PCCM

AN INTRODUCTION TO

PRIMARY CARE CASE MANAGEMENT

Texas Medicaid & Healthcare Partnership
A State Medicaid Contractor
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Goals of the Workshop

- Introduction to the PCCM
- Goals and benefits of PCCM
- Client eligibility
- Role of primary care providers, hospitals, and specialists
- PCCM authorization process
- Covered services and how to bill for them
- Resources

What is PCCM?

- Network of Medicaid primary care providers (PCPs) and hospitals
- Medical home through PCP
- Referrals to any Medicaid specialist
- Health and Human Services Commission (HHSC)-operated through TMHP
- Not an Health Maintenance Organization (HMO)
When and Where

- Established in 1993 by the Texas Legislature
  - Successfully operating in other service areas
- September 1, 2005
  - Expansion into 197 counties
  - PCCM only Medicaid health plan in expansion area
  - Providers can participate in HMOs and PCCM

Goals of the Texas PCCM Program

- Improve access to health care
- Increase quality and continuity of care
- Ensure appropriate utilization of services
- Improve cost effectiveness
- Improve provider and client satisfaction
PCCM Benefits

- Network of Medicaid PCPs and hospitals
- Preventative care
- Continuity of care
- Appropriate care
- Referrals to any Medicaid specialist
- PCCM case management fee for PCPs
  - $2.93 per client per month plus fee for services reimbursement
- Special health services for clients
  - PCCM Nurses Helpline 1-800-304-5468

Medicaid Team

- Providers
- Clients
- HHSC
- Department of State Health Services (DSHS)
- Department of Aging and Disability Services (DADS)
- Texas Medicaid & Healthcare Partnership (TMHP)

Texas PCCM

- HHSC
- Enrollment Broker
- TMHP
  - Claims Administrator
  - PCCM Administrator
- Institute for Child Health Policy (ICHP)
  - Contracted research organization
  - Request information from providers
PCCM Provider Services

- TMHP Contact Center: 1-800-925-9126
- Provider Relations representatives
- Provider education and training
  - Workshops
  - One-on-one visits
- PCP and specialist recruitment
- Ongoing provider support

PCCM Special Services for Clients

- PCCM Community Health Services
  - 1-888-276-0702
  - Fax: 1-512-302-0318
- Community Health Coordinators
  - Assist PCPs
  - Assess health needs of clients
  - Develop and implement plan of care with PCP
  - Individual and group client education
  - Medicaid benefit education and outreach
  - Connect clients to local resources

PCCM Special Services for Clients

Nurse helpline features:
- Nurse helpline toll free #: 1-800-304-5468
- 24/7 clinical consultation line
- Staffed by Registered Nurses (RN)
- Follow approved clinical practice guidelines
- Information on self-care and referral to PCP, urgent or emergent care
**PCCM Clients**

- Over 700,000 Clients in Expansion
- TANF and TANF-related (mandatory)
  - Pregnant women, low-income families and children
- Supplemental Security Income (SSI) beneficiaries 21 years of age and older (mandatory)
- SSI beneficiaries under the age of 21 (voluntary)
- PCP Selection
  - Clients will select a PCP
  - Clients may change PCP
  - Client questions

**PCCM Special Services for Clients**

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**How to Identify a PCCM Client**

- TMHP Website (www.tmhp.com)
  - Monthly panel report
  - Eligibility verification
- TDHconnect
- Medicaid ID Form 3087
- Medicaid ID Form 1027 (temporary)
- Automated Inquiry System (AIS): 1-800-925-9126
- TMHP Contact Center: 1-800-925-9126

**Who Can be a PCCM PCP?**

- Physicians
  - Family Practice
  - Pediatrics
  - Internal Medicine
  - Obstetrician/Gynecologists
  - General Practice
  - Specialists who would like to act as a PCP providing primary care
- Federally Qualified Health Centers (FQHC)
- Rural Health Clinics (RHC)
- Advanced Practice Nurses
- Certified Nurse Midwives
PCP and Hospital Enrollment

- PCP Individual
  - Data Collection Form
  - Addendum B
- PCP Group/FQHC/RHC
  - Data Collection Form
  - Addendum C
  - Appendix A
- Hospitals
  - Addendum A
  - Appendix A
  - Contact Jim Dettmann at 1-512-506 3605

PCCM Provider Responsibilities

- Provide a medical home
- Provide 24-hour/7-day a week health care
- Coordinate patient care
  - Render or refer to Texas Health Steps (THSteps)
  - Refer to specialists
- Obtain prior authorizations on certain procedures
- Admit to PCCM hospitals
- Verify eligibility

Continuous Coverage

- 24-hour PCP availability
- Notify clients of the normal office hours
- Notify clients of after hours access
  - Direct access
  - On-call arrangements
- Office visit standards
  - Urgent care in 24 hrs
  - Routine exam 14 days
  - Well exam in 4-8 wks
Continuous Coverage

After-Hour Guidelines

- Have at least one of the following arrangements:
  - Office phone answered by professional answering service
  - Office phone answered by answering machine
  - Office phone transferred to another location
- Direct client to a qualified medical professional
- Nurses helpline cannot be only reference
- Call TMHP Provider Relations for assistance

Language Services for Non-English Speakers

- PCCM Primary Care Provider and Hospital List
  - Lists languages spoken in offices
  - Available in both English and Spanish
- Client Handbook - English/Spanish
- Linguistic services - Client Helpline at 1-888-302-6688
- Provider responsibilities

Provider Participation in Continuous Quality Improvement Program

- Quality Management and Improvement Committee (QMIC)
- Focused studies
- Develop standards and guidelines
- Site surveys and medical record reviews
PCP Changes

