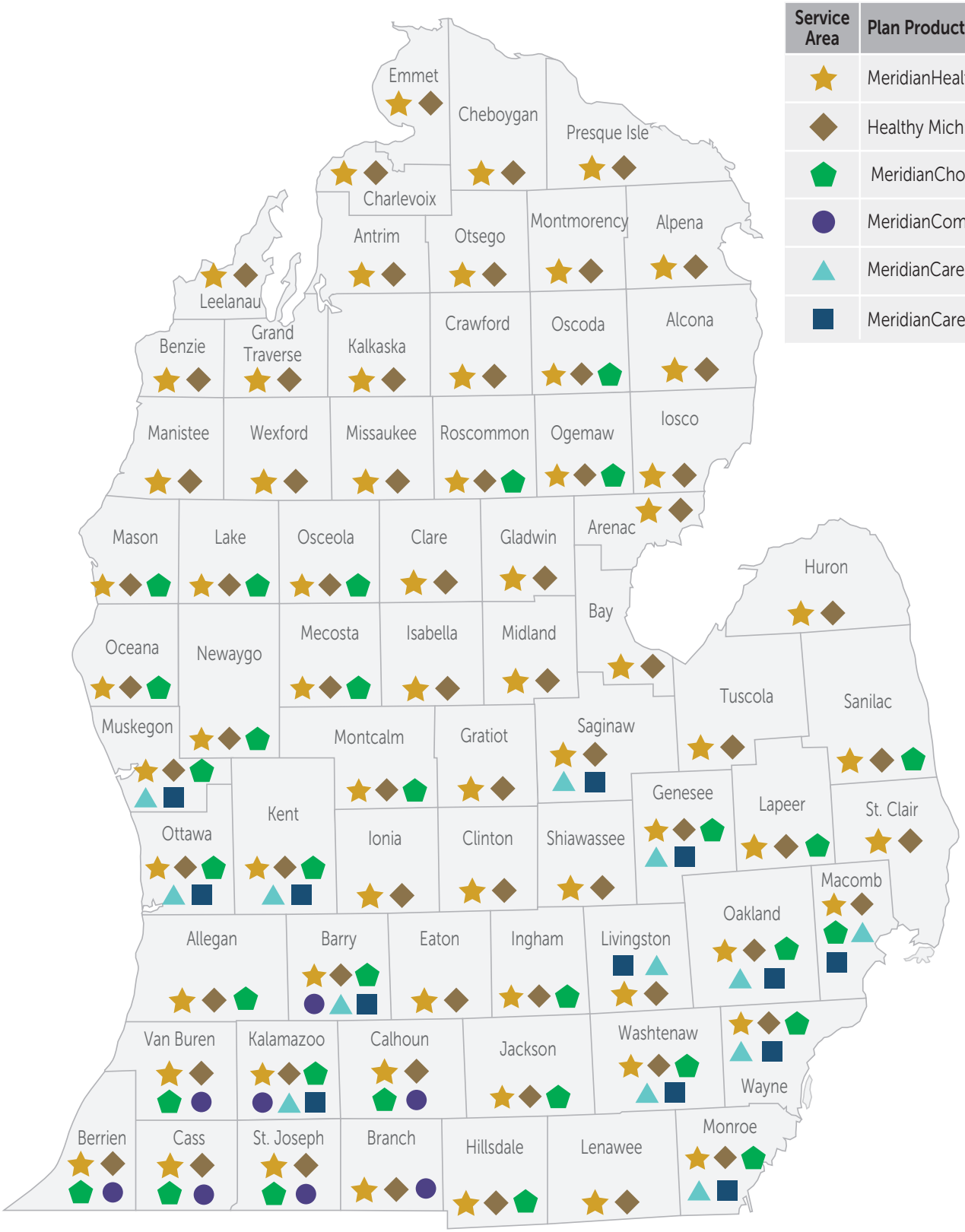
A federal Health Insurance Marketplace Qualified Health Plan (QHP) that offers individual and family Catastrophic (Healthy Essentials), Bronze, Silver and Gold plans. Ninety-one percent of members are between 100% and 400% of the federal poverty level and qualify for a government-sponsored premium subsidy.

MeridianComplete (Medicare-Medicaid Plan)

Integrates managed care for individuals who are eligible for both Medicare and Medicaid under one plan under a demonstration program with CMS and the State of Michigan.



WHERE WE SERVE



Service Area	Plan Product
★	MeridianHealth
◆	Healthy Michigan Plan
⬟	MeridianChoice
●	MeridianComplete
▲	MeridianCare (HMO SNP) Plans
■	MeridianCare (HMO) Plans

⬟ **Partial Counties:** Ingham, Lake, Lapeer, Monroe, Oceana, Osceola, Oscoda, Roscommon and Sanilac

PRIOR AUTHORIZATION REQUESTS

Prior Authorization Submission Options

Meridian offers multiple methods to submit authorization requests. For the most efficient and timely service, Meridian's Online Prior Authorization (PA) Form is the preferred method.

1. **Online Electronic Submission** - The Meridian Online PA Form can be accessed in two ways:
   - Meridian Corporate Website
   - Secure Provider Portal

2. **Fax Submission** - Refer to UM's referral type fax numbers. Please include pertinent clinical documentation with the request if indicated

3. **Phone Submission** - Monday - Friday, 8 a.m. - 6 p.m.
   Please note: Many authorizations cannot be processed via phone, as clinical review and supporting documentation is required. Requests should only be submitted via the phone for services related to pending hospital discharges.

When submitting a Prior Authorization request, please include the following information:

- Member's name
- Member's identification number
- Date(s) of service
- Facility where services are to be rendered
- Diagnosis/procedure code(s), as applicable

Prior Authorization forms are available on the Meridian website at www.mhplan.com under "Provider Tools" in the "For Providers" tab.

The Prior Authorization forms, along with any pertinent clinical information, must be completed and sent to the Meridian Utilization Management (UM) department.

Clinical information is required for all clinical review requests to ensure timely decisions by Meridian. The decision time frame is based on the date we receive the request, not date we receive the supporting clinical information. To ensure a timely decision, make sure all supporting clinical information is included with the initial request. The preferred method of clinical review submission is via Meridian's Online PA Form. The Online PA Form makes it easy to submit clinical information after the initial request is received. When submitting additional clinical information, be sure to enter both the confirmation number and attachment reference number provided on the confirmation page of the initial request.

Clinical information includes any relevant information regarding the member's:

- History of presenting problem
- Physical assessment
- Diagnostic results
- Photographs
- Consultations
- Previous and current treatment
- Response to treatment

PRIOR AUTHORIZATION REQUESTS

Clinical information should be provided at time of submission of the request. The provider or facility is responsible for ensuring authorization. Meridian provides a reference number on all authorizations.

For a full list of services requiring authorization, please refer to the Prior Authorization Requirements page on the Meridian website.

The objective of Meridian's UM department is to ensure that the medical services provided to members are medically necessary and/or appropriate, as well as in conformance with the plan benefits. To guide the decision-making process, UM applies systematic evaluations to appropriate medical necessity criteria and considers circumstances unique to the member.

