



PROVIDER PORTAL USER GUIDE



Google Chrome is the preferred browser of choice for this site

Table of Contents

- INTRODUCTION.....4
- MEMBER ELIGIBILITY & IDENTIFICATION4
- POVIDER PORTAL (RESTRICTED).....4
- New User Account Access 4**
- Portal Log In..... 5**
-
- DATA FORMS OVERVIEW HOME PAGE6
- USER MANAGEMENT>USER ACCOUNTS.....6
-
- User Accounts..... 6
- Create New User 7
- Grant Portal Screen Roles/Permissions..... 8
- Create/Reset User Password 8
- UnLock User Account 9
- Deactivate Accounts 9
- User Permissions..... 9
-
- ELECTRONIC FUNDS TRANSFER (EFT)10
-
- Portal EFT Enrollment Steps 10
- De-Activation Steps..... 12
-
- CLAIMS ENTRY.....13
-
- CMS-1500 13
- CLAIM REPORT..... 15
- UB-04 Form..... 15
- Long Term Care Claim Submission 16
-
- ELIGIBILITY.....16
-
- Check Eligibility..... 16
- Share of Cost (Soc) 18
- Adding Member to batch from Eligibility Screen 18
- Batch Eligibility 19
-
- TRANSACTION SERVICES20
-
- Medi-Reservation 20
- Share of Cost..... 21
-
- AUTHORIZATION21
-
- Authorization..... 21
- Upload Attachments 24
- Procedures Requiring a Tar 25
-
- REPORTS.....26

Daily Claims	26
Capitation	26
Pcp Mid-Month.....	26
Case Management	26
Patient Profile.....	27
Claim Status.....	27
Claim Report.....	27
Explain Codes.....	27
Pcp 834 Download	27
Submitter Report	27
Er Report	27
COORDINATION OF CARE.....	27
Practice Summary	27
Case Load Summary	28
Assigned Members.....	28
Gaps In Care.....	29
Specialized Program.....	29
Authorization Utilization	30
Mental BHT Services	30
Hospital Utilization	30
PROCEDURE PRICER	30
SMART PROGRAMS.....	31
Diabetes Smart	31
PCP REASSIGNMENT REQUESTS.....	33
PHARMACY FORMS.....	34
CenCal Health Medical Request Form (MRF).....	34
CenCal Health Pharmacy Authorization Form (PAF)	34
Hepatitis C Medication Request Form.....	34
Synagis Medication Request Form.....	34
P & T Formulary Additions/Deletions Form	34
RADIOLOGY BENEFIT MANAGER (RBM).....	34
Applicable Service	34
Expectations	35
Required Information.....	35
ELECTRONIC EXPLANATION OF PAYMENT (EEOP) REPORT	35
CONTACT US	36

INTRODUCTION

Welcome to the CenCal Health Website www.cencalhealth.org. The Website contains many interactive capabilities such as checking member eligibility, request pre-authorizations, claims billing and report capabilities.

This document contains step-by-step instructions on how to access CenCal Health's interactive portal for Providers, Administrators and Staff. Websites are not static documents they are updated and changed constantly to meet the needs of users, to improve functionality, and to meet nationally recognized standards and regulations in healthcare.

MEMBER ELIGIBILITY & IDENTIFICATION

CenCal Health does NOT determine eligibility and a member's eligibility with CenCal Health can change. Medi-Cal members receive a permanent plastic identification card called a Benefits Identification Card or "BIC" and a CenCal Health Insurance card.

GROUP PLAN IDENTIFICATION KEY

110 Santa Barbara Health Initiative (SBHI) Medi-Cal
1120 San Luis Obispo Health Initiative (SLOHI) Medi-Cal

These card must be used for identification purposes but does not provide proof of eligibility. These cards are issued only once and reissued only when information on the card has changed.



FOR PROVIDERS

There are many ways to access our Provider Portal once you select 'Providers' icon.



POVIDER PORTAL (RESTRICTED)

[New User Account Access](#)

This area is "restricted" to authorized users only. New In-Network contracted providers will receive a username and password after they have contacted CenCal Health. For questions on this portal or account access, contact the Web Master at webmaster@cencalhealth.org.

Please appoint a 'Physician/Administrator' for your office as this staff member will manage all user access to the portal and will be responsible for setting your office staff accounts through this portal.

CenCal Health encourages all individual user accounts to be secure and not used by multiple users. CenCal Health will not be held responsible for any erroneous use of a provider user account.

User Account Information Requirements:

- Provider/Organizations Name
- Tax Identification Number
- National Provider Identifier (NPI)
- Physician/Administrator E-mail address (preferred, organizational email address)
- Point of Contact

Portal Log In



Once you click on the  icon, you will see the following screen:

First Time Login:

All individual accounts are created by your 'Physician/Administrator' User within your practice. After your account is created, the individual User will login with their email address as their Username, and a temporary password will be provided. The system will prompt the user to create their own individual password.

Password Change Policy:

The system will prompt each User to change their password after 180 days of entry.

Password Entry Error or Password Assistance:

If you enter your information after (3) three invalid attempts, the system will lock your account. Your 'Physician/Administrator' can also 'Unlock' your account or provide assistance on creating new accounts.

Forgot your Password?

All Users can reset their password through the 'Forgot your password?' function and the system auto assign a temporary password for access.

Automatic Deactivation Policy:

CenCal Health will automatically deactivate all User accounts if no activity of the portal is utilized after 90days. It is still the responsibility of the Administrative User to deactivate accounts if staff no longer work for your practice.

User Screen Role Access:

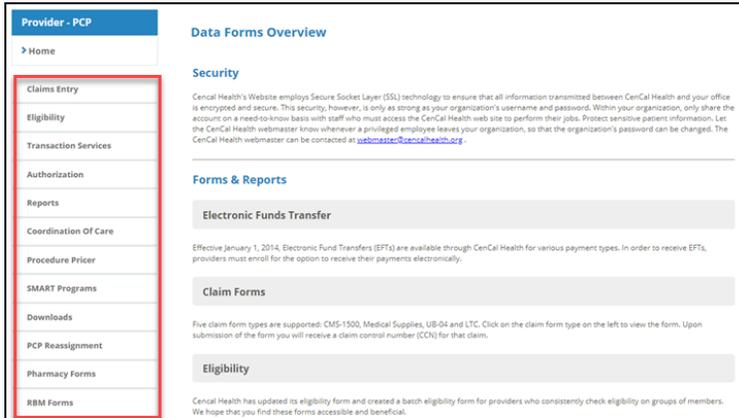
All interactive features are listed along the left column of the page and are specific to each 'User Role' (i.e. if you submit claims you should see the 'Claims Entry'). Please contact your 'Physician/Administrator' within your organization if you need access to specific roles so you can have them added to your interactive tab.