- Client Initiated
  - Client calls 1-888-302-6688
- PCP Initiated
  - Provider notifies client and PCCM (1-888-834-7226)
  - Community health coordinators help with PCP changes

Referrals from PCPs

- PCP can refer to any Medicaid specialist
- PCP’s nine-digit Texas Provider Identifier (TPI) is referral
- Document referral in chart
- Refer by phone or optional form
- Specialist-to-specialist referrals
- Referrals do not require TMHP notification

Overview of Referrals

- Referrals to any enrolled Medicaid specialist
- Optional referral form
- Universal referral form
- Claims filing
  - Referring provider field

PCCM-Texas Health Network Referral Form
Services That Do Not Require a PCCM PCP Referral

- Texas Health Steps
- Family Planning (male and female)
- Children and Pregnant Women
- Emergency Services
- Early Childhood Intervention
- Obstetrics/Gynecology Services (OB/GYN)
- Vision Services (refractive only)
- School Health and Related Services
- Mental Health and Mental Retardation
- Behavioral Health (mental health & substance abuse)

Emergency Services

- No referral or authorization needed
- Nurse helpline: 1-800-304-5468
- Client education available for over-utilization

OB/GYN Direct Access

- No referral needed
- One well-woman exam per year
- Care related to pregnancy
- Care for all active gynecological conditions
**Newborn Billing**

- Medicaid ID Form 3087 may indicate “Newborn Call Plan”
  - Use “PCCNEWB01” as referring physician on claim
- Bill after newborn has a Medicaid client number

**Texas Health Steps**

- Be enrolled as THSteps Medical provider
- Document complete medical checkup
- Referral for dental checkup
- Referral for other appropriate services
- Coordinate care with PCP

**Outpatient Behavioral Health**

- PCCM does not change process
- Clients may self-refer
- PCP may refer or treat if within scope of practice
- PCP encouraged to contact behavioral health providers
  - Requires patient consent
  - PCCM Behavioral Health Consent Form
- Behavioral health providers responsible for prior authorization beyond 30 visits per year limitation
Outpatient Authorization

Outpatient Procedures Requiring Prior Authorization

- All laser surgeries
- Some endoscopic procedures
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- All podiatry procedures
- Sleep studies
- Some surgical procedures

Outpatient Procedures Not Requiring Prior Authorization

- Anesthesia services (type of service 7)
- Fractures/dislocations (closed or open treatment)
- Tonsillectomy for client’s under age 12
- Bronchoscopy
**PCCM Outpatient Prior Authorization (PA) Process**

- Complete PCCM Inpatient/Outpatient Authorization Form
- Requests submitted by fax at 1-512-302-5039 or telephone at 1-888-302-6167, option 2
- Faxed requests worked within 3 business days following the day of receipt
- Completed authorization required for claims to process
- Update authorization as needed prior to claim submission to avoid denial

**Outpatient PA Incomplete Requests**

- Letter sent to provider requesting specific information
- Provider contacted (three attempts if needed)
- Fourth business day a letter is sent to the client that the PA request cannot be processed without requested information from provider
- Seven calendar days after the client letter, provider and client notified of the denial if information is incomplete

**Inpatient Authorization**
Urgent/Emergent Admissions

- Requires notification, not prior authorization
- Notify prior to claim submission
  - 95 days from discharge to file claim
- Facility completes PCCM Authorization Form or calls Inpatient Prior Authorization Department
- Authorization number is issued
- Claim will deny without authorization number

Inpatient Behavioral Health Services

- PCCM does not change process
- Inpatient behavioral health care at acute care PCCM facility follows same guidelines as medical care
  - Urgent/Emergent notification prior to claim submission
  - Scheduled admissions require prior authorization
- Prior authorization required admissions of patients for under 21 years old to freestanding psychiatric facility
  - Facility faxes Psychiatric Hospital Inpatient Admission Form (D.45 of 2005 Texas Medicaid Provider Procedures Manual) to TMHP/Comprehensive Care Inpatient Psychiatry at 1-512-514-4211

Obstetrical and Newborn Admissions Routine

- Notification not required for routine newborn and obstetrical admissions
- No process change for routine obstetrical and newborn clients
- Routine length of stay
  - Less than or equal to 48 hours for vaginal deliveries
  - Less than 96 hours for Cesarean section deliveries
Obstetrical and Newborn Admissions
Non-Routine

- Notification of admission and clinical documentation required prior to claim submission
- All obstetrical and newborn admissions with non-routine clinical status
- Non-routine length of stay
  - Over 48 hours for vaginal deliveries
  - Over 96 hours for Cesarean section deliveries
- Authorization number required for claims processing

Scheduled Inpatient Admissions

- Prior authorization required
- Shared responsibility of admitting facility and physician
- Authorization number required for claims processing

Admission from Observation Services

- Observation to Inpatient status
- Notify Inpatient Prior Authorization Department prior to claim submission
- Observation payment included with inpatient authorization
- Authorization number required for claims processing
Obstetrical and Newborn Admissions

- Non-Routine
  - Notification of admission and clinical documentation required prior to claim submission
  - All obstetrical and newborn admissions with non-routine clinical status
  - Non-routine length of stay
    - Over 48 hours for vaginal deliveries
    - Over 96 hours for Cesarean section deliveries
  - Authorization number required for claims processing

Scheduled Inpatient Admissions

- Prior authorization required
- Shared responsibility of admitting facility and physician
- Authorization number required for claims processing

Admission from Observation Services

- Observation to Inpatient status
- Notify Inpatient Prior Authorization Department prior to claim submission
- Observation payment included with inpatient authorization
- Authorization number required for claims processing

**Updating an Authorization**

- Facility completes PCCM Authorization Form or calls Inpatient Prior Authorization Department
- Update prior to claim submission
- Clinical documentation required when updating
- Updated authorization number required for claims processing