The UM process consists of the following:

Preservice Review: Also known as prior authorization or precertification, is the review of medical information prior to the delivery of the healthcare services. The purpose of preservice review is to determine if the care and setting are medically appropriate, according to established guidelines

Concurrent Review: The review of ongoing clinical care to determine if the services being provided meet the clinical guidelines for the appropriate level of care and setting

Retrospective Review: The process of reviewing a service request and making an organization determination after a service has been rendered by the provider

Meridian requires review of select services before they are provided. The primary reasons for clinical review are to determine whether the service is clinically appropriate, is performed in the appropriate setting, and is a benefit. Clinical information is necessary for all services that require clinical review for medical necessity.

Utilization decisions are based on appropriateness of care and service, as well as the member's eligibility. Meridian does not specifically reward our providers, associates, consultants, or other individuals for any denials of coverage or care issued, nor do we use incentives to encourage denial of care or service.

UM staff refer to plan documents for benefit determination and Medical Necessity Coverage Guidelines to support UM decision-making. All utilization review decisions to deny coverage are made by Meridian's medical directors. These guidelines include McKesson InterQual® criteria, Meridian Medical Review Criteria (developed by Meridian medical directors in conjunction with community providers), and applicable federal and state benefit guidelines.

Meridian's Medical Necessity Guidelines are based on current literature review, consultation with practicing providers and medical experts in their particular field, government agency policies, and standards adopted by national accreditation organizations. It is the attending provider's responsibility to make clinical decisions regarding medical treatment. These decisions should be made consistent with generally accepted principles of professional medical practice and in consultation with the member.

PRIOR AUTHORIZATION REQUESTS

Copies of the criteria utilized in decision-making are available free of charge upon request by calling the UM department at 888-437-0606. In certain circumstances, an external review of service requests are conducted by licensed physicians with the appropriate clinical expertise.

UM decisions determine the medical necessity of a service and are not a guarantee of payment. Claims payment is determined by the member's eligibility and benefits at the time the services are rendered.

Services that are not listed on the Michigan Medicaid Fee Schedule are not reimbursable to the provider.

Concurrent Review, Discharge Planning, and Transition of Care
Meridian's nurse reviewers are assigned to members at specific acute care facilities to promote collaboration with the facility's review staff and management of the member across the continuum of care.

Meridian's nurse reviewers assess the care and services provided in an inpatient setting and the member's response to the care by applying InterQual® criteria. Together with the facility's staff, UM's clinical staff coordinates the member's discharge needs.

Meridian's nurse reviewers interface with the hospital/facility discharge planners to:

- Obtain the member's discharge planning needs
- Identify the member's discharge planning needs
- Facilitate the transition of the member from one level of care to another
- Obtain clinical information and facilitate the authorization of post-discharge services, such as DME, home health services, and outpatient services

Medication Prior Authorization Request

Instructions:

1. Only 1 medication per form
2. All fields must be completed and legible for review.
3. Prior Authorizations cannot be submitted over the phone. To submit *electronically*, go to **meridianrx.com** and select "Submit Prior Authorization."

Date of Request:	
Patient Information	**Prescriber Information**
Patient Name:	Prescriber Name and Specialty:
Member ID #:	NPI #:
Sex: ☐ Male ☐ Female	Office Phone:
Date of Birth:	Office Fax:
Plan Name:	Contact Person:
Patient Phone:	

Requestor Information	
Requestor Name:	
Relationship to Member*:	Phone:
Email Address:	

***If the requester is not the Member or a Prescriber, attach documentation showing the authority to represent the enrollee (a completed Authorization of Representation Form CMS-1696 or a written equivalent. We also accept copies of legal documents recognized by the state or other legal documentation showing authority). For more information on appointing a representative, you may contact your plan.**

Diagnosis and Medical Information			
Medication:		Strength & Route of Administration:	
Urgency:	Frequency:	Expected Length of Therapy:	
Quantity:	Days Supply:	Height & Weight:	
BMI:	Date Calculated:	Blood Pressure:	Date Calculated:
Service Type: ☐ Retail ☐ Home Infusion			
Diagnosis Related to Medication Request:		Vacation Fill:	
Drug Allergies:		Early Refill:	

Rationale for Prior Authorization

History of a medical condition, allergies or other pertinent information requiring the use of this medication:

Previous use of non-authorized and prior authorized medications tried and failed for this condition:

Name of Medication and Reason for Failure:

You must include all necessary clinical documentation, office notes and all related laboratory results to ensure a complete PA review.

Prescriber's Signature:	Date:

Confidentiality Notice: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the

PRIOR AUTHORIZATION REQUESTS

Online Prior Authorization Form Overview

The Online Prior Authorization (PA) Form is available at **www.mhplan.com**. The form assists with accurately routing PA requests and allows for more streamlined processing. Providers can directly upload supporting documentation to the completed Online PA Form for submission. In addition to submitting a new PA request, providers can submit additional documentation via fax or electronically without having to complete a new request.

All PA requests should be submitted using Meridian's Online PA Form.

PA requests initiated from the Provider Portal are completed using the Online PA Form. Fax capabilities are also available.

The Online PA Form has required fields marked with a red asterisk. All required fields must be filled out in order for the form to be submitted.

Submitting the Form

Once providers have filled out the Online PA Form, they have the option to fax or submit electronically.

If the provider selects **Fax Submission** on the Online PA Form, they will be prompted to "Print Cover Page." This printed cover confirmation page will populate on the provider's web browser. This cover page must be used when faxing the PA request to Meridian with applicable documentation. Providers may reference the "Confirmation #" in the top right-hand corner to receive a status update when calling Meridian.

If the provider selects **Electronic Submission** on the Online PA Form, they will have the ability to electronically attach documents within the web browser. Once the form is completed and applicable documents are attached, the provider will be prompted to "Submit." A confirmation page will populate on the provider's web browser. This page serves as a confirmation that the submission was received by Meridian. Providers may reference the "Confirmation #" in the top right-hand corner to receive a status update when calling Meridian.

Meridian accepts the following file types for Electronic Submissions: PDF, JPG, PNG and BMP. Any DOC and DOCX files (Word documents) or TIFF files must be converted to PDF for Electronic Submission. If the DOC, DOCX and TIFF files cannot be converted to PDF, the provider must select the Fax Submission option and fax in the Online PA Form with documentation.

Attaching Additional Documentation

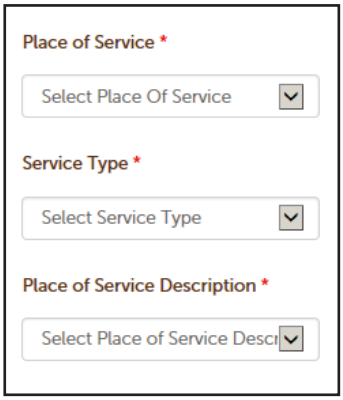
Providers will now have the option to submit **Additional Documentation** via fax or electronically. Providers will need to enter the "Confirmation #," along with the "Attachment Reference #" (Attachment Ref #), both located in the top right-hand corner of the confirmation page from the original PA request.

It is important the user enters the "Confirmation #" **and** "Attachment Ref #" for the additional documentation submission. Meridian will receive the submission and link the additional documentation to the original PA request.

PRIOR AUTHORIZATION REQUESTS

Delivery Requests
New functionality is added to the Online PA Form if the provider selects "Delivery."

When "Elective Admission – Scheduled Delivery" or "Emergent Admission - Delivery" is selected in the Service Type dropdown, the EDC/EDD Date **or** the LMP Date fields are required. Meridian asks that providers submit the Delivery Date/Baby's DOB at the time of submission if known.



Service Information fields have been updated to **Place of Service**, **Service Type,** and **Place of Service Description.** Dynamic dropdown options are provided for each of these fields.