Multi-User Access:

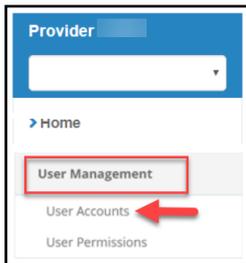
Users could have 'multi-user' access for more than one group (i.e. third party billers that have access to more than one IRS#). In this instance, the User will be able to toggle to each specific IRS# they are assigned to by clicking the IRS drop down box.

DATA FORMS OVERVIEW HOME PAGE

The screen above indicates all active forms available on the portal. Please contact your Physician/Administrator should you need access to any of the above screens. The details provided below contain step-by-step instructions on how to access CenCal Health's interactive portal.



USER MANAGEMENT>User Accounts



The User Management screen allows all Administrative Users to manage all user accounts within your group, create new user accounts, set roles, reset individual temporary passwords, and terminate accounts for those that no longer need access.

[User Accounts](#)

Allows the Admin User to view an alphabetized list of your staff's UserName by their organizational email address. To view a full list of Active and Inactive, click on the

Include Inactive Users box located in the top right corner as needed.

CenCal Health - User Accounts			
UserName	Job Role	Active	Actions
	Office Staff	Y	Edit Password UnLock Access
	Physician/Administrator	Y	Edit Password UnLock Access
	Physician/Administrator	Y	Edit Password UnLock Access

Edit: Allows the Admin User to make changes to your staffs name, activation status, and more remarks.

Password: Allows you to change the users password and create a temporary password

UnLock: Allows the Admin User to unlock the individual's password if they try and log into the portal three (3) times incorrectly. This does not change the password, unless you click on 'Reset Password'.

Access: This function will allow the Admin User to add/delete screen permissions to your staffs account. These screen permissions are specific to the Provider Portal screens (Eligibility, Auths, Reports, etc.).

Create New User

Click on 'Create New User' when you want to give portal permissions to a new staff member

CenCal Health - User Accounts

Create New User

Find by First Name, Last Name or Email: Include Inactive Users

UserName	Job Role	Active	Actions
	Office Staff	Y	Edit Password UnLock Access
	Physician/Administrator	Y	Edit Password UnLock Access
	Physician/Administrator	Y	Edit Password UnLock Access

Enter your staff members individual email address (this will become their individual UserName when logging into the portal) along with all other required fields.

The 'Department' and 'Remarks' field is free hand text boxes. The 'Job Role' drop down box will allow you to choose job roles with predefined permission sets for your staff (if you want to customize it, click on 'Other'),

then click .

Email* 1

LastName* 2

FirstName* 3

MiddleName

PhoneNumber 4

Department

If Applicable

Remarks 5

Select a Job Role that most closely describes your job function. (If none apply, or if you have multiple job roles, select "Other")
Note: Permissions for the selected JobRole will be applied on Save!

Job Role* 6

Physician/Administrator
Office Staff
Other
Billor

****Helpful Tip:** If you enter the wrong 'Email' address, you will need to deactivate the account and create a new one with the correct email address.

This next screen will auto populate the details for this user and allow the Admin User to manage 'Edit' or add 'Permissions' to the new account.

Application Access for:

[Back to User List](#) | [Edit User](#)

Type	Vendor Name	Effective Date	End Date	Job Role	Job Other	Default Access	Actions
Vendor		10/17/2019		Physician/Administrator	N/A	<input checked="" type="checkbox"/>	<input type="button" value="Edit Permissions"/>

Page 1 of 1

Edit: Allows the Admin User to make changes the user's JobRole, Active Status, and End_Date the account.

Edit Access to

[Back to List](#) | [Permissions](#)

Edit User Access

UserName

Access Type
Vendor

OrganizationName

Effective_Date
10/17/2019 12:00:00 AM

End_Date mm/dd/yyyy

Select a Job Role that most closely describes your job function. (If none apply, or if you have multiple job roles, select "Other")
Warning: Changing JobRole will delete all permissions for this user and apply permissions for the selected JobRole!

JobRole*

Active

DefaultAccess

JobRoles: This function will allow the Admin User to add/delete screen permissions to your staffs account. These screen permissions are specific to the Provider Portal screens (Eligibility, Auths, Reports, etc.).

Back to List: Takes you back to the original staff Application User Account list

If you need to give access to a separate user that has multiple accounts with other provider groups (e.i. a Biller that bills for many different doctors), please contact our Webmaster at www.webmaster@cencalhealth.org or directly at (805) 562-1676 and they will assist with this user account.

Grant Portal Screen Roles/Permissions

Will allow the Admin User to create additional portal screen permissions to a user account. All screen permissions will be listed in the top blue box.

Application Access for: [Redacted]

[Back to User List](#) | [Edit User](#)

Type	Vendor Name	Effective Date	End Date	Job Role	Job Other	Default Access	Actions
Vendor	[Redacted]	10/17/2019		Physician/Administrator	N/A	<input checked="" type="checkbox"/>	Edit Permissions

Page 1 of 1

1

Manage Access Permissions

Permissions for John Doe (Other):

Permissions	Effective Date	End Date	Last_Modified_Date	Last_Modified_By
Authorization	11/20/2018 2:42:23 PM	11/20/2018 2:42:23 PM	11/20/2018 2:42:23 PM	ANGARCABENCALHEALTH.ORG
Authorization-FarmH	5/24/2018 11:22:45 AM	5/24/2018 11:22:45 AM	5/24/2018 11:22:45 AM	ANGARCABENCALHEALTH.ORG
Authorization-Farm2D	5/24/2018 11:22:44 AM	5/24/2018 11:22:44 AM	5/24/2018 11:22:44 AM	ANGARCABENCALHEALTH.ORG
Authorization-ProcedureS	5/24/2018 11:22:44 AM	5/24/2018 11:22:44 AM	5/24/2018 11:22:44 AM	ANGARCABENCALHEALTH.ORG
Authorization-RAF	10/2/2019 12:00:00 AM	10/2/2019 11:57:54 AM	10/2/2019 11:57:54 AM	EGHDEBCENCALHEALTH.ORG
Authorization-Report	5/24/2018 11:22:44 AM	5/24/2018 11:22:44 AM	5/24/2018 11:22:44 AM	ANGARCABENCALHEALTH.ORG
Authorization-TAR	5/24/2018 11:22:42 AM	5/24/2018 11:22:42 AM	5/24/2018 11:22:42 AM	ANGARCABENCALHEALTH.ORG

Add a group of Permissions to Access using a Job Role

Effective Date: 10/10/2019 Select to change Job Role

End Date: mm/dd/yyyy

Add

Add a group of Permissions to Access using a Default Role

Effective Date: 10/10/2019 Select to add group screen permissions (Authorizations, Claims, etc.)

End Date: mm/dd/yyyy

Add

Add a Permission to Access

Effective Date: 10/10/2019 Select to add individual screen permissions access (RAF, TAR 50-4, Check Elig, etc.)