**PCCM Inpatient Authorization Process**

- PCCM Inpatient/Outpatient Authorization Form required for all faxed requests
- Requests submitted by fax at 1-512-302-5039 or telephone at 1-888-302-6167, option 1
- Completed authorization required for claims to process
- Update authorization as needed prior to claim submission to avoid denial

**Billing Information**
Billing Information

- File claims to Claims Administrator (TMHP)
  - Electronic submission
    - Vendor software
    - TDHconnect 3.0
  - Paper submission
- Bill claims using your TPI number
- Combined remittance and status (R&S) reports received from TMHP

Suspended Claims

- Prevent suspended claims or denials due to:
  - No Diagnosis Related Grouping (DRG) information from facility
  - CPT 4 codes physician/facility mismatch

Appeals

Information required by the PCCM for technical denial:
- Copy of most recent R&S on which the denied claim appears
- An explanation letter including reason for appeal
- Copy of denial letter from the PCCM, if you received one
- Medical record(s) specific to episode of care
- HHSC has an appeals process available
**Appeals**

- Submit correspondence, adjustments, and appeals to the Claims Administrator:
  - TMHP
    - P.O. Box 200645
    - Austin, TX 78720-0645
- HHSC Appeals
  - Texas Health and Human Services Commission
  - HHSC Claims Administrator Contract Management
    - P.O. Box 204077
    - Austin, TX 78720-4077

**Resources**

- 2005 Texas Medicaid Provider Procedures Manual
- Periodic and special Medicaid bulletins
- R&S report
- Panel report
- TMHP website: www.tmhp.com
- TMHP Contact Center/AIS: 1-800-925-9126
- Electronic Data Interchange (EDI) Help Desk: 1-888-863-3638
- TMHP Provider Relations Representatives

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**Question and Answer**
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Acronyms

• AIS        Automated Inquiry System
• C-Section  Cesarean Section
• CMS        Centers for Medicare and Medicaid Services
• CSI        Claim Status Inquiry
• CSR        Customer Service Representative
• DADS       Department of Aging and Disability Services
• DEA        Drug Enforcement Agency
• DPS        Department of Public Safety
• DRG        Diagnosis Related Group
• EDI        Electronic Data Interchange
• EOB        Explanation of Benefits
• EOPS       Explanation of Pending Status
• EPSDT      Early and Periodic Screening, Diagnosis, and Treatment
• ER&S       Electronic Remittance and Status Report
• FQHC       Federally Qualified Health Center
• HHSC       Health and Human Services Commission
• HMO        Health Maintenance Organization
• ICN        Internal Control Number
• MCO        Managed Care Organization
• MRA        Magnetic Resonance Angiography
• MRI        Magnetic Resonance Imaging
• OCR        Optical Character Recognition
• PCCM       Primary Care Case Management
• PCP        Primary Care Provider
• R&S        Remittance and Status Report
• RHC        Rural Health Clinic
• SSI        Supplemental Security Income (Program)
• STAR       State of Texas Access Reform
• DSHS       Texas Department of State Health Services
• THSTEPS    Texas Health Steps
• TMHP       Texas Medicaid & Healthcare Partnership
• TPI        Texas Provider Identifier
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Inpatient Authorization
Scheduled/Elective Admissions

The prior authorization request is received by telephone or fax.

The Inpatient Prior Authorization Department reviews it for completeness.

If the information is not complete, the Inpatient Prior Authorization Department requests additional information from the provider.

The nurse reviews the request for medical necessity. If medical necessity is met, the nurse approves the request.

If the information is complete, the nurse processes the authorization request.

If further review is required, the nurse will forward it to the medical director.

Notification letters are sent to the performing provider and the facility.

The TMHP medical director approves, denies, or modifies the request.
Admission Requiring Notification

Required notification of urgent/emergent or non-routine newborn/obstetrical admission is received prior to claim submission.

- If the information is not complete, the Inpatient Prior Authorization Department requests additional information from the provider.
- Provider submits information
- If the information is complete, the Inpatient Prior Authorization Department processes the authorization request.

- If the client is admitted for non-routine newborn or obstetrical services, the Inpatient Prior Authorization Department reviews clinical information to determine medical necessity or appropriateness of the DRG.
- If the client is admitted for urgent/emergent services, the Inpatient Prior Authorization Department enters the authorization with the DRG requested by the facility.

- If the DRG is not appropriate based on the clinical assessment, the Inpatient Prior Authorization Department refers authorization to the TMHP medical director.
- The TMHP medical director approves, denies, or modifies the request.
- Notification of the DRG approval is sent to the facility.
Updating an Existing Authorization

The request for an update to an existing authorization with clinical information, when applicable, is received by fax, mail, or telephone.

The additional information provided supports the change requested.

The requested changes are reviewed.

The information provided does not support the change requested.

The authorization is not updated.

The authorization is updated to reflect the changes submitted.

Approval or denial letters are sent to the provider.
Outpatient PA Process

The authorization request is received via fax, telephone, or mail.

The request is reviewed for eligibility and medical necessity.

Medical necessity is not established.

The provider is notified via fax or mail regarding the denial.

Medical necessity is established.

A letter is sent to the provider with the authorization number, procedure codes approved, and approval dates.

The provider schedules procedure and informs the hospital of the authorization number.

The hospital verifies the authorization via internal process.

The hospital instructs the provider to obtain prior authorization.