If you have any questions regarding the use of the Online PA Form, please contact your local Provider Network Managment Representative (PNMR). You may also contact Provider Services at 888-773-2647.

We look forward to improving your user experience submitting PA requests.

PROVIDER APPEAL

Providers can only appeal preservice (before services) if the service is urgent. If the service is not urgent, they have to appeal on member's behalf with a signed Agent of Record (AOR). Providers/members are only verbally notified of the decision if the appeal was requested urgent. Members and providers are notified in writing of all appeal decisions.

MeridianHealth Michigan Contact Grid

ONLINE ELECTRONIC SUBMISSION	
Phone	**Web**
888-322-8844	Prior Authorization Form
ONLINE FAX SUBMISSION	
Phone	**Fax**
888-322-8844	313-309-8580
All online requests MUST be faxed in using our online prior authorization fax form.	
INPATIENT ADMISSIONS	
Phone	**Fax**
888-322-8844	313-324-1835
Please send all requests for Emergent Admission, Skilled Nursing Facility, Inpatient Rehab, Transplants, and Long-Term Acute Care Hospitals (LTACH).	
PRESERVICE ONLY	
Phone	**Fax**
888-322-8844	313-324-1808
Please send all requests for Surgeries, Home Care, Hospice, Office Visits, Therapies, DME, and Pain Management.	
POST-ACUTE REQUEST	
Phone	**Fax**
888-322-8844	313-202-3956

BEHAVIORAL HEALTH SERVICES		
Plan	**Phone**	**Fax**
Medicaid	888-222-8041	Inpatient: 313-309-8588 Outpatient: 313-202-1268 Case Management: 313-309-8588
CLAIMS		
Plan	**Phone**	**Fax**
All Plans	800-203-8206	313-324-3642
DIABETIC TESTING SUPPLIES		
Plan	**Phone**	**Fax**
Medicaid	866-779-8512 *Healthy Living Medical Supply is the exclusive vendor*	866-779-8511 *Healthy Living Medical Supply is the exclusive vendor*
PHARMACY PA REQUESTS		
Plan	**Phone**	**Fax**
Medicaid	866-984-6462	877-355-8070
PROVIDER SERVICES		
Plan	**Phone**	**Fax**
Medicaid	888-773-2647	313-202-0008

PROVIDER INCENTIVE PROGRAM - HEDIS® INCENTIVE PROGRAM OVERVIEW

Meridian is committed to ensuring its members receive quality preventive healthcare services. To encourage our providers to meet this goal, Meridian has developed incentive programs based on specific Healthcare Effectiveness Data and Information Set (HEDIS®) measures, which
are tailored to specific member types based on Medicaid Program Codes.

Meridian pays a quality incentive to PCPs for providing many types of services that help prevent members from needing hospital care. By offering incentives to those providing preventive care, Meridian is able to lower costs and improve enrollee health status over the long term.

Incentive Eligibility Requirements	Meridian will continue the HEDIS® Incentive Program for all contracted primary care providers. The yearly incentive period will cover all HEDIS® services provided between dates of service January 1 and December 31 of each year. These services must be reported to Meridian on a claim form or via fax each year by February 28 in order to be eligible for a incentive payment. Providers may also submit HEDIS® service information via a direct feed from their EMR system. Reach out to your PNMR for additional information.
HEDIS® Incentive Payments	Incentives will be paid out quarterly.
Monthly HEDIS® Reports	• Delivered through the Provider Portal or in hard copy each month • Lists all members needing HEDIS® services • Required immunizations remain on the list until all are received or the second birthday passes • Required well-child visits remain on the list until all six are received or the 15-month birthday passes • Members who change PCPs appear on the new PCP list
Medical Record Review	• Meridian Medical Record Abstractors conduct on-site reviews in your office • New technology allows staff to quickly and efficiently review your records • Helps providers achieve increased HEDIS® incentives • Abstractors may also contact your office by fax to request medical records • All medical records requested by Meridian are to be provided at no cost from the provider. This includes administrative fees, copying fees, paper fees, and fees delegated from a third-party vendor. Medical records should be provided to Meridian within 10 business days of request, unless otherwise agreed. Accomodations can be arranged for individuals designated by Meridian to assist in extracting medical records to ease the burden on providers for this request. Where possible, electronic access to medical records should be arranged
Electronic Data Exchange and Electronic Health Record Remote Access	Meridian offers providers two methods of electronic data sharing which can reduce or eliminate the administrative burden incurred by faxing medical record documentation, as well as maximize HEDIS® incentives. Meridian's Quality Improvement and IT departments partner with providers to establish a secure connection for both methods.

PROVIDER INCENTIVE PROGRAM - HEDIS® BONUS PROGRAM OVERVIEW

Comprehensive Child and Adolescent Care				
Service	**Procedure**	**Plan†/ Incentive**	**Performance Criteria**	**Member Incentives**
Childhood Immunizations - Combo 10 Before Age 2	4 Diphtheria, Tetanus and Acellular Pertussis (DTaP) 3 Polio (IPV/OPV) 1 Measles, Mumps and Rubella (MMR) 3 Haemophilus Influenza Type B (HiB) 3 Hepatitis B (HepB) 1 Chicken Pox (VZV) 4 Pneumococcal Conjugate (PCV) 1 Hepatitis A (HepA) 2 or 3 Rotavirus (RV) 2 Influenza (Flu)	Medicaid: $100	Incentive paid upon completion of all qualifying immunizations under Combo 10 within the HEDIS® guidelines. - One of the Hep B vaccinations can be the newborn vaccination given within the seven days after birth - DTaP, IPV, HiB, PCV, and Rotavirus must be given at least 42 days after birth - Influenza must be given at least 180 days after birth - MMR, Hep A and VZV must be given on or between the child's first and second birthdays - Number of Rotavirus vaccines required depends on which vaccine is administered One incentive paid per member, paid quarterly for services completed in the preceding quarter.	X
Adolescent Immunizations – Before Age 13	2 or 3 dose series: Human Papillomavirus (HPV) 1 Tdap 1 Meningococcal	Medicaid: $25	Incentive paid upon completion of all qualifying immunizations under Combo 2 within the HEDIS® guidelines. - HPV vaccine must be administered on or between the child's 9th and 13th birthdays - If only two doses of the HPV vaccine are given, they must be at least 146 days apart, otherwise three doses are required - Tdap vaccine must be administered on or between the child's 10th and 13th birthdays - Meningococcal vaccine must be administered on or between the child's 11th and 13th birthdays One incentive paid per member, paid quarterly for services completed in the preceding quarter.	X
Well-Child Visits Ages 0-15 Months*	6 visits	Medicaid: $15	Complete six visits per age-specific EPSDT Visit Schedule per member prior to 15 months of age. One incentive paid per calendar year, paid annually in the final incentive payment.	X
Well-Child Visit – Ages 3-6		Medicaid: $15	According to age-specific EPSDT Visit Schedule. One incentive paid per calendar year, paid quarterly for services completed in preceding quarter.	X
Adolescent Well Visit – Ages 12-21		Medicaid: $15	According to age-specific EPSDT Visit Schedule. One incentive paid per calendar year, paid annually in the final incentive payment.	
Blood Lead Testing – Ages 0-2		Medicaid: $20	Complete one blood lead test by 2nd birthday. One incentive paid per calendar year, paid quarterly for services completed in preceding quarter.	

