ACCOUNTABLE
HEALTH CARE IPA

To: Contracted Providers

From: Provider Network Operations

Date: November 27, 2017

Re: Authorization Requests for AHCIPA

AUTHORIZATION SUBMISSIONS

Effective December 1, 2017, all referrals/authorization requests for patients assigned to Accountable Health Care IPA (AHCIPA) will be processed by Network Medical Management (NMM). We are in the process of setting up web portal accounts for all contracted providers in the AHCIPA network. We encourage for your office to participate in the series of WebEx Orientation meetings we have scheduled through the end of this month.

Starting November 27th, we will start contacting your office(s) via telephone or fax, to provide you with the web portal log in and password information. To access the NMM Web Portal, please visit **www.nmm.cc** or, enter the following address https://provider-portal-ahc.nmm.cc.

In the event your web portal account is not setup by December 1, 2017, enclosed is the authorization request form you can send to us via fax. Please make note of the new UM fax numbers for AHCIPA:

- Routine Referral Fax (626) 943-6302
- Urgent Referral Fax (626) 943-6304
- Trace/Notes Fax (626) 943-6303

We are working towards having all provider web portal accounts issued by December 4th at the very latest. We apologize for any inconvenience.

If you have any questions or concerns, please call us at (562) 435-3333. You can also email us at, ProviderNetworkOperations.Dept@nmm.cc.

We thank you for your continued support!

NETWORK MEDICAL MANAGEMENT, INC

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HEALTH CARE IPA

MEDICAL GROUP FAX NUMBER REQUESTS

UM Fax Numbers:
Routine: (626) 943-6302
Urgent: (626) 943-6304
Notes/Medical Records: (626) 943-6303

REFERRAL REQUESTE DATE:___________________

(Circle One):

ROUTINE **(5 days)** ***URGENT*** **(72 hours)**

RETRO **(30 days)**

DATE OF SERVICE:_______________

FORM WILL BE RETURNED IF MEMBER'S NAME, ID#, HEALTH PLAN or/and CLINICAL INFORMATION ARE NOT COMPLETE OR NOT LEGIBLE

PATIENT INFORMATION:

Patient Name: Last ________________________ **First** ______________________ **Middle** ________________ **DOB** ______/______/______ **AGE** _____ **Sex**: (M) (F)

Address:____ **City:** ________________________ **Zip** ____________**Phone #** (   ) ________ - __________

Health Plan ________________________________ **Member ID #**____________________________________ **Member Effective Date** _______/_______/_______

PCP ________________________________ **Phone #** (   ) ___________ - __________________ **Fax** (   ) _____________ - ____________________

Referring Provider Name :____

M.D. Office Contact Name:____

Phone: (______)________-____________ **Fax:** (______)_______-___________

Referred to Specialty:____

Provider Name:____

Phone: (______)________-____________ **Fax:** (______)_______-___________

Services to be provided at: Office = 11, Inpatient Stay = 21, Outpatient Hospital = 22 **REQUESTED FACILITY:**____

DIRECT REFERRALS ONLY: **(CHECK ONE) ANY FOLLOW VISITS OR PROCEDURES MUST BE PRE –AUTHORIZED BY NMM**

☐ Well Woman Exam - **99385 (age 18-39)** ☐ **99386 (age 40-69)** ☐ **99396 (age 71 and over)** ☐ Pregnant OB Care (full term) - **59400**
☐ Mammography – **77057 (40 – 50 years eligible every 2 years)** ☐ Chest, Long Bone or KUB X- Rays **(indicate CPT)**

☐ **PATIENT REQUEST** ☐ **M.D. REQUEST**

Diagnosis: ____ **ICD-10 code(s)**______________________________

Requested Services/Treatments

Procedure description:____ **CPT CODE** ________________________________

Procedure description:____ **CPT CODE** ________________________________

Clinical Problem & Duration:____

____

Pertinent Clinical History / Lab / X-Ray:____

____

Treatment tried/failed:____

Why is this referral or test (s) necessary? ____

PHYSICIAN SIGNATURE:____ **DATE:** ______________________________

FOR USE BY NETWORK MEDICAL MANAGEMENT ONLY

☐ **Authorized/Modified UM Signature:**_________________________ **Date:** ______/______/______ **AUTH #** ____________________________

☐ **Pended Date:** _____/_____/_____ **Pended Reason:**_____________________________ **Response Date:** ____/____/____ **Signature** _________________

☐ **Denied Reason:**____ **Date:** _____/_____/_____ **UM Signature:**___________________________

Date PCP Notified: _____/_____/_____ **Date Specialist Notified:** _____/______/______ **Member Notification:** ______/______/______ **by United States Mail**

Phoned PCP of Denial: ______/_____/______ **Time:** ______.______ **Phoned Specialist of Denial:** ______/ ______/_______ **Time:** _____._____

STATEMENT FOR PROVIDER: Further care must be authorized before it is rendered. If additional treatment is required contact the referring physician. Additionally, consultant's findings and recommendations **must** be sent to the referring physician. **ALL LABORATORY WORK MUST BE PERFORMED AT** LABCORP **Authorization does not guarantee payments: All claims are subject to Eligibility, Contracted provisions and Exclusions. This certificate is good for 60 days from approval day. All Lab work and Imaging studies should be done at a Network Medical Management contracted facility.**

UM decisions are based on standardized criteria. Provider may view criteria upon request. Call 626-282-0288 for more information.

Effective Date: 12/01/2017