No

Yes

The procedure is completed.
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**HEALTH INSURANCE CLAIM FORM**

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<thead>
<tr>
<th>6. PATIENT RELATIONSHIP TO INSURED</th>
<th>7. INSURED’S ADDRESS (No., Street)</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Relationship]</td>
<td>[Insured’s Address]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>8. PATIENT STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Status]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>9. CITY</th>
<th>STATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>[City]</td>
<td>[State]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>10. ZIP CODE</th>
<th>TELEPHONE (Include Area Code)</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Zip Code]</td>
<td>[Telephone]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>11. INSURED’S POLICY GROUP OR FECA NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Policy Group or FECA Number]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>12. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial)</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Other Insured’s Name]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>13. INSURED’S I.D. NUMBER (FOR PROGRAM IN ITEM 1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Insured’s I.D. Number]</td>
</tr>
</tbody>
</table>

**READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.**

**12. PATIENT’S OR AUTHORIZED PERSON’S SIGNATURE**

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

**SIGNED**

**DATE**

**13. INSURED’S OR AUTHORIZED PERSON’S SIGNATURE**

I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

**SIGNED**

**DATE**

**14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)**

<table>
<thead>
<tr>
<th>[Date]</th>
</tr>
</thead>
</table>

**15. PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY**

<table>
<thead>
<tr>
<th>[Date]</th>
</tr>
</thead>
</table>

**16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION**

<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
</tr>
</thead>
</table>

**17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE**

<table>
<thead>
<tr>
<th>[Name]</th>
</tr>
</thead>
</table>

**18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES**

<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
</tr>
</thead>
</table>

**19. RESERVED FOR LOCAL USE**

**20. OUTSIDE LAB? $ CHARGES**

<table>
<thead>
<tr>
<th>[Yes]</th>
<th>[No]</th>
<th>[Amount]</th>
</tr>
</thead>
</table>

**21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3, OR 4 TO ITEM 24E LINE)**

| 1. | [Diagnosis] |
| 2. | [Diagnosis] |

**22. MEDICAID RESUBMISSION CODE**

<table>
<thead>
<tr>
<th>[Code]</th>
</tr>
</thead>
</table>

**23. PRIOR AUTHORIZATION NUMBER**

<table>
<thead>
<tr>
<th>[Number]</th>
</tr>
</thead>
</table>

**24. PROCEDURES, SERVICES, OR SUPPLIES**

<table>
<thead>
<tr>
<th>[Procedure]</th>
<th>[Type of Service]</th>
<th>[Description]</th>
</tr>
</thead>
</table>

**25. FEDERAL TAx I.D. NUMBER SSN EIN**

<table>
<thead>
<tr>
<th>[Tax ID]</th>
<th>[SSN]</th>
<th>[EIN]</th>
</tr>
</thead>
</table>

**26. PATIENT’S ACCOUNT NO.**

<table>
<thead>
<tr>
<th>[Account]</th>
</tr>
</thead>
</table>

**27. ACCEPT ASSIGNMENT? (FOR GOVT. CLAIMS, SEE BACK)**

<table>
<thead>
<tr>
<th>[Yes]</th>
<th>[No]</th>
<th>[Amount]</th>
</tr>
</thead>
</table>

**28. TOTAL CHARGE**

<table>
<thead>
<tr>
<th>[Total]</th>
</tr>
</thead>
</table>

**29. AMOUNT PAID**

<table>
<thead>
<tr>
<th>[Paid]</th>
</tr>
</thead>
</table>

**30. BALANCE DUE**

<table>
<thead>
<tr>
<th>[Due]</th>
</tr>
</thead>
</table>

**31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE A PART THEREOF.)**

**SIGNED**

**DATE**

**32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (IF OTHER THAN HOME OR OFFICE)**

<table>
<thead>
<tr>
<th>[Name]</th>
<th>[Address]</th>
</tr>
</thead>
</table>

**33. PHYSICIAN’S, SUPPLIER’S BILLING NAME, ADDRESS, ZIP CODE & PHONE**

<table>
<thead>
<tr>
<th>[Billing Name]</th>
<th>[Address]</th>
<th>[Zip Code]</th>
<th>[Phone]</th>
</tr>
</thead>
</table>

**Approved by AMERICAN COLLEGE OF MEDICAL SERVICE 8/88**

**HCFA 1500**

**PLEASE PRINT OR TYPE**

FORM HCFA-1500 (12-90), FORM OWCP-1500, FORM RRB-1500

---

2005 PCCM Expansion
### Table

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Column 2</th>
<th>Column 3</th>
<th>Column 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data 1</td>
<td>Data 2</td>
<td>Data 3</td>
<td>Data 4</td>
</tr>
</tbody>
</table>

### Due From Patient

- **Due**: Due amount
- **From**: Patient name
- **Patient**: Patient ID
- **Insured's Name**: Insured's ID
- **Provider**: Provider ID
- **Insured**: Insured's ID
- **Due Date**: Due date
- **Insurance ID**: Insurance ID
- **Insured Group**: Insured's group
- **Treatment Authorization Code**: Treatment authorization code
- **Employer Name**: Employer name
- **Employee Location**: Employee location
- **Provider Location**: Provider location
- **Other Provider ID**: Other provider ID
- **Remarks**: Remarks

---

*Image and text content are placeholders and do not reflect actual content.*
# PCCM Client Education Request Form

## PCP INFORMATION

<table>
<thead>
<tr>
<th>Provider Name:</th>
<th>Contact Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>TPI Number:</td>
<td>Phone Number:</td>
</tr>
</tbody>
</table>

## CLIENT INFORMATION

| Client Name: | Medicaid ID#: | Phone Number: |

### Reason for Referral:

- [ ] Appointment No Show
- [ ] Noncompliance
- [ ] Referral Process
- [ ] Abuse of Emergency Room
- [ ] Abuse of Doctor/Staff
- [ ] Other