End Date: mm/dd/yyyy

Add

Update Permission of Access

Effective Date: 10/10/2019

End Date: mm/dd/yyyy

Update

Update a group of Permissions from Access using a Default Role

Effective Date: 10/10/2019

End Date: mm/dd/yyyy

Update

Update All Permissions From Access:

Effective Date: 10/10/2019

End Date: mm/dd/yyyy

Update All

Click 'Add' to change screen permissions, and 'update' effective dates to remove screen access.

'End Date' will need to be entered in order to remove screen permissions

Create/Reset User Password

On the main User Account page, search for your staff member and click 'Password'. This allows the Admin User to create, reset, or change the Users password and create a temporary password.

CenCal Health - User Accounts

[Create New User](#)

Find by First Name, Last Name or Email: [SEARCH](#) Include Inactive Users

UserName	Job Role	Active	Actions
[Redacted]	Office Staff	Y	Edit Password UnLock Access
[Redacted]	Physician/Administrator	Y	Edit Password UnLock Access
[Redacted]	Physician/Administrator	Y	Edit Password UnLock Access

The screen will auto assign a temporary password for your user when creating or resetting a password. The Admin User can also create a different temporary password as long as it meets the specific minimum character criteria. After you click [SET/RESET PASSWORD](#), the system will then send your staff member their temporary password, along with a confirmation email to the Admin User.

The account will then be placed in a temporary status and your user will need to log in with the assigned temporary password and create their own password.

Set/Reset User's Application Password.

[Back to List](#)

Set or Reset johndoe@mdclinic.org password.

UserName
 ← The system will automatically create a temporary password for each user or the Admin User can create one.

Confirm generated password or Create
 Min Length 8 Characters, Min 1 Uppercase, Min 1 Lowercase, Min 1 Special Character

Password

Confirm password

SET/RESET PASSWORD

UnLock User Account

If a user logs into the Provider Portal and it is entered incorrectly three (3) times, the system will automatically lock the user account, and they will need to contact their Administrator to 'UnLock' their account. The User can also create a new password for themselves through the 'Forgot your password?' function.

GenCal Health - User Accounts

[Create New User](#)

Find by First Name, Last Name or Email: **SEARCH** Include Inactive Users

UserName	Job Role	Active	Actions
	Office Staff	Y	Edit Password UnLock Access
	Physician/Administrator	Y	Edit Password UnLock Access
	Physician/Administrator	Y	Edit Password UnLock Access

Deactivate Accounts

Go to the main 'Application Access List' and locate your staff name via the search tool and click 'Edit'.

GenCal Health - User Accounts

[Create New User](#)

Find by First Name, Last Name or Email: **SEARCH** Include Inactive Users

UserName	Job Role	Active	Actions
	Office Staff	Y	Edit Password UnLock Access
	Physician/Administrator	Y	Edit Password UnLock Access
	Physician/Administrator	Y	Edit Password UnLock Access

Switch 'Active' drop down to 'N', enter an 'End_Date' and click 'Save'.

Edit Access to

[Back to List](#) | [Permissions](#)

Edit User Access

UserName:

Access Type:

OrganizationName:

Effective_Date: 10/8/2019 12:00:00 AM

End_Date:

JobRole:

Active: **N**

DefaultAccess:

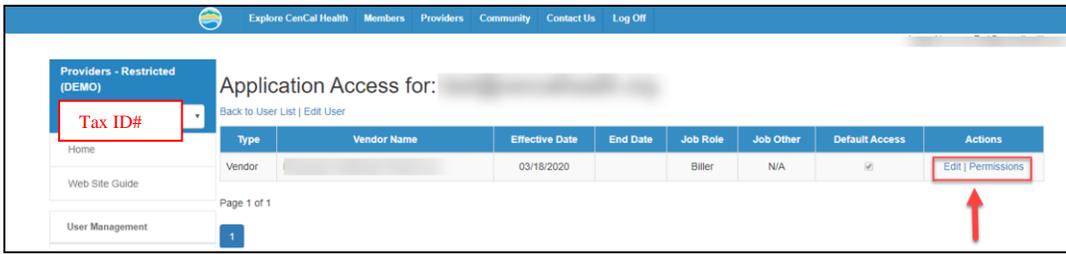
SAVE

User Permissions

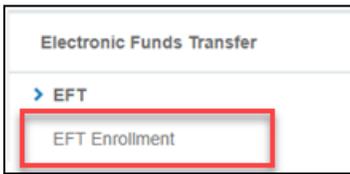
The screen below indicates 'Permissions' and the ability to 'Edit' all of your staff that are under the same group Tax ID#.

Edit: Allows the Admin User to edit that Users account details

Permissions: Allows the Admin User to change their individual screen permission access and/or to make them additional Admin Users.



ELECTRONIC FUNDS TRANSFER (EFT)



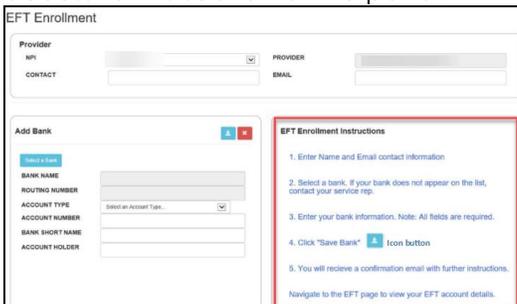
Electronic Fund Transfers (EFT) is a method of a weekly payment offered by CenCal Health to our participating contracted providers. EFT automatically credits all payments due for healthcare services performed directly to your savings or checking account. This payment method replaces issuing a paper check for various payment types, including or related to claims processing, i.e. EOPs, Capitation and Incentive payments (PCP Incentive Program, Inpatient

Readmission Program, Diabetes SMART Program and the Breathe (Asthma) SMART Program). For additional information go to www.cencalhealth.org/providers/claims

In order to receive EFT, providers must enroll for the option through our Provider Portal to receive electronic payments. Follow the steps below to enroll or deactivate an account in this method of payment.

Portal EFT Enrollment Steps

Providers can enroll for EFT through the 'Electronic Funds Transfer' section of our website (user job role must be included in your individual user access). Please contact your portal Physician/Administrator if you need access to this section of the portal.



The Bank Information section should be completed with the information for the bank account for which EFTs will be deposited. This includes EOP payments, and for Primary Care Providers, capitation and incentive payments.

Once you select a bank, the name of the bank associated with that routing number will automatically be filled in the Bank Name field.

Click  and an email will be sent to the individual noted in the 'Contact' section acknowledging that the enrollment process has been initiated.

Once a provider's enrollment has been submitted through the portal, a notification to the authorized person at the practice will be required to  the information submitted within two (2) business days through the provider portal.