PROVIDER INCENTIVE PROGRAM - HEDIS® BONUS PROGRAM OVERVIEW

Comprehensive Women's Care				
Service	**Procedure**	**Plan†/ Incentive**	**Performance Criteria**	**Member Incentives**
Breast Cancer Screening - Females ages 50-74	Mammogram	Medicaid: $20	One screen completed annually. One incentive paid per calendar year, paid quarterly for services completed in preceding quarter.	X
Cervical Cancer Screening - Females ages 21-64	Cervical Cytology	Medicaid: $15	One incentive paid per calendar year, paid annually in the final incentive payment.	X
Chlamydia Screening - Females ages 16-24	Chlamydia Screening	Medicaid: $20	One incentive paid per calendar year, paid annually in the final incentive payment.	

Comprehensive Diabetes				
Service	**Procedure**	**Plan†/ Incentive**	**Performance Criteria**	**Member Incentives**
Comprehensive Diabetes Care - 18-75 year olds with diabetes (Types 1 & 2)	HbA1c Screen	Medicaid: $25	Incentive paid upon completion of all five sub-measures. One incentive paid per calendar year, paid annually in the final incentive payment.	X
	HbA1c Good Control (<8%)			
	Fundoscopic Eye Exam			
	Microalbuminuria Screen			
	Blood Pressure Control (<140/90)			

Provider Centric			
Service	**Plan†/ Incentive**	**Performance Criteria**	**Member Incentives**
Appropriate Testing for Children with Pharyngitis	Medicaid: $15	A group A streptococcus test in the seven day period, from the three days prior to date of diagnosis through three days after the date of diagnosis. Incentive paid annually in the final incentive payment for services completed during the measurement year.	

Obstetrical Care			
Service	**Plan†/ Incentive**	**Performance Criteria**	**Member Incentives**
Prenatal Care – Timeliness (Paid to Servicing Provider)	Medicaid: $30	First prenatal visit must be performed in the first trimester (<13 weeks), or within 42 days of enrollment with Meridian. Incentive paid to servicing provider. Incentive paid annually in the final incentive payment for services completed during the measurement year.	
Postpartum Care (Paid to Servicing Provider)	Medicaid: $30	Postpartum Care visit must be on or between 21 days and 56 days after delivery. Incentive paid to servicing provider. Incentive paid annually in the final incentive payment for services completed during the measurement year.	

PROVIDER INCENTIVE PROGRAM - HEDIS® BONUS PROGRAM OVERVIEW

Medication Management			
Service	**Plan†/ Incentive**	**Performance Criteria**	**Member Incentives**
Medication Management for People with Asthma	Medicaid: $15	One incentive paid per calendar year, paid annually in the final incentive payment.	
Statin Therapy for Patients with Diabetes– 80% Adherence	Medicaid: $20	One incentive paid per calendar year, paid annually in the final incentive payment.	
Statin Therapy for Patients with Cardiovascular Disease – 80% Adherence	Medicaid: $20	One incentive paid per calendar year, paid annually in the final incentive payment.	
Healthy Michigan Plan (HMP) Health Risk Assessment (HRA) Program			
Service	**Plan†/ Incentive**	**Performance Criteria**	**Member Incentives**
Initial Visit with PCP and Completed HRA - All genders ages 19 – 64	Healthy Michigan Plan: $25	Incentive paid once per member for initial visits performed within the first 150 days of enrollment with Meridian and billed with the appropriate HRA CPT codes 96160. Completed and attested HRAs must be received by Meridian within 30 days of initial visit. One incentive paid per calendar year, paid quarterly for services completed in preceding quarter.	X*
Blank HRAs can be downloaded from www.mhplan.com/hmp. Completed HRAs may be faxed to Meridian at 313-324-9120.			

Results may be faxed to **313-202-0006**. All procedures must be completed within strict HEDIS® and MDCH Guidelines. For a complete list of covered CPT codes for these measures or to view the Drug Formulary for a list of covered drugs, visit **www.mhplan.com**. For more information, contact your local Provider Network Management Representative or the Provider Services department at **888-773-2647**.

†Plan Definitions:

Medicaid	Meridian Medicaid members
Healthy Michigan Plan	Meridian Medicaid expansion members

Meridian maintains the right to modify or discontinue the incentive program at any time. Meridian will notify providers of any changes or incentive program alterations.

X: There are member incentives associated with this particular HEDIS® measure. Members will only receive an incentive mailing if they are within the population due for the measure. Members qualify for incentives once the provider bills with appropriate codes. These incentives are drawings and are not guaranteed. Meridian will contact winners of the associated drawings. Drawings are subject to change at any time.

X*: Healthy Michigan members are eligible to qualify for a 50% premium reduction dependent on their income/federal Poverty level. Qualification is as follows: The member must attest to a healthy behavior (at the bottom of the HRA) and the provider bills appropriately. Members can complete one HRA every 11 months to qualify.

CPT II AND HCPCS CODES

Please use the following documents to alert your billers and billing companies.

Attention Billers:
WellCare Health Plans pay $0.01 for CPTII and HCPCS codes associated with Quality Measures. The following codes must be billed on all claims and encounters when applicable:

Category of Codes	CPTII Codes	HCPCS Codes
HbA1c Results	• 3044F Most recent hemoglobin A1c (HbA1c) <7% • 3045F Most recent hemoglobin A1c (HbA1c) 7% – 9% • 3046F Most recent hemoglobin A1c (HbA1c) >9%	
Eye Exams	• 2022F Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed • 2024F Seven (7) standard filed stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed • 2026F Eye Imaging validated to match diagnosis from 7 standard field stereoscopic photos results documented and reviewed • 3072F Low risk for retinopathy (no evidence of retinopathy in the prior year)	• S0621 Diabetic Retinal Screening • S0620 Diabetic Retinal Screening • S3000 Diabetic Retinal Screening
Nephropathy	• 3061F Negative microalbuminuria test result documented and reviewed • 3062F Positive macroalbuminuria test result documented and reviewed • 3066F Documentation of treatment for nephropathy (e.g.,patient receiving dialysis, patient being treated for ESRD, CRF, ARF or renal insufficiency, any visit to a nephrologist) • 4010F Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) therapy prescribed or currently being taken • 3060F Positive microalbuminuria test result documented and reviewed	
Blood Pressure Control	• 3074F Most recent Systolic <130mm Hg • 3075F Most recent Systolic 130–139mm Hg • 3077F Most recent Systolic ≥140mm Hg • 3078F Most recent Diastolic <80mm Hg • 3079F Most recent Diastolic 80–89mm Hg • 3080F Most recent Diastolic ≥90mm Hg	
Medication Review (2 codes: Review and List)	Medication Review • 1160F Bill with 1159F Review of all medications by a prescribing practitioner or clinical pharmacist documented in the medical record Medication List • 1159F Bill with 1160F Medication list in the medical record	• G8427 Medication List
Medication Reconciliation	• 1111F Discharge medications reconciled with the current medication list in the outpatient record.	
Functional Status Assessment	• 1170F Functional status assessed	
Pain Assessment	• 1125F pain present • 1126F no pain present	

BILLING INFORMATION

Meridian follows Michigan Medicaid and CMS billing guidelines unless otherwise noted. Per the Michigan Department of Health and Human Services (MDHHS) Provider Manual, Section 11 – Billing Beneficiaries: *When a provider accepts a patient as a Medicaid beneficiary, the beneficiary cannot be billed for the difference between the provider's charge and the Medicaid payment for service. Members will not be balanced billed by a provider for the cost of any covered service, which includes any coinsurance, deductibles, financial penalties, or any other amount in full or in part.*