### Case Management/Health Education Needs:

- [ ] Asthma
- [ ] Childhood Illness
- [ ] Community Resources
- [ ] Cardiac
- [ ] Nutrition
- [ ] Transportation
- [ ] Dental
- [ ] Parenting
- [ ] Behavioral Psych
- [ ] Diabetes
- [ ] Prenatal Disorder
- [ ] Exercise
- [ ] Tobacco Use
- [ ] Children with Special Health Care Needs
- [ ] Other:

### Comments:

---

## For Primary Care Case Management Clients Only

Fax to Community Health Services at 1-512-302-0318

---

2005 PCCM Expansion
# PCCM-Texas Health Network Referral Form

<table>
<thead>
<tr>
<th>PCP INFORMATION</th>
<th>CLIENT INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Name</td>
<td>Client Name</td>
</tr>
<tr>
<td>Texas Provider Identifier (TPI)</td>
<td>Date of Birth</td>
</tr>
<tr>
<td>Contact Name and Phone Number</td>
<td></td>
</tr>
<tr>
<td>Client’s Medicaid Number</td>
<td>Phone</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>REFERRING PROVIDER INFORMATION (If different from PCP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Name</td>
</tr>
<tr>
<td>Texas Provider Identifier (TPI)</td>
</tr>
<tr>
<td>Contact Name and Phone Number</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider Signature</th>
<th>Referral Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>/ /</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CONSULTING PROVIDER/FACILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider/Facility Name</td>
</tr>
<tr>
<td>Medicaid Provider # (if known)</td>
</tr>
<tr>
<td>Appointment Time and Date</td>
</tr>
<tr>
<td>Address</td>
</tr>
<tr>
<td>Phone</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reason for Referral:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>TO THE CONSULTANT</th>
</tr>
</thead>
</table>

This notice authorizes the following care:

- Evaluation Only
- Evaluation and Single Treatment
- Evaluation and Treatment

Number of Treatments _____

Reason For Referral (Check all that apply):

- Asthma
- Childhood illnesses
- Children with special needs
- Chronic Conditions
- Community Resources
- Housing
- Utility
- Food
- Childcare
- Other

Consultant Comments: 

Consultant Signature | Date

Please return findings and report to PCP listed above.

Revised April 2005

2005 PCCM Expansion
Primary Care Case Management (PCCM) Inpatient/Outpatient Authorization Form

This form is used to obtain prior authorization (PA) for elective inpatient admission/procedures and outpatient services, update an existing inpatient or outpatient authorization and provide notification of emergency admissions.

Phone: 1-888-302-6167 (Option 1 Inpatient, Option 2 Outpatient) Fax: 1-512-302-5039

Please check the appropriate action you are requesting

**Inpatient Services:**
- [ ] Notification (complete fields in Sec 1 excluding clinical documentation)
- [ ] DRG or clinical update (complete Sec 2)
- [ ] Non Routine OB/NB (complete Sec 1)
- [ ] Prior Authorization of scheduled admission/procedure (complete Sec 1)

**Outpatient (OP) Services:**
- [ ] Prior authorization for outpatient services (complete Sec 1)
- [ ] Update/change codes from original OP PA request (complete Sec 2)

Facility TPI #: ___________________________ Facility Name: _____________________________ Reference # (if available) __________
PCN #: _____________________________ Client Name: _____________________________ DOB: _____________________________
Requesting (Admitting) Physician TPI #: __________ Requesting (Admitting) Physician Name: _____________________________
Form Completed by: _____________________________ Date Completed: _____________________________
Phone #: _____________________________ Fax #: _____________________________

**Section 1**
Service Type: [ ] Outpatient Service(s) [ ] Emergent/Urgent Admit [ ] Scheduled Admission/Procedure [ ] Admit Following Observation
Date of Service: _____________________________ Procedure Code(s): _____________________________
Diagnosis Codes: Primary - _____________________________, Secondary - _____________________________, _____________________________, _____________________________, _____________________________, _____________________________, _____________________________, _____________________________.
*DRG Code: _____________________________ Discharge Date (if available): _____________________________
Clinical Documentation Supporting Medical Necessity for a scheduled admission/procedure, outpatient services or non-routine OB/NB:
__________________________________________________________________________________________________________________
__________________________________________________________________________________________________________________
__________________________________________________________________________________________________________________
__________________________________________________________________________________________________________________

**Section 2 Updated Information (When necessary)**
Diagnosis Code(s): Primary - _____________________________ Secondary - _____________________________
Date of Service: _____________________________ Procedure Code(s): _____________________________ *DRG Code: _____________________________
Clinical Documentation to Support Medical Necessity of DRG or Procedure Code Change:
__________________________________________________________________________________________________________________
__________________________________________________________________________________________________________________
__________________________________________________________________________________________________________________
__________________________________________________________________________________________________________________

*Only required for DRG inpatient admission*
PCCM Behavioral Health Consent Form

PLEASE FILL OUT THE INFORMATION BELOW:

I, _______________________________________________________________________________________________________
Name Address ( )
City, State Phone
authorize: ________________________________________________________________________________________________
Provider Name
to disclose to: ______________________________________________________________________________________________
Provider Name Address ( )
City, State Phone
from (date) ______________________________  to (date) ________________________________ the following information:
Please indicate what, if any, information you would like to release.

☐ Total Medical Records to be released to primary care provider
☐ Medication Information Only to be released to primary care provider
☐ Medical Records to health plan

I understand that my records are protected under Federal (42 CFR Part 2) and/or State Confidentiality Regulations. This authorization may be withdrawn at any time in writing except to the extent that the program or person which is to make this disclosure has acted in reliance on it. Upon revocation of authorization, further release of information shall cease immediately. File copy is considered equivalent to the original. This release of information expires in thirty (30) days or sixty (60) days following completion or termination of treatment, whichever is later.

I further acknowledge that the information to be released was fully explained to me and this consent is given of my own free will.