Bank(s)

Active

BANK NAME: [Redacted]
 ROUTING NUMBER: [Redacted]
 ACCOUNT STATUS: PENDING
 EFT STATUS: (PROCESSED)
 BANK ENROLL DT: 2/18/2019 1:36:27 PM
 ACCOUNT TYPE: [Redacted]
 ACCOUNT NUMBER: [Redacted]
 BANK SHORT NAME: [Redacted]
 ACCOUNT HOLDER: [Redacted]

Confirm DeActivate

BANK 1 of 1

Edit Information

1. Check EFT Status. If EFT Status = "PROCESSED", continue to step 2. If EFT Status not = "PROCESSED" check back later.
2. You should have received 2 test transactions deposited into the bank account requested for EFT. You will need the exact deposit amounts to complete the confirmation process.
3. Click "Confirm" and a Confirm Verification Amounts pop-up window will appear. Enter the amounts of the test transactions.
4. Click the "Confirm" button on the Confirm Verification Amounts pop-up window.
5. If the transaction amounts you entered match our records, an "Update Bank" button will appear.
6. Click "Update Bank" and the bank confirmation process will be complete and your EFT Bank Account status will be updated to "Verified".

Once your bank has been verified, you will be able to select what payment type(s) you wish to configure for this EFT Bank Account.

Once confirmed, CenCal Health will initiate two (2) verification transactions (two deposits totaling \$0.25) to each bank account enrolled. The assigned user will be able to enter the two deposit amounts themselves when you log back into the portal under EFT Enrollment.

Confirm Verification Amounts

Enter Amounts prefixed with 0.

Ver Amount 1:
Enter Amount 0.00

Ver Amount 2:
Enter Amount 0.00

Cancel Confirm

Once you verify the exact two amounts, press confirm. Please note: In order to track EFT transactions to bank statement(s) and/or to electronic remittance advice (835 files), providers will need to contact their financial institution and request that the Transaction Reassignment Number (TRN) be added to their statements for these transactions. This request should only need to be made once.

Bank(s)

Active

BANK NAME: JPMORGAN CHASE BANK, NA
 ROUTING NUMBER: [Redacted]
 ACCOUNT STATUS: VERIFIED
 BANK ENROLL DT: 2/18/2019 1:36:27 PM
 ACCOUNT TYPE: CHECKING
 ACCOUNT NUMBER: [Redacted]
 BANK SHORT NAME: [Redacted]
 ACCOUNT HOLDER: [Redacted]

DeActivate

BANK 1 of 1

Payment Configuration

PMT_TYPE	BANK_NAME	MODIFIED_BY	MODIFIED_DATE
EOB	[Redacted]		2/28/2019 3:25:21 PM

EOB: 1 JPMORGAN CHAI

CAP: 2 Select A Bank...

INC: 3 Select A Bank...

Click Save

Click the pencil to indicate your payment types

Please add your bank to all three (1-3) payment types by clicking on the drop-down boxes. Payment configuration will be added to all three (1-3) payment types after you click the blue icon to save.

Back to List

Provider

EFT ENROLL DATE: 2/18/2019 1:36:27 PM

CONTACT: [REDACTED] EMAIL: [REDACTED]

Bank(s)

Active

BANK NAME: JPMORGAN CHASE BANK, NA

ROUTING NUMBER: [REDACTED]

ACCOUNT STATUS: VERIFIED

BANK ENROLL DT: 2/18/2019 1:36:27 PM

ACCOUNT TYPE: CHECKING

ACCOUNT NUMBER: [REDACTED]

BANK SHORT NAME: [REDACTED]

ACCOUNT HOLDER: [REDACTED]

Deactivate

BANK 1 of 1

Payment Configuration

PMT_TYPE	BANK_NAME	MODIFIED_BY	MODIFIED_DATE
INC	JPMORGAN	[REDACTED]	2/28/2019 3:29:35 PM
EOB	JPMORGAN	[REDACTED]	2/28/2019 3:25:21 PM
CAP	JPMORGAN	[REDACTED]	2/28/2019 3:29:35 PM

When all of the steps listed above are completed, and verified by CenCal Health, your first test payment will be received two (2) business days after the payment has been initiated. A one time verification confirmation will be sent to the authorized person at your practice via email confirming that all payments will now be received electronically to your bank after payment is initiated (ACH payments require two days to process).

CenCal Health will continue to send payments to the Financial Institution indicated until notified by Provider/Submitter of a change of the Financial Institution authorized to receive payments. The Provider Portal 'EFT' section of the website will allow the assigned user to 'Edit' or 'DeActivate' your EFT enrollment account(s).

If Financial Institution information changes, or you receive payment failure, or for general questions, please notify CenCal Health via email at eft@cencalhealth.org or contact our Finance Department at (805) 562-1081.

[De-Activation Steps](#)

Log back into the portal EFT section of the website, and select the 'Edit' button for the account you want to deactivate.

EFT Account

Active

MS	NAME	BANK_NAME	ACCOUNT(EFT) STATUS	REP	PAYMENT TYPES	ACTIONS
[REDACTED]	[REDACTED]	RABOBANK, NA	VERIFIED	No Rep Code	EOB <input type="checkbox"/> Capitation <input type="checkbox"/> Incentive <input type="checkbox"/>	Edit
[REDACTED]	[REDACTED]	RABOBANK, NA	VERIFIED	No Rep Code	EOB <input type="checkbox"/> Capitation <input type="checkbox"/> Incentive <input type="checkbox"/>	Edit
[REDACTED]	[REDACTED]	BANK OF AMERICA, N.A., CA	VERIFIED	No Rep Code	EOB <input checked="" type="checkbox"/> Capitation <input checked="" type="checkbox"/> Incentive <input checked="" type="checkbox"/>	Edit
[REDACTED]	[REDACTED]	RABOBANK, NA	VERIFIED	No Rep Code	EOB <input type="checkbox"/> Capitation <input type="checkbox"/> Incentive <input type="checkbox"/>	Edit

Under 'Payment Configuration' select the pencil icon to edit, then you will need to detach the bank account from each payment type by using selecting 'Select A Bank' in the drop down box.

Bank(s) + [edit]

Active

BANK NAME BANK OF AMERICA, N.A., CA

ROUTING NUMBER [REDACTED]

ACCOUNT STATUS VERIFIED

BANK ENROLL DT 3/8/2019 2:45:18 PM

ACCOUNT TYPE CHECKING

ACCOUNT NUMBER [REDACTED]

BANK SHORT NAME [REDACTED]

ACCOUNT HOLDER [REDACTED]

DeActivate

BANK 1 of 3

Payment Configuration [confirm]

PMT_TYPE	BANK_NAME	MODIFIED_BY	MODIFIED_DATE
EOB	BANK OF AMERICA, N.A., [REDACTED]	[REDACTED]	3/8/2019 2:45:41 PM
CAP	BANK OF AMERICA, N.A., [REDACTED]	[REDACTED]	3/8/2019 2:45:41 PM
INC	BANK OF AMERICA, N.A., [REDACTED]	[REDACTED]	3/8/2019 2:45:41 PM

Once all accounts are in the 'Select A Bank' status select icon to save.