Submitting Claims to Meridian

By Mail

Meridian
1 Campus Martius, Suite 700
Detroit, MI 48226

Electronic Claim Submission (EDI) Vendors

Availity Customer Support: 800-Availity Claim Types: Professional/Facility Payer ID: 52563	**PayerPath** Customer Support: 877-623-5706 Claim Types: Professional Payer ID: 52563
Blue Cross Blue Shield of MI Customer Support: 800-542-0945 Claim Types: Professional Payer ID: 98999 Office Number: 2936	**Per-Se** Customer Support: 877-737-3773 Claim Types: Professional/Facility Payer ID: 52563
Emdeon (WebMD) Customer Support: 800-845-6592 Claim Types: Professional/Facility Payer ID: 83253	**Relay Health** Customer Support: 800-527-8133 Claim Types: Professional/Facility Payer ID: 52563
NDC Customer Support: 800-942-3022 Claim Types: Facility Payer ID: 52563	**SSI Group** Customer Support: 800-880-3032 Claim Types: Professional/Facility Payer ID: 52563
	ZirMed Customer Support: 877-494-7633 Claim Types: Professional/Facility Payer ID: Z1054

CLAIMS PAYMENT & STATUS

Provider can status claims in several ways.

Meridian Provider Portal	Phone	Fax	Mail
hpprovider.atlascomplete.com	800-203-8206	313-324-3642	Meridian Claims Department 1 Campus Martius, Suite 700 Detroit, MI 48226

CLAIMS APPEAL PROCESS

Meridian sees its providers as partners in care. In cases where a claim was denied, providers may submit a written appeal within 120 days of the last claim denial provided the initial claim was submitted within one year of the date of service. There is only one level of appeal. Please include the following information in your appeal:

1. **Member name & ID #**
2. **Reason for appeal**
3. **Any supporting clinical information**
4. **Date of service or claim number (found on last claim denial or date of service)**

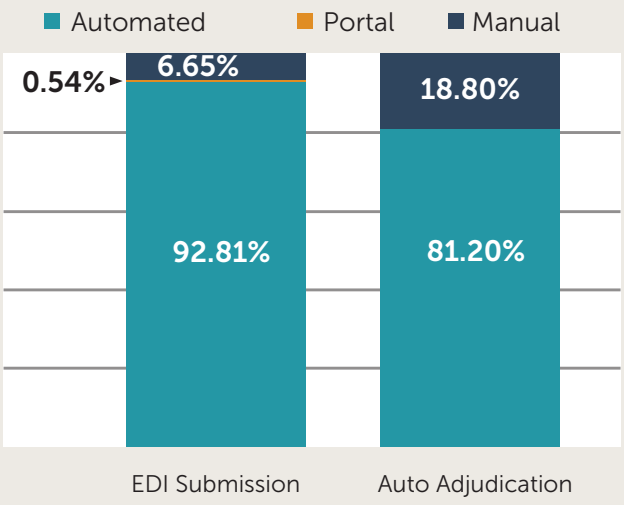
Provider claims appeals are reviewed by the Meridian Appeals Committee and resolved within 30 days.

CLAIMS EFFICIENCY

Meridian monitors electronic claims submission and auto-adjudication data to continually improve efficiency in claims payment. **Meridian consistently meets the State of Michigan performance requirements for timely claims payment.**

Efficiency of Claims Processing

- Total Claims Process for all Lines of Business: **18,410,199**
- Total Claims Process for Michigan: **8,992,342**
- Claims Accuracy Level: **98.54%**



FRAUD, WASTE & ABUSE

Healthcare fraud, waste and abuse affects everyone. It is estimated to account for between 3% and 10% of the annual expenditures for health care in the United States. Healthcare fraud is both a state and federal offense. Based on the HIPAA regulations of 1996, a dishonest provider or member may be subject to fines, imprisonment of not more than 10 years or both (18USC, Ch. 63, Sec 1347).

Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.
Waste	Involves the taxpayers not receiving reasonable value for money in connection with any government-funded activities due to an inappropriate act or omission by players with control over or access to government resources (e.g. executive, judicial or legislative branch employees, grantees or other recipients). Waste goes beyond fraud and abuse and most waste does not involve a violation of law. Waste relates primarily to mismanagement, inappropriate actions and inadequate oversight.
Abuse	Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.

EXAMPLES OF FRAUD, WASTE & ABUSE

F **Fraud:**

- Billing for services not provided
- Making false statements to receive medical or pharmacy services
- Altering prescriptions written by a provider
- Misusing Medicaid card to receive medical or pharmacy services
- Performing inappropriate or unnecessary services
- Billing for the same service more than once (double billing)

W&A **Waste & Abuse**

- Going to the emergency department for non-emergency medical services
- Misusing Medicaid card to receive medical or pharmacy services

FRAUD, WASTE & ABUSE

Meridian encourages members, providers and employees to report all cases of fraud, waste and abuse. If you know of any Medicaid members or providers, including doctors, hospitals and pharmacies, who have committed actions of fraud, waste or abuse, you can report them using the process described below. You may report them anonymously if you choose.

Meridian members, providers or employees can also report potential instances of fraud, waste and abuse anonymously to the following places:

State of Michigan Police	Meridian
Office of Inspector General PO Box 30479 Lansing, MI 48909 Phone: 855-MI-FRAUD	1 Campus Martius, Suite 700 Detroit, MI 48226 Phone: 844-667-3560 Fax: 313-202-0009

FALSE CLAIMS ACT

The False Claims Act aims to establish a law enforcement partnership between federal law enforcement officials and private citizens who learn of fraud against the government. Under the False Claims Act, those who knowingly submit, or cause another person or entity to submit, false claims for payment of government funds are liable for up to three times the government's damages plus civil monetary penalties. The False Claims Act explicitly excludes tax fraud.

The False Claims Act permits a person with knowledge of fraud against the United States government to file a lawsuit on behalf of the government against the person or business that committed the fraud. The lawsuit is known as a "qui tam" case, but it is more commonly referred to as a "whistleblower" case. If the lawsuit is successful, the qui tam plaintiff is rewarded with a percentage of the recovery, typically between 15% and 25%. Any person who files a qui tam lawsuit in good faith is protected by law from any threats, harassment, abuse, intimidation or coercion by his or her employer. For more information on the False Claims Act, please contact the Meridian Corporate Compliance Officer at **877-218-7949.**

PROVIDER & STAFF TRAINING

In order to accommodate the needs of diverse populations, it is important for providers and their staff to annually participate in ongoing training and education efforts that encompass a range of activities from self-study education materials to interactive group learning sessions. The Meridian Provider Services department supports these efforts by collaborating with providers and their staff to offer up-to-date training resources and programs.

Available Trainings		
✓ Provider Orientation ✓ **HIPAA Privacy and Security** ✓ **Fraud, Waste and Abuse** ✓ Recipient Rights and Reporting ✓ **Abuse and Neglect and Critical Incidents** ✓ Person-Centered Planning ✓ American with Disabilities Act (ADA ✓ **Model of Care**	✓ Independent Living and Recovery ✓ Wellness Principles ✓ Delivering Services to LTSS and HCBS Populations ✓ Self-Determination ✓ Disability Literacy Training ✓ **Cultural Competency** ✓ Care Coordination	✓ Interdisciplinary Care Team (ICT) Training, including: • Roles & Responsibilities of the ITC • Communication Between Providers and the ICT • Care Plan Development • Consumer Direction • Any HIT Necessary to Support Care Coordination

Please note that trainings in bold are mandatory for providers.