EXECUTED THIS ______________  DAY OF _______________
(Witness) (Patient)
(Parent, Guardian, or Authorized Representative, if required)

The person signing this authorization is entitled to a copy.

TO THE INDIVIDUAL FILLING THIS OUT:
You have the right to ask us about this form. You also have the right to review the information you give us on the form. (There are a few exceptions). If the information is wrong, you can ask us to correct it. The Health and Human Services Commission has a method for asking for corrections. You can find it in Title 1 of the Texas Administrative Code, section 351.17 through 351.23. To talk to someone about this form or ask for corrections, please contact the Texas Medicaid & Healthcare Partnership (TMHP). You can write to the Texas Medicaid & Healthcare Partnership Contact Center at 1-800-925-9126.

TO THE RECIPIENT OF CONFIDENTIAL INFORMATION, PROHIBITION ON DISCLOSURE:
If the information disclosed to you is related to substance abuse treatment, these records’ confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient to release substance abuse records. The Federal Rules restrict any use of the information to criminally investigate or prosecute any substance abuse patient. State laws may also protect the confidentiality of patient’s records.

Revised June 1, 2005
TDHconnect Order Form

TDHconnect is the versatile, reliable, and free Windows-based claims submission software provided by TMHP. Technical support, upgrades, and training for TDHconnect are also available free from TMHP. Providers can use the software to submit claims, eligibility requests, claim status inquiries, adjustments, appeals, and to retrieve ER&S reports. TDHconnect training can be obtained through the Provider Relations workshops. Information about these workshops and other classes related to Medicaid billing can be found at www.tmhp.com/Providers under TMHP Provider Services Representatives and TMHP Provider Workshops. Technical support for TDHconnect is available weekdays from 7a.m. to 7p.m. through the EDI Helpdesk at 1-888-863-3638. Technical support, software updates, and training are provided free of charge.

Mailing Information

<table>
<thead>
<tr>
<th>Provider or Organization Name</th>
<th>Provider Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact Name</td>
<td>Contact Number</td>
</tr>
<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td>State</td>
</tr>
</tbody>
</table>

The TDHconnect software and Quick Start Guide should arrive within 15 business days of TMHP’s receipt of the order form. Overnight and 2nd Day services are available through UPS at the expense of the person(s) ordering TDHconnect. Orders received without a valid UPS account number or for any other package service will be sent through standard U.S. Mail. A signature is required for all UPS orders.

☐ Standard mail delivery
☐ UPS Overnight at provider’s expense
☐ UPS 2nd Day Air at provider’s expense

UPS Account Number: ..........................................................

Authorized Signature _______________________________  Title _______________

Date __________  Telephone _______________________________

Fax Number: 1-512-514-4228 or 1-512-514-4230
Mailing Address: Texas Medicaid & Healthcare Partnership
Attention: EDI Helpdesk MC-B14
P.O. Box 204270
Austin, TX 78720-4270

Hardware and Software Requirements for TDHconnect

| Platforms | 400 MHz or greater processor is recommended with 256MB of RAM
|-----------|--------------------------------------------------
| Windows 98, Windows ME, Windows XP Home, Windows XP Pro, Windows NT 4.0 with Service Pack 5 or later, and Windows 2000 Pro |
| Hard Drive | Free space of 100MB for installation and 50MB per database |
| Peripherals | CD-ROM Drive Any speed |
| Display | 800 X 600 VGA, 256 or more colors |
| Connectivity | 9600bps minimum dial-up modem or Internet connection |
| Software | Adobe Acrobat Reader—latest version (Version 4.05 is included on the TDHconnect installation disk) |
| Internet Explorer—Version 6.0 or later |
Electronic Funds Transfer (EFT) Information

Electronic Funds Transfer (EFT) is a payment method to deposit funds for claims approved for payment directly into a provider’s bank account. These funds can be credited to either checking or savings accounts, provided the bank selected accepts Automated Clearinghouse (ACH) transactions. EFT also avoids the risks associated with mailing and handling paper checks, ensuring funds are directly deposited into a specified account.

The following items are specific to EFT:

Applications are processed within five workdays of receipt.
Pre-notification to your bank takes place on the cycle following the application processing.
Future deposits are received electronically after pre-notification.
The Remittance and Status (R&S) report furnishes the details of individual credits made to the provider’s account during the weekly cycle.
Specific deposits and associated R&S reports are cross-referenced by both Texas Provider Identifier (TPI) and R&S number.
EFT funds are released by TMHP to depository financial institutions each Friday.
The availability of R&S reports is unaffected by EFT and they continue to arrive in the same manner and time frame as currently received.

TMHP must provide the following notification according to ACH guidelines:

Most receiving depository financial institutions receive credit entries on the day before the effective date, and these funds are routinely made available to their depositors as of the opening of business on the effective date. Please contact your financial institution regarding posting time if funds are not available on the release date.

However, due to geographic factors, some receiving depository financial institutions do not receive their credit entries until the morning of the effective day and the internal records of these financial institutions will not be updated. As a result, tellers, bookkeepers, or automated teller machines (ATMs) may not be aware of the deposit and the customer’s withdrawal request may be refused. When this occurs, the customer or company should discuss the situation with the ACH coordinator of their institution who, in turn should work out the best way to serve their customer’s needs.

In all cases, credits received should be posted to the customer’s account on the effective date and thus be made available to cover checks or debits that are presented for payment on the effective date.

To enroll in the EFT program, complete the attached Electronic Funds Transfer Authorization Agreement. You must return a voided check or deposit slip with the agreement to the TMHP address indicated on the form.