CLAIMS ENTRY

[CMS-1500](#)

Claims Entry

- CMS-1500
- UB-04
- LTC
- LTC (Entry Only)

There are four different types of claim forms that are supported on the Website: CMS-1500, UB-04, LTC, and LTC (Entry Only) Form. Below we will use the most common claim form type, the CMS-1500, for illustration.

Once you submit your claim you will receive a **Claim Control Number (CCN)**. Every CCN is a unique identifier for each claim submitted to CenCal Health. The CCN consists of the date the claim is received (e.g. 20050309), the provider type (e.g. 02 is medical), the claim type (e.g. 88 is a Medi-Medi crossover claim), and a sequence number. For website submitted claims, the claim type is 09.

An example of a CCN appears below:

CenCal Health CMS-1500 Form

Your form was received successfully.

Your Claim Control Number is **2016091402923640**

CenCal Health CMS-1500 Form

CCN []

Plan [] Claim Type [Physician] Provider# [1225184963] Member# [] Condition Related to [] Anesthesia [] PickUp []

Onset Date [] Referring Prov# [] Relationship [Self] Pat. Status [] Auto Acc [] Stop []

Other Acc [] SOC []

Reserved For Local Use []

Diagnosis Codes: A. [] B. [] C. [] D. [] E. [] F. [] G. [] H. [] I. [] J. [] K. [] L. []

Hospitalization From [] To [] Outside Lab? []

	Dates of Service From	To	Place of Svc	Emg	BL	Proc#	Modif*	Diag Codes	Charge	Quan	Fam Plan	Rendering Prov#	Taxonomy**	Auth#	NDC#
1															
2															
3															
4															
5															
6															

Patient Acct# [] Total Charge [] Provider Taxonomy** []

[Submit Form] [Query] [Reset Form]

To maneuver through the screen use your Tab key. Shift + Tab will allow you to move back one box. Click on the 'Submit Form' button to send the claim. Note: Your Enter key will reset the screen NOT submit the claim.

Dates are entered in the YYYYMMDD format (e.g. 20010321 for March 21, 2001).

Once the claim is completed, press the **Submit Form** icon. Keep in mind your 'Enter' key will reset the form. After submitting, you will receive a message, "Your form was received successfully. Your Claim Control Number is YYYYMMDD0#9#####" as shown above.

You may then select Edit this Claim or Continue to a new Claim. If you select Edit this Claim, it will take you to the CenCal Health Claim Editor (see below). You will see a summary of the claim including the Explain Codes (Ex Codes). This is how the claim will appear on your next Explanation of Benefits (EOB).

CenCal Health Claim Editor

CCN [2016] Provider# [WEBPROV] Name [John Doe]

Plan [SBHI] Member# [WEBMEMB] Name [Smith, Jennifer] DOB [20000101] Sex [F]

Line#	Eff Date	End Date	Proc/Drug	Mod	Quantity	Allowed Amt	Paid Amt	Paid	Ex Codes
0100	20160915	20160915	99213		1.0	\$32.20	\$0.00	DN	3L

Explain Codes

3L MEMBER'S AID CODE NOT COVERED BY CENCAL HEALTH - PROVIDER MUST BILL STATE MEDI-CAL

If your claim is denied, you may make corrections to the claim by selecting Modify this Claim. Once you're done making the corrections, press the Edit Claim button. Please be aware that some claims might be in a pended status and will be reviewed by CenCal staff.

You may edit the claim up to the time that it appears on the EOB. If you need to make corrections to a claim that already appeared on an EOB, you may do so by submitting a new claim along with the required correction online.

You may not use the Back button on your web browser to make changes. Instead, use the Edit this Claim button to edit the claim, and the claim will re-appear just as you submitted it, except that the CCN will appear in the top left corner of the claim.

CenCal Health CMS-1500 Form

CCN [] Plan [] Claim Type [Physician] Provider# [WEBPROV] Member# [] Condition Related to [] Anesthesia [] PickUp []

Onset Date [] Referring Prov# [] Relationship [Self] Pat. Status [] Auto Acc [] Stop [] Other Acc [] SOC []

Reserved For Local Use []

Diagnosis Codes: A [] B [] C [] D [] E [] F [] G [] H [] I [] J [] K [] L []

Hospitalization [] Outside Lab? []

Dates of Service	Place of Svc	Emg	BL	Proc#	Modif*	Diag Codes	Charge	Quan	Fam Plan	Rendering Prov#	Taxonomy**	Auth#	NDC#
1													
2													
3													
4													
5													
6													

Patient Acc# [] Total Charge [] Provider Taxonomy** []

Submit Form Query Reset Form

When you are finished entering your claims, you may select the Reports option on the left side of the screen, and choose Daily Claims.

CLAIM REPORT

Reports

Daily Claims

Enter the 'Claims Entry Date' and a list will appear. On this Daily Claim Report, you will see for each claim line the CCN, Line Number, Provider Number, Member Number, Procedure Code used, any Modifiers, Quantity, Paid Amount, Payment Status, and Explain Codes.

Reset Form **CenCal Health Daily Claim Report**

Claim Entry Date: 20160914

Submit Form Reset Form

CenCal Health Daily Claim Report
Web Claims for : 20160914

CCN	Line#	Prov#	Member#	Proc / Drug#	Mod	Quantity	Paid Amt	Paid	Ex Codes
2016091402923630	0100	Webprov	Webmember	G0154		4.0	\$150.00	PN	,10
	0200	Webprov	Webmember	G0162		4.0	\$30.13	PN	,10,03
	1						\$180.13		

You may also query and pull up a previously submitted claim by entering the CCN and pressing the Query button at the bottom of the claim screen.

If the claim line has appeared on your EOB, you cannot make changes to the claim.

UB-04 Form

CenCal Health UB-04 Form

CCN [] Plan [] Claim Type [Outpatient] Provider# [WEBPROV] Member# [] Patient# [] Statement From / Thru [] Bill Type [] Taxonomy** []

Mar. Stat [] Admit Date [] Hour [] Type [] Src [] Dhr [] Stat [] Medical Rec# [] Condition Codes [] Delay Reason []

Occurrence Codes / Dates [] Value Codes / Amount []

Rev Cd	Proc#	Mod	Serv Date	End Date	Units	Total Charge	Authorization	SOC	NDC#
1									
2									
3									
4									
5									
6									
7									
8									
9									

Authorization [] Total Charge [] SOC [] DRG [] Attending Prov# [] Operating Prov# [] Admitting Prov# [] Admit Diag [] Relationship []

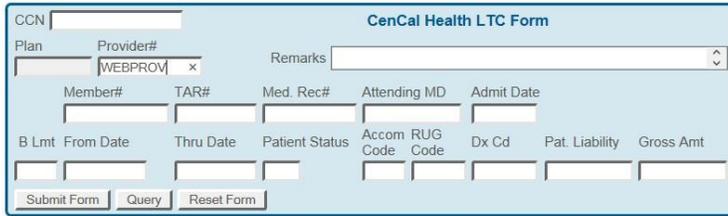
Diagnosis Codes / POA Indicator []

Principal Proc/Date [] Other Proc/Date [] Other Proc/Date [] Remarks []

Submit Form Query Reset Form

Long Term Care Claim Submission

For Long Term Care claim submissions, there are two forms. Below you will find the information for each one. There are two separate forms for submitting website claims for Long Term Care (LTC). The first form, LTC, allows the provider to enter one claim line at a time. This allows the online adjudicator to review the claim and make a determination as to it being payable, deniable, or pended. If you use this form, you will be able to review each and every claim line immediately, and then make corrections.