If you would like to request a training session, please call your Provider Network Management Representative or the Provider Services department at 888-773-2647.

CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEM (CAHPS®) SURVEY

CAHPS® is a standardized member satisfaction survey. The CAHPS® survey not only asks patients how they rate their health plan, but also their providers. Topics covered in the CAHPS® survey includes how people rate their:

1. **Personal Doctor**
2. **Specialist**
3. **Health Care**
4. **Health Plan**

Reasons for Patient Dissatisfaction & Tips for Improvement		
First Impressions	**Provider Clinical Skills**	**Provider Interpersonal Skills**
• Hire staff that are attentive, professional and friendly • Ensure you have enough staff to properly manage phone calls and in-office patients • Work to reduce wait times, and communicate wait times to patients regularly • Keep an organized, clutter-free front desk to offer a professional appearance	• Ask patients about their specific problems • Organize the visit process efficiently • Establish an internal quality improvement mechanism • Evaluate your interpersonal skills. Patients may confuse interpersonal skills with clinical skills	• Make patients feel welcome in your practice • Provide clear directions and thorough explanations in a language patients are sure to understand • Encourage patient questions and participation in developing treatment plans • Devote enough time to meet patient needs • Make frequent eye contact with patients and avoid prolonged focus on an EMR • Ensure that all patient concerns have been addressed

Meridian is proud to partner with provider offices to maximize patient satisfaction. Your time and dedication to improving the care of Meridian members is appreciated. Together, we can meet and exceed the benchmarks in this quality endeavor.

WEBSITES

Meridian Websites		MeridianRx Website	
www.mhplan.com (Medicaid)		www.meridianrx.com	
• Provider Manual • Bulletins • Forms • Live online chat services • Provider Directory	• Formulary • Useful links and information • Login to the Provider Portal • Healthy handouts for patients	• Formulary access • Review prior authorization requirements • See options for generic alternatives • View dosage requirements • Submit/check status of a prior authorization	• View pharmacy pricing • Submit a medical appeal • Login to the MeridianRx Provider Portal • Download the MeridianRx Mobile App

PROVIDER PORTAL

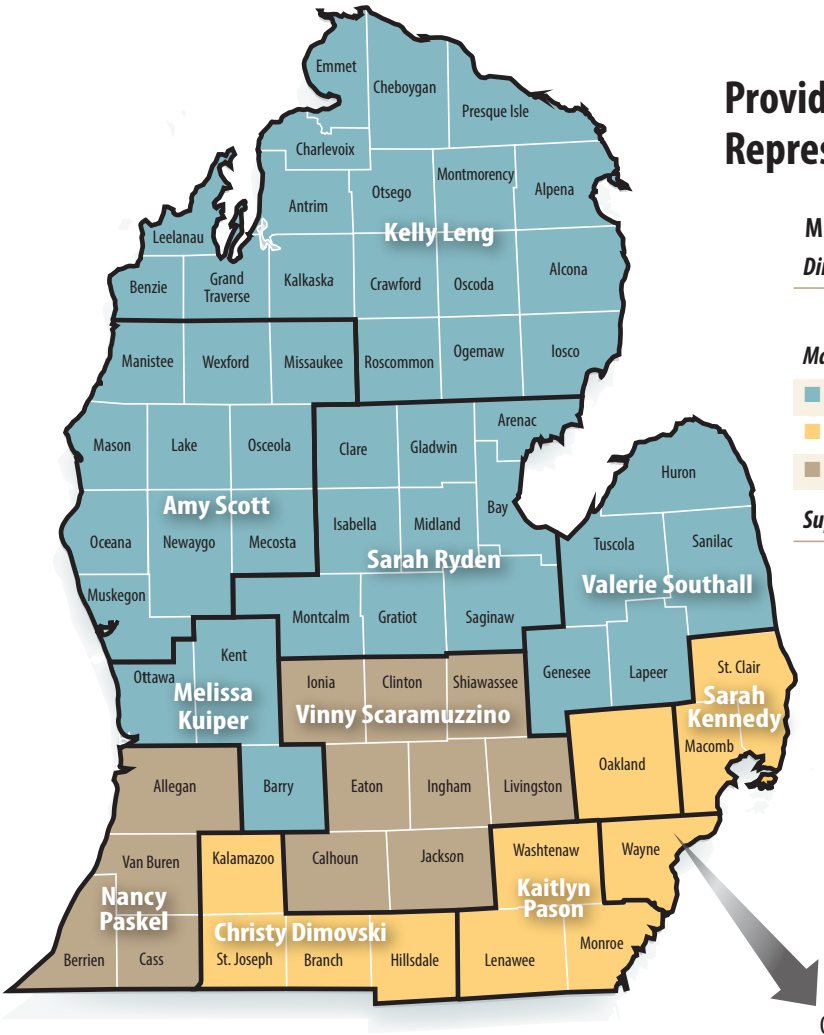
The free, secure online Provider Portal makes caring for Meridian members simpler. Visit **www.mhplan.com/mi/mcs** to sign up and learn more. The Provider Portal features:

Eligibility verification for any Meridian member	Member information & reports	HEDIS® self-reporting*
Authorization submissions	Enrollment lists	Mail HEDIS® postcards to members
Claim status and submission/corrections	HEDIS® bonus information	Plus much more

**Medical record documentation must be faxed to 313-202-0006*

CONTACT MERIDIAN

Provider Network Management Representative Coverage Map



MICHIGAN

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Manager of Network Management

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Lisa Aglamishian	**313-802-0387**	lisa.aglamishian@mhplan.com

Supervisor of Network Management - OAS

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Provider Network Management Representatives

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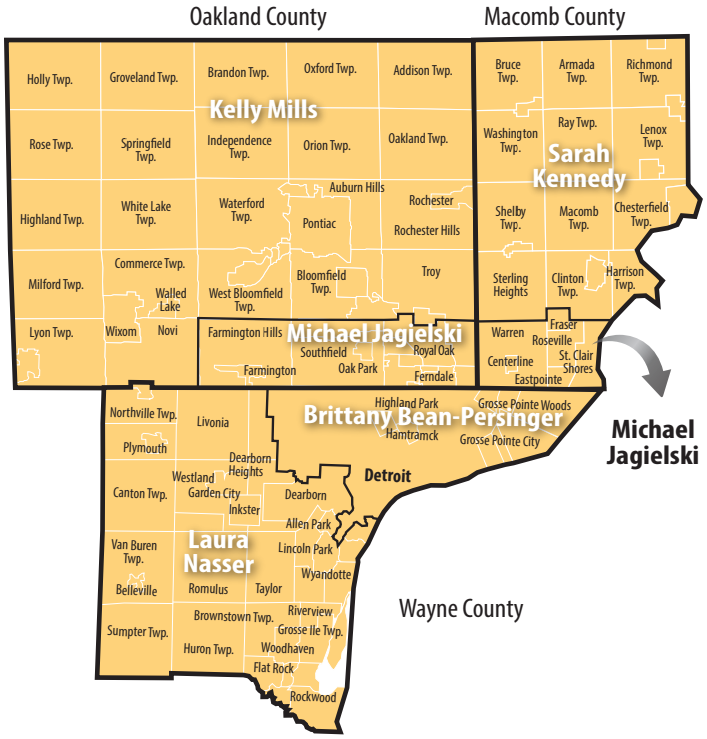
OHIO - LUCAS COUNTY