Contact TMHP Customer Service at 1–800–925–9126 if you need assistance.
### Electronic Funds Transfer (EFT) Authorization Agreement

**Enter ONE Texas Provider Identifier (TPI) per Form**

**NOTE:** Complete all sections below and attach a voided check or a photocopy of your deposit slip.

<table>
<thead>
<tr>
<th>Type of Authorization:</th>
<th>NEW</th>
<th>CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider Accounting Address</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bank Name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bank Phone Number</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bank Address</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nine–Character Billing TPI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider Phone Number</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ABA/Transit Number</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Account Number</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type Account (check one)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Checking</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Savings</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

I (we) hereby authorize Texas Medicaid & Healthcare Partnership (TMHP) to present credit entries into the bank account referenced above and the depository named above to credit the same to such account. I (we) understand that I (we) am responsible for the validity of the information on this form. If the company erroneously deposits funds into my (our) account, I (we) authorize the company to initiate the necessary debit entries, not to exceed the total of the original amount credited for the current pay period.

I (we) agree to comply with all certification requirements of the applicable program regulations, rules, handbooks, bulletins, standards, and guidelines published by the Texas Health and Human Services Commission (HHSC) or its contractor. I (we) understand that payment of claims will be from federal and state funds, and that any falsification or concealment of a material fact may be prosecuted under federal and state laws.

I (we) will continue to maintain the confidentiality of records and other information relating to clients in accordance with applicable state and federal laws, rules, and regulations.

<table>
<thead>
<tr>
<th>Authorized Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Title</th>
<th>Email Address (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Contact Name</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Return this form to:
Texas Medicaid & Healthcare Partnership
ATTN: Provider Enrollment
PO Box 200795
Austin TX 78720–0795

DO NOT WRITE IN THIS AREA — For Office Use

Input By: Input Date:
Electronic Remittance and Status (ER&S) Agreement

Before your ER&S Agreement* can be processed, you MUST choose ONE of the following:

* These changes affect ONLY the ELECTRONIC version of the Remittance & Status Report. To make changes to the PAPER version of the R&S report, contact TMHP Provider Enrollment.

- [ ] Set up INITIAL (first time). Use Production User ID*: ____________________________ (9 digits)
- [ ] CHANGE Production User ID
  - FROM: ____________________________ (9 digits)
  - TO: ____________________________ (9 digits)
- [ ] REMOVE Production ID
  - Remove: ____________________________ (9 digits)

** The TMHP Production User ID (Submitter ID) is the electronic mailbox ID used for downloading your Electronic Remittance & Status (ER&S) reports. For assistance with identifying and using your Production User ID and password, contact your software vendor or clearinghouse.

This information MUST be completed before your request can be processed.

<table>
<thead>
<tr>
<th>Provider Name (must match TPI number)</th>
<th>BILLING TPI Number</th>
<th>Provider Tax ID Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider’s Physical Address</td>
<td></td>
<td>Provider Phone Number</td>
</tr>
<tr>
<td>Provider Contact Name (if other than provider)</td>
<td>Provider Contact Title</td>
<td>Contact Phone Number</td>
</tr>
</tbody>
</table>

Do not complete this block UNLESS the ER&S will be downloaded by anyone OTHER than the provider.

<table>
<thead>
<tr>
<th>Name of Business Organization to Receive ER&amp;S</th>
<th>Business Organization Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Business Organization Contact Name</td>
<td>Business Organization Contact Phone No.</td>
</tr>
<tr>
<td>Business Organization Address</td>
<td>Business Organization Tax ID</td>
</tr>
</tbody>
</table>

Check each box after reading and understanding the following statements. If you are unsure about anything that is stated below, contact the TMHP EDI Help Desk at (888) 863-3638. All three statements must be checked before we can process your Electronic Remittance & Status Agreement.

- [ ] I (we) request to receive Electronic Remittance and Status information and authorize the information to be deposited in the electronic mailbox as indicated above. I (we) accept financial responsibility for costs associated with receipt of Electronic R&S information.
- [ ] I (we) understand that paper formatted R&S information will continue to be sent to my (our) accounting address as maintained at TMHP until I (we) submit an Electronic R&S Certification Request form.
- [ ] I (we) will continue to maintain the confidentiality of records and other information relating to recipients in accordance with applicable state and federal laws, rules, and regulations.

Provider Signature ____________________________ Date ____________________________

Title ____________________________ Fax Number ____________________________

**DO NOT WRITE IN THIS AREA — For Office Use**

Input By: ____________________________ Input Date: ____________________________ Mailbox ID: ____________________________
Before faxing or mailing this agreement, ensure that all required information is completely filled out, and that the agreement is signed.

Incomplete agreements cannot be processed.

Mail to: Texas Medicaid & Healthcare Partnership
         Attention: EDI Help Desk MC–B14
         PO Box 204270
         Austin, TX 78720-4270

Fax to:  (512) 514-4228
         OR
         (512) 514-4230
Claim Status Inquiry Authorization

This form is for ACUTE CARE providers only.

If you are a Long Term Care provider, contact TMHP’s EDI Help Desk at 888-863-3638 to request the correct form.

The following information MUST be completed before you can be granted Claim Status Inquiry (CSI) access.

1. Enter your Production User ID: 

2. Enter your Production User ID Password:

   The TMHP Production User ID (Submitter ID) is the electronic mailbox ID used for downloading your Claim Status Inquiry reports. For assistance with identifying and using your Production User ID and password, contact your software vendor or clearinghouse.

3. Select Action:
   - A  Add Claim Status Inquiry Privileges
   - B  Revoke Claim Status Inquiry Privileges

4. Enter organization information:

   List the billing Texas Provider Identifier (TPI) number(s) you choose to access using the Production User ID given above. Submit additional copies of this form if you need to add more TPI numbers.

   Provider Name
   Must be the name associated with the TPI Base number listed at right.