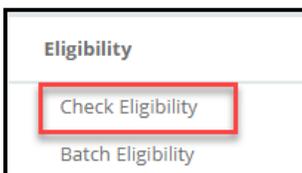


The second form, **LTC (Entry Only)** has multiple claim lines, so the online adjudicator will not be able to review the claim and therefore you will not see the Claim Editor. Claims submitted this way can be reviewed and edited through the LTC entry form.

On this form you must select the appropriate CenCal health program from the drop down box at the top of the form.

ELIGIBILITY

Check Eligibility



This system only looks within CenCal Health's member/subscriber database for the eligibility. CenCal Health does NOT determine eligibility and a member's eligibility with CenCal Health can change.



Check Eligibility/ Save as PDF/ Reset Form Fields

Required Filters

1. Enter the Member's nine (9) digit ID Number **or** Last four (4) numbers of Member's social security number (SSN)
2. Enter Date of Birth **or** Member's First Name/ Last Name
3. Enter Date of Service (DOS) current or past date in the format mm/dd/yyyy
4. Click  'Check Eligibility' icon
 - ❖ Tip: Click the 'reset'  icon to refresh your search

Member Info: As Of 08/02/2019 Inquiry Date: 8/5/2019 1:19:47 PM - Confirmation: 89550

Member ID	Name	Sex	Special Case
		M	None
Medicare Parts - A,B,D	HIC#	DOB	Other Carriers
			HUMANA INSURANCE COMPANY (800) 281-691

Eligibility History: Last 12 Months As Of 08/02/2019

PCP Name (Phone)	Plan	Date range	Eligible	SOC	Benefits	Other Insurance (COB)
CenCal Health 8778141861	SBHI	08/01/2019 - 08/31/2019	Y	\$999.00	Full	D - Medicare Part D Prescription Drug Coverage

Services: As Of 08/02/2019

	Allowed	Used	Remaining
Medi-Services (MTD)	2	0	2
PT Visits (YTD)	18	0	18

Case Management: Last 12 Months As Of 08/02/2019

Program	Reason	Case Manager	Date Range
There are no Case Managers during the date range provided			

* Specialized Programs:
 CM = CenCal Health Case Management
 PHD-CM = Public Health Department Case Management
 TCRC = Tri Counties Regional Center

* Restricted Services - Noted by Eligible Aid Code:
 Restricted to LTC and Related Services (53)
 Restricted to Breast and Cervical Cancer Treatments (OR, OU, OT)

Primary Care Provider (PCP) Name (Phone) drop down indicates last (12) twelve months of eligibility as of the date of service entry.

Eligibility History: Last 12 Months As Of 08/02/2019

PCP Name (Phone)	Plan	Date range	Eligible	SOC	Benefits	Other Insurance (COB)
CenCal Health 8778141861	SBHI	08/01/2019 - 08/31/2019	Y	\$999.00	Full	D - Medicare Part D Prescription Drug Coverage
CenCal Health 8778141861	SBHI	07/01/2019 - 07/31/2019	Y	\$999.00	Full	D - Medicare Part D Prescription Drug Coverage
CenCal Health 8778141861	SBHI	06/01/2019 - 06/30/2019	Y	\$999.00	Full	D - Medicare Part D Prescription Drug Coverage
CenCal Health 8778141861	SBHI	05/01/2019 - 05/31/2019	Y	\$864.00	Full	D - Medicare Part D Prescription Drug Coverage
CenCal Health 8778141861	SBHI	04/01/2019 - 04/30/2019	Y	\$864.00	Full	D - Medicare Part D Prescription Drug Coverage
CenCal Health 8778141861	SBHI	03/01/2019 - 03/31/2019	N	\$864.00	Full	D - Medicare Part D Prescription Drug Coverage
CenCal Health 8778141861	SBHI	01/01/2019 - 02/28/2019	Y	\$864.00	Full	D - Medicare Part D Prescription Drug Coverage
CenCal Health 8778141861	SBHI	12/01/2018 - 12/31/2018	Y	\$864.00	Full	D - Medicare Part D Prescription Drug Coverage
CenCal Health 8778141861	SBHI	11/01/2018 - 11/30/2018	Y	\$999.00	Full	D - Medicare Part D Prescription Drug Coverage
CenCal Health 8778141861	SBHI	05/01/2018 - 10/31/2018	Y	\$999.00	Full	D - Medicare Part D Prescription Drug Coverage

If you have a non eligible member, you will see a red 'N' listed under 'Eligibility' and you can 'Check with DHS' directly by clicking on the orange box above.

Member ID or Last 4 of SSN Date of Birth First Name Last Name Date of Service (DOS)

Member is not eligible on 03/13/2019 DHS Check SOC Trans

Member Info: As Of 03/13/2019 Inquiry Date: 8/5/2019 1:44:28 PM - Confirmation: 89554

Member ID	Name	Sex	Special Case
		M	None
Medicare Parts - A,B,D	HIC#	DOB	Other Carriers

Eligibility History: Last 12 Months As Of 03/13/2019

PCP Name (Phone)	Plan	Date range	Eligible	SOC	Benefits	Other Insurance (COB)
CenCal Health 8778141861	SBHI	03/01/2019 - 03/31/2019	N	\$864.00	Full	D - Medicare Part D Prescription Drug Coverage

Case Management: Last 12 Months As Of 03/13/2019

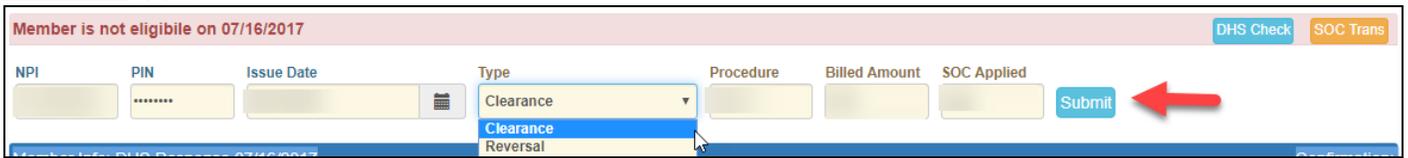
Program	Reason	Case Manager	Date Range
There are no Case Managers during the date range provided			

* Specialized Programs:
 CM = CenCal Health Case Management
 PHD-CM = Public Health Department Case Management
 TCRC = Tri Counties Regional Center

* Restricted Services - Noted by Eligible Aid Code:
 Restricted to LTC and Related Services (53)
 Restricted to Breast and Cervical Cancer Treatments (OR, OU, OT)

Share of Cost (Soc)

A red 'Member is not eligibility' indicator will appear if a member is not eligible. The User can then check eligibility with 'DHC Check'  and/or clear the members share of cost through the 'SOC Trans'  icon.