Kaitlyn Pason	**313-720-1065**	kaitlyn.pason@mhplan.com



CONTACT MERIDIAN

meridianhealth

CARE MANAGEMENT

• Process referrals • Collect supporting clinical information for select services • Conduct discharge planning activities	• Perform corporate preservice review of select services • Conduct inpatient review • Care coordination
Surgeries, Home Care, Hospice & Office Visits	
Phone: 888-322-8844	**Fax:** 313-324-1808 or 313-202-3956
Admissions (emergent, skilled nursing facility, inpatient rehab, transplants & long-term acute care hospitals)	
Phone: 888-322-8844	**Fax:** 313-324-1835
Therapies, DME & Pain Management	
Phone: 888-322-8844	**Fax:** 313-324-1808 or 313-202-3956

MEMBER SERVICES

• Verify member eligibility • Obtain member schedule of benefits • Obtain general information and assistance • Determine claims status • Encounter inquiry	• Record member personal data change • Obtain member benefit interpretation • File complaints and grievances • Verify/record newborn coverage • Coordination of benefits questions
Phone: 888-437-0606	**Fax:** 313-202-0007

PROVIDER SERVICES

• Fee schedule assistance • Contractual issues • Primary care administrations	• Discuss recurring problems and concerns • Provider education assistance • Initiate provider affiliation, disaffiliation & transfer
Phone: 888-437-0606	**Fax:** 313-202-0007

QUALITY IMPROVEMENT

• Requests and questions about clinical practice guidelines • Requests and questions about preventive healthcare guidelines • Questions regarding HEDIS® medical record requests received • Questions about quality initiatives	• Questions about quality improvement regulatory requirements • Questions about Disease Management programs • Questions regarding HEDIS® criteria • Fax all medical record documentation to Quality Improvement
Phone: 888-437-0606	**Fax:** 313-202-0006

OTHER IMPORTANT PHONE & FAX NUMBERS

Phone		Fax	
Pharmacy Benefit Manager (MeridianRx)	866-984-6462	Administration Fax	313-202-0009
Non-Emergent Transportation	800-821-9369	Main Fax	313-202-0006
Behavioral Health	888-222-8041	Behavioral Health Fax	313-309-8588
Claims	800-203-8206	Women & Children's Fax	313-463-5262

MEDICAID KEY FEATURES

Time Claims Processing	• Meridian pays clean claims within 30 days • Electronically billed claims are paid even faster
Simplified Administration & Authorization Process	• Secure, online Provider Portal allows providers to view member eligibility, enter authorizations, verify claims status, request direct assistance from Care Coordination, Behavioral Health and Member Services, and review member health history, including previous utilization from other health plans • Authorizations are not needed for in-network providers for diagnostic lab or X-ray (including MRI, CT Scan, etc.)
Incentive Programs	• Our HEDIS® program is a pay-for-performance incentive that rewards providers for delivering quality preventive healthcare services. Incentives range from $15-$100 for services such as immunizations, well-child visits, prenatal and postpartum care, management of chronic conditions, and more. Payments are made in four installments, unless noted otherwise
Hassle-Free Policies & Procedures	• Meridian will reimburse PCPs for well and sick visits provided during the same visit • Comprehensive drug formulary and licensed pharmacist available at MeridianRx for consultation
Provider Manual	• Provides detailed information about Meridian policies and procedures and rights and responsibilities for members and providers • View a copy from the website www.mhplan.com/mi/providers
Charitable Activities	• Engages with local communities throughout the state • Donates time and dollars to numerous organizations and events • Demonstrates commitment to improving quality of care in low resource environments
Personalized Service	• Assigned local Provider Network Management Representative (PNMR) to handle all questions and concerns
Quality-Focused	• Commendable Health Plan Accreditation rating from the National Committee for Quality Assurance (NCQA) • NCQA HEDIS® Compliance Audit Certification

COMMITTED TO QUALITY

Meridian sets high standards for itself and providers when it comes to providing quality care. Quality improvement is a corporate priority, with the goal of becoming the top Medicaid health plan in the state based on Healthcare Effectiveness Data and Information Set (HEDIS®) performance. Meridian monitors HEDIS® performance throughout the year and conducts improvement activities to meet its goals, including education and outreach to members and providers.

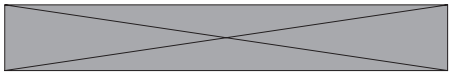
Our achievement and commitment to quality earned Meridian a spot in the top five Medicaid plans in the state for 17 HEDIS® measures according to the 2019 Quality Compass Reports. Our outstanding and consistent performance in providing quality care supported the NCQA awarding Meridian Commendable Health Plan Accreditation. NCQA is the most widely recognized accreditation program in the country and has improved the managed care experience for health plans, patients, providers and employers. For more information on NCQA standards, visit www.ncqa.org.

PERSON-CENTERED CARE APPROACH

Meridian is focused on ensuring the delivery of high-quality healthcare services to our members while simultaneously achieving meaningful cost savings to states and taxpayers. We achieve this goal through collaboration with providers and relentless emphasis on preventive care and population management. Our focus on preventive health outreach includes:

Member Outreach & Education by Local Employees	Every new enrollee receives a welcome call within the first 30 days of enrollment. We do this to explain Meridian's benefits and verify PCP selection. Members also receive regular telephone calls and mailings reminding them to schedule preventive services.
Health Risk Assessment (HRA)	Meridian's local outreach specialists complete a HRA for every member within 90 days of enrollment. This allows Meridian to assign each member to an appropriate level of personalized care coordination and to begin focusing on improving the health of our sickest members so they can progress to a less intensive management level. Healthy Michigan Plan members are mailed a paper HRA upon enrollment to bring to their first PCP visit. The member fills out Section 1 – 3. PCPs fill out Section 4 with the member, then sign as an attestation of the agreed upon healthy behavior and the appointment.
Disease Management (DM)	Meridian's DM program is designed to educate and support members in the optimal management of their conditions before they worsen. Meridian's Quality Improvement department maintains regular communication with DM program members and their healthcare provider, which ensures members receive appropriate care while containing costs.
Complex Case Management (CCM)	The goal of Meridian's CCM program is to avoid unnecessary hospitalizations of members who have multiple medical issues. Members needing CCM are immediately assigned to a local nurse case manager who works with the enrollee to identify achievable goals to optimize health, improve self-management and support provider plans of care. The CCM program emphasizes the use of appropriate outpatient services to maintain member health and decrease costly inpatient admissions.
CSHCS	Beneficiaries with both Medicaid and Children's Special Health Care Services (CSHCS) are enrolled with Meridian. To assist our contracted PCPs with the added coordination of care for these beneficiaries, Meridian pays a per-member per-month (PMPM) administrative payment for the CSHCS population. For beneficiaries that are part of the CSHCSABAD program, Meridian pays an $8 PMPM, and for beneficiaries that are part of the CSHCS-TANF program, Meridian pays a $4 PMPM.