   7–Digit BILLING TPI Base Number
   The first 7 digits of the 9 digit TPI number. *

   *Note: Performing TPI numbers do not have Claim Status Inquiry access. Enter only BILLING TPI numbers.

5. Enter Requestor Information:

   Name: 
   Title: 

   Signature: 
   Telephone Number: ext.
   Fax Number: ext.

6. Return this form to: Texas Medicaid & Healthcare Partnership
   Attention: EDI Help Desk, MC–B14
   PO Box 204270
   Austin, TX 78720-4270
   Or Fax to 512-514-4228 or 512-514-4230

DO NOT WRITE IN THIS AREA — For Office Use

Input By: Input Date: Mailbox ID:

TMHP — A STATE MEDICAID CONTRACTOR
CSIAUTH11.24.2003_v0.2 44
Complete this form and submit to update your provider files. Mail or fax the completed form or mail to the appropriate entity. PLEASE PRINT OR TYPE THE INFORMATION SUBMITTED ON THIS FORM.

Date: ____________________

Nine-Character Texas Provider Identifier (TPI):

If you have more than one TPI that will also use this same information, list the other TPIs:

<table>
<thead>
<tr>
<th>Physical Address</th>
<th>Accounting/Mailing Address</th>
<th>Secondary Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannot be a PO Box</td>
<td>W–9 Form Required</td>
<td>Plan Use Only</td>
</tr>
</tbody>
</table>

Telephone

Fax

Type of Change: (please check the appropriate box below)

☐ Change of Physical Address, telephone and/or fax number
☐ Change of Billing/Mailing Address, telephone and/or fax number
☐ Change/Add Secondary Address, telephone and/or fax number
☐ Change of Provider Status (i.e., termination from plan, moved out of area, specialist, etc.). Please Explain:
☐ Other (i.e., panel closing, capacity changes, age acceptance, etc.)

Tax Information—IRS ID Number:

Attach W–9

Effective Date: ____________________

List the exact name reported to the IRS for the above Tax ID number:

Important: Must be signed and dated or changes cannot be completed.

Provider Signature: ____________________ Date: ____________________

E–mail Address:

Texas Medicaid & Healthcare Partnership
ATTN: Provider Enrollment, MC–B05
PO Box 200795
Austin, TX 78720-0795
FAX: 1-512-514-4214

Send your completed change form to:

Office Use

| TMHP Representative: | Date: |

TO THE INDIVIDUAL FILLING THIS OUT:
You have the right to ask us about this form. You also have the right to review the information you give us on the form. (There are a few exceptions). If the information is wrong, you can ask us to correct it. The Health and Human Services Commission has a method for asking for corrections. You can find it in Title 1 of the Texas Administrative Code, section §351.17 through §351.23. To talk to someone about this form or ask for corrections, please contact the Texas Medicaid and Healthcare Partnership Helpline at 1-800-925-9126.
2005 PCCM Expansion Workshop Evaluation

Location (city): ___________________________ Date: ___________________________
Presenters: (1) ___________________________ (2) ___________________________

How well do you feel this workshop reviewed and helped you understand the following goals and objectives (evaluate from 1 to 5):

<table>
<thead>
<tr>
<th>Goal</th>
<th>Effective</th>
<th>Ineffective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduce providers to Medicaid Managed Care and the PCCM</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Detail the goals and benefits of PCCM</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Educate providers on the role of primary care providers, hospitals, and specialists</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Review client eligibility guidelines</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Introduce providers to PCCM authorization process</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Detail covered services and how to bill for them</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Help providers understand resources</td>
<td>5</td>
<td>4</td>
</tr>
</tbody>
</table>

How do you feel this workshop covered these goals (evaluate from 1 to 5):

<table>
<thead>
<tr>
<th>Goal</th>
<th>Effective</th>
<th>Ineffective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did this workshop provide a basic understanding of PCCM?</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Did this workshop help you understand which Medicaid clients are eligible to enroll in PCCM?</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Did this workshop help you understand the various ways to verify PCCM client eligibility?</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Did this workshop provide an overview of PCCM client benefits?</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Did this workshop assist you in determining which provider types can enroll as PCPs in the PCCM network?</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Did this workshop teach you about PCP responsibilities in PCCM?</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Did you learn about 24/7 coverage?</td>
<td>5</td>
<td>4</td>
</tr>
</tbody>
</table>
How do you feel about the workshop (evaluate from 1 to 5):

<table>
<thead>
<tr>
<th>Question</th>
<th>Effective</th>
<th>Ineffective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did you learn about PCCM’s open network of specialty providers?</td>
<td>5 4 3 2 1</td>
<td></td>
</tr>
<tr>
<td>Did you learn about the referral process?</td>
<td>5 4 3 2 1</td>
<td></td>
</tr>
<tr>
<td>Did the workshop teach you about hospital responsibilities in PCCM?</td>
<td>5 4 3 2 1</td>
<td></td>
</tr>
<tr>
<td>Did this workshop provide an overview of the authorization process?</td>
<td>5 4 3 2 1</td>
<td></td>
</tr>
<tr>
<td>Did this workshop help you learn how to obtain, understand, and use a monthly panel report?</td>
<td>5 4 3 2 1</td>
<td></td>
</tr>
<tr>
<td>Did this workshop make you aware of available PCCM resources?</td>
<td>5 4 3 2 1</td>
<td></td>
</tr>
</tbody>
</table>

Comments/Suggestions:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

How did you hear about this workshop?

________________________________________________________________________

Complete the following section if you would like to request information or if you have a question/problem you need help resolving:

Name: ___________________________ TPI: ___________________________

Provider Name: ___________________________ Mailing address: ___________________________

Phone Number: ___________________________ ___________________________

I would like a visit to discuss the following question(s)/problem(s):

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________