Enter providers NPI#, PIN, Issue Date, Clearance (drop down can also 'Reverse' transaction), Procedure Code, Billed Amount, and SOC Applied (members payment). Click 'Submit'  icon for confirmation details. Click the 'Save as PDF'  icon for print version for receipt of payment.



Note: It is the State, not CenCal Health that clears SOC. Although CenCal Health has the mechanisms to transmit this information to the State, no records are kept in our database. We strongly suggest that you print out the information if possible and place in the members record/file.

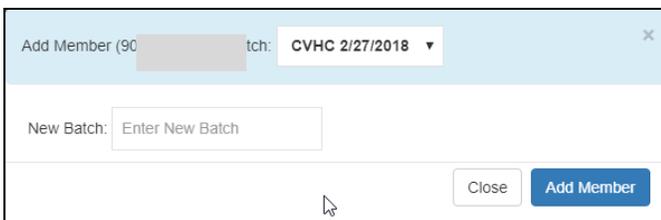
Note: Individuals within families may have varying SOC's. In these instances only the corresponding case number will need to be entered.

If for some reason an error has been entered, you will be able to make corrections by changing the Type to 'Reversal'. If it has been cleared to \$0.00 by mistake please document what happened in the member chart. Once a subscriber has been certified as having met the Share of Cost, reversal transactions may no longer be performed. Reversals may only be performed for partial clearance prior to the time the subscriber is certified as eligible.

Adding Member to batch from Eligibility Screen

After viewing eligibility, you may check eligibility  for a new member, Add Member to Batch , Save as PDF , or Reset Form  located on the top of the screen.

By clicking on the Add Member to Batch , the member information will auto populate, enter new batch name, and click . To add member to an existing batch, click the correct drop down name, and click .

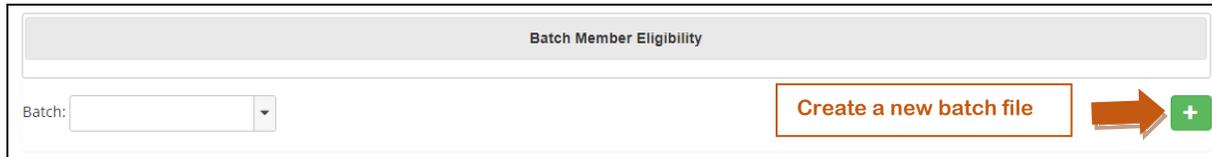


Batch Eligibility

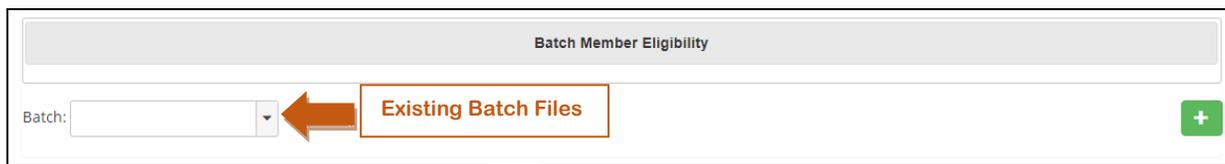


Batch Eligibility is used to verify eligibility for several Members. All provider types have access to this function and is not limited to Primary Care Physicians (PCP). The purpose of this screen is to allow providers to create files of members that are seen in their office on a regular basis, and view their eligibility within one file (i.e. CCS Members, Other Health Coverage Members, etc.)

To create a new batch, click the 'New Batch'  icon, and create your file name.

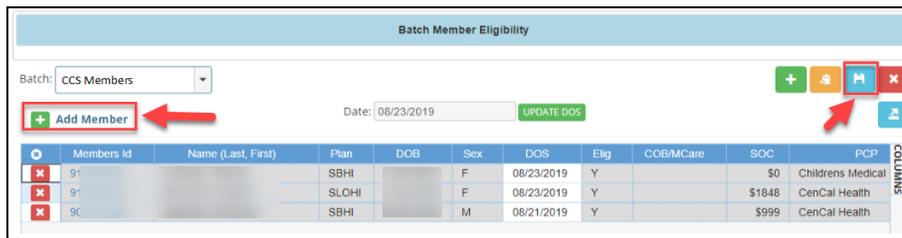


To review an 'Existing Batch' click on the drop down box to locate the file.



To add a member, click the green '+'  icon, and an additional row will be added.

Enter the Member ID, Name (Last, First), Date of Birth (DOB), and click the save  icon. You will then see the eligibility status of the member you manually enter, and/or add from the eligibility screen.



The member will then be added to the list and list their eligibility status.



To delete a member from the list, click on the red box  icon, and then click save .



Batch Member Eligibility

Batch: CCS Members

Create New Batch File, Copy a Batch, Save, Delete + 🔄 ✖

+ Add Member Date: 08/23/2019 UPDATE DOS Export to CVS 📄

	Members Id	Name (Last, First)	Plan	DOB	Sex	DOS	Elig	COB/MCare	SOC	PCP	COLUMNS
✖	91		SBHI		F	08/23/2019	Y		\$0	Childrens Medical	
✖	91		SLOHI		F	08/23/2019	Y		\$1848	CenCal Health	
✖	90		SBHI		M	08/21/2019	Y		\$999	CenCal Health	

Providers can create a new batch +, copy an existing batch to modify 🔄, or delete ✖ by clicking on the icons above. If you make changes to this screen, the Warning box will appear to save changes ✔, Do not save changes ⚠, or cancel request ✖.

Warning ✖

Would you like to save your changes?

✔ ⚠ ✖

TRANSACTION SERVICES

Medi-Reservation

Transaction Services

Medi-Reservation

Share of Cost

A two service per month limitation applies to all Limited Service Providers. Limited Service Providers consist of Audiologists, Acupuncturists, and Chiropractors. Services applied to the two services per month limitation do not require a Referral Authorization Form (RAF) from the member's PCP, but must be reserved through the Medi Reservation system below. A confirmation number will be given once the service is reserved. Please note: if a member needs additional audiology beyond the 2 service limit, additional authorization will be required. Members are restricted to a combined total of 2 acupuncture and chiropractic visits per month and will not be granted authorization for additional services beyond this limit.

The procedure code on the reservation must match the procedure code on the claim. If the code billed is different than the code reserved, reverse the reservation and resubmit it with the correct code. This can be done by selecting 'Reversal' in the drop down.

Reset Form **CenCal Health MEDI Reservations**

Type: Reservation

Prov#:

Member ID:

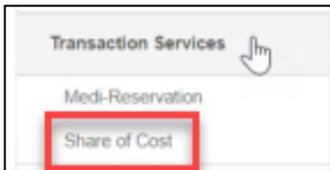
Service Date:

Procedure:

Submit Form Reset Form

Note: Providers should not reserve a Medi-Service unless certain that the service will be rendered. Providers who do not provide a Medi-Service that has been reserved must reverse the reservation to allow the recipient to obtain another service.

Share of Cost



A Share of Cost also known as SOC is a monthly dollar amount which a patient is required to pay before they become eligible with Medi-Cal and CenCal Health. We are not involved with determining this dollar amount, it is based on criteria supplied by the member to their Eligibility Worker at Department of Social Services. SOC patients are considered 'cash pay' patients until the SOC is met

every month and members will need to pay prior to becoming eligible for benefits. If a provider collects a payment prior to rendering service, it is their responsibility to clear the members share of cost through this tool, or directly from the members eligibility screen.

Data Requirements:

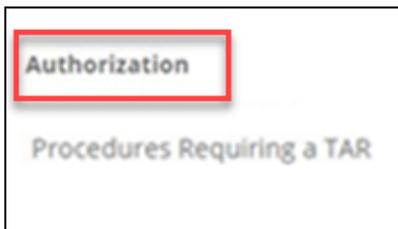
1. Type (Clearance/Reversal)
2. Provider Group NPI#
3. Provider PIN#
4. Member ID#
5. Case No (can be left blank)
6. Members Date of Birth
7. Issue Date
8. Service Date
9. Procedure Code
10. Billed Amount (Customary charge for service)
11. SOC Applied (Amount collected from the Member)

A screenshot of the 'DHS Share of Cost' form. The form has a title bar with 'Reset Form' and 'DHS Share of Cost'. Below the title bar, there are several input fields and dropdown menus, each with a red circle containing a number from 1 to 11. The fields are: Type (dropdown, 1), Prov# (text, 2), Issue Date (text, 7), Pinst (text, 3), Service Date (text, 8), Member ID (text, 4), Procedure (text, 9), Case No (text, 5), Billed Amount (text, 10), Date of Birth (text, 6), and SOC Applied (text, 11). At the bottom of the form, there are 'Submit Form' and 'Reset Form' buttons.

Then click 'Submit Form'. The next screen will provide you with a receipt which shows the dollar amount collected and possibly the remaining amount due (if applicable). It is very important to clear the soc as soon as they are seen. In some circumstances, members will see other specialists in the same day or try and pick up their prescriptions, please print this receipt for the member for proof of payment.

AUTHORIZATION

Authorization



There are four (4) Authorization types that providers can submit online such as the Medical TAR (50-1), Request for Extension of Stay in Hospital (18-1), LTC Authorization Form (20-1), and the PCP Referral Authorization Form (RAF).

The main home screen allows a provider to see a list of authorization types, a hyperlink to view a specific authorization, the status,

Requesting Provider, and Servicing Provider.

Providers can filter their search by entering the Authorization Number (Auth No), Member ID, Member Name, Status (Pended, Approved, Denied), Received Date, Date of Service, Decision Date, and then click  to filter your search. Once filtered, you may download the file into a CSV by clicking the  icon.

A screenshot of the 'Authorizations Module' search and results screen. The top section is the 'Search Criteria' area, which includes a 'Requesting Provider' dropdown, 'Auth No', 'Member ID', 'Member First Name', 'Member Last Name', and 'Status' dropdown. Below these are 'Received Date', 'Date of Service', 'Decision Date', and 'Result Size' dropdowns. A search icon is present. The bottom section is a table with columns: Auth No, Member..., Member, Type, Status, Requesting Provider, Servicing Provider, Rec Date, Dec Date, and St Date. The table contains three rows of data.

Auth No	Member...	Member	Type	Status	Requesting Provider	Servicing Provider	Rec Date	Dec Date	St Date
50-1			50-1	Pending	Central Coast ENT Speci...	Sansum Clinic	07/29/2021	07/29/2021	08/0...
18-1			18-1	Pending	Central Coast ENT Speci...	Central Coast ENT Speci...	07/29/2021	07/29/2021	08/0...
18-1			18-1	Approved	Coastal Valley Health Ce...	Coastal Valley Health Ce...	07/29/2021	07/29/2021	08/0...

To [submit a new authorization](#) request click the  icon.

When submitting a new authorization, **the form will require member verification by entering the Member ID#, First/Last Name, or Date of Birth (DOB).**

The form will then provide the user with the Member's PCP Group Name, PCP Group NPI#, PCP phone number, PCP fax number, and the member's eligibility effective dates.

Once entered, choose your **authorization type** (18-1, 20-1, 50-1, RAF) via the drop down arrow, and the form will auto populate with the field requirements.

Treatment Authorization Request (TAR 50-1) is submitted by the requesting provider for medical services including physician-administered-drugs, which need to be reviewed for medical necessity and appropriateness of care by CenCal Health.

Extension of Stay in Hospital 18-1 form is used to determine the medical necessity for admission and for continued acute care and to facilitate a transfer or transition of care. This should be submitted by the Admitting inpatient hospital, rehab clinic, or Long Term Acute Care (LTAC) facility.

LTC Authorization 20-1 form is used to determine the medical necessity for admission and for continued stay in a skilled nursing facility, subacute care, and a congregate living health facility, and should be submitted only by those facilities.

Referral Authorization Form (RAF) allows a PCP Group to refer their assigned members to a Specialist for consultation.

Then you will enter the **'Start Date'** and **'Expiration Date'** for your authorization. The users contact information will auto populate based off of the users access and will allow CenCal Health Medical Management Department to contact you for additional details (as needed).

Category drop down will allow the user to determine 'Pre-service' which is a prior authorization, 'Post-service' which would be used for retro authorizations, 'Concurrent' which would be used if the member was receiving additional services, or 'Pre-service/Concurrent Urgent' requests.

Remarks allows the user to 'Add Remarks:' specific to the service which is reviewed by our Medical Management Department.

If you are submitting a TAR, please provide the RAF# within your medical justification notes.

Requesting Provider is your provider group NPI# and if you have multiple NPI#'s associated to your IRS# it will provide you with a list so you can determine what site your member is assigned to.

Servicing Provider/Facility is used when a PCP is referring their member to a specialist. Users can enter a Specialist's NPI#, or search via the  icon.

Providers can search from a list of contracted CenCal Health Specialists by Plan, Area, and Specialty Type.

Click on the check box circle next to the Provider's NPI# from the list that you would like to refer to, and the providers NPI#, First Name, and Last Name will auto populate on the