WELL-CHILD VISITS: AVOID MISSED OPPORTUNITIES



With a focus on preventive care, Meridian encourages providers to make the most of the most common type of visit performed – well-child visits. Meridian pays for one well-child visit per calendar year. The visits do not need to be 12 months apart or coincide with a birthday. Complete all preventive services, including immunizations and lead testing if needed, to maximize bonus potential.

Well-Child Visit Components

1. **Physical Exam**
2. **Health Education/Anticipatory Guidance**
3. **Health & Developmental History (physical & mental)**

Avoid missed opportunities for HEDIS® incentives by thoroughly documenting and utilizing appropriate billing codes for services performed. Provider Network Management Representatives and the Quality Improvement department can provide information on the necessary documentation and codes.

Turn a Sick Visit into a Well-Child Visit	Turn a Sports Physical into a Well-Child Visit	Make Every New Patient Visit a Well-Child Visit
Get reimbursed for a well-child and sick visit performed the same day.	Schools and communities often require a physical for participating.	New patients usually require health and developmental history and a physical exam. Add health education for a well-child visit.
Add a modifier 25 to the sick visit and bill for the appropriate well visit.	Add developmental history and anticipatory guidance to a sports physical medical history and physical exam to turn it into a well-child visit	Include the appropriate ICD-10 diagnosis code to the claim, along with the appropriate CPT code for the new patient visit.

MEMBER OUTREACH

Meridian is committed to ensuring its members receive quality preventive healthcare services. To encourage members to receive preventive care and help providers maximize provider incentive bonus potential, Meridian dedicates significant resources to its member outreach programs.

PATIENT-CENTERED MEDICAL HOME (PCMH) INCENTIVE PROGRAM

Being a PCMH means committing to providing comprehensive, patient-first health care. To reward forward-thinking clinicians like you, MeridianHealth (Meridian) offers our PCMH Incentive Program to Primary Care Providers (PCPs) who are contracted with us.

Qualifications for the Meridian PCMH Program:

- Contracted – Fee for Service
- Open to and accepting new Meridian members
- Meridian membership of 100+
- NCQA, PGIP, URAC, AAAHC, TJC, or CARF recognition

Incentive Program Payment Structure			
PCMH Recognitions Accepted	**Per Member, Per Month (PMPM)**		**Care Coordination (CC)/ Case Management (CM)***
NCQA, PGIP, URAC, AAAHC, TJC, CARF	January-June: $0.75 paid monthly to the servicing PCP	July-December: $1.50 paid monthly to the servicing PCP	$20 per code; paid quarterly to the Meridian contracted PHO

The state-preferred PCMH model was developed to maintain and grow PCMHs throughout the managed care space while creating consistent requirements for the program.

Qualifications for the Meridian State-Preferred PCMH Incentive Program:

State-preferred PCMH providers completed an application expressing interest in the state-preferred PCMH model, facilitated by Michigan Department of Health and Human Services (MDHHS) in the spring of 2019. The state-wide PCMH program began with the State Innovation Model (SIM) PCMH model as its foundation and MDHHS-established criteria for PCMH providers. State-preferred providers have shown their dedication to expanding and sustaining the PCMH model in Michigan. Meridian state-preferred providers received a letter in the mail identifying their eligibility for this program.

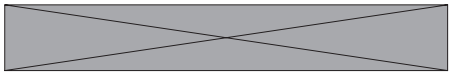
Incentive Program Payment Structure			
PCMH Recognitions Accepted	**Per Member, Per Month (PMPM)**		**Care Coordination (CC)/ Case Management (CM)***
State-Preferred	January-June: $1 paid monthly to the servicing PCP	July-December: $2 paid monthly to the servicing PCP	$20 per code; paid quarterly to the Meridian contracted PHO

Additional Notes for Both Programs:

- $10,000 annual PMPM limit per provider
- Providers can be incentivized for up to 60 CC/CM codes per NPI per year
- Incentives for this program include MeridianHealth and Healthy Michigan Plan members only. This program excludes MeridianComplete, MeridianChoice, and WellCare members
- These programs are subject to change at any time

We look forward to partnering with you to provide the best care for our members!

*Any member who is enrolled in the Michigan Care Team Program is excluded from the CC/CM incentive portion of the 2020 PCMH Program.



Care Coordination (CC)/Case Management (CM) Codes

PCMH-designated providers are encouraged to continue to utilize the CC/CM code sets when seeing patients to demonstrate and promote coordinated care. Meridian recommends alignment of the extra incentive dollars with embedded case managers in an effort to reduce barriers to quality health care. The eligible codes and descriptions are displayed in the table below.

Code Description	Code
Comprehensive Assessment	G9001
In-Person Encounter	G9002
Care Team Conference	G9007
Physician Coordinated Care Oversight Services	G9008
Telephone CC/CM Services	98966, 98967, 98968
Education/Training for Patient Self-Management	98961, 98962
Care Transition	99495, 99496
End of Life Counseling	S0257

Seeking PCMH Designation? We Can Help!

Meridian also encourages non-PCMH providers to take the next step toward becoming PCMH-designated. If you are interested in becoming a PCMH through the National Committee for Quality Assurance (NCQA), Meridian has a partnership with NCQA **that provides a 20 percent discount on initial recognition application fees** to all of our PCPs. Please contact your local Provider Network Management Representative for more information!

HLMS HEALTHY LIVING MEDICAL SUPPLY

2111 Woodward Ave., Suite 1100, Detroit, MI 48201
Phone: 866.779.8512 | Fax: 866.779.8511 | myhlms.com

For online prescriptions: myhlms.com/providers

Diabetic Testing Supply Prescription

Referred by:	Medications from Pharmacy: YES ☐ NO ☐	
Name:	Birthdate:	Sex: Male ☐ Female ☐
Address:	City:	State: MI Zip:
Email:	Cell:	Other Phone:

Insurance:

Meridian ID:	HMO Plan:
Medicaid ID:	Policy ID:

Duration of Need:

☐ 12 months ☐ Other: _____ (Default is 12 months if nothing is marked.)

Diagnosis Code:

Type 1 = ☐ E10.9 (no complication) ☐ E10._____ (list additional numbers to specify complications)

Type 2 = ☐ E11.9 (no complication) ☐ E11._____ (list additional numbers to specify complications)

Other: _____ Gestational = _____ Due Date: _____

Is patient treated with **insulin**? YES ☐ NO ☐ If yes, are they using an insulin pump? YES ☐ NO ☐

Diabetes Testing Supplies: Glucose Monitor: HAS / NEEDS * **(circle one)**☒

☐ Test Strips ☐ Lancets ☐ Alcohol Pads ☐ Syringes: _____vol_____G_____mm QTY____

☐ Control Solution ☐ Other: _____ ☐ Pen Needles _____G _____mm QTY_____

Recommended Testing Frequency:

☐	1 time/day	= up to 50 test strips/100 lancets/mo	☐	4 times/day	= up to 150 test strips/200 lancets/mo
☐	2 times/day	= up to 100 test strips/100 lancets/mo	☐	5 times/day	= up to 175 test strips/200 lancets/mo
☐	3 times/day	= up to 105 test strips/100 lancets/mo	☐	6 times/day	= up to 200 test strips/200 lancets/mo
			☐	Other: _____ times/day	Qty: _____

Please note reason for testing more than 6 times per day:_____

Provider Information:

Provider Name:		
Provider Signature:		Date:
Address:	DEA:	NPI:
City:	Email:	
State: Zip:	Phone:	Fax:

NOTES

NOTES

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Provider Orientation
March 2020

PSOV01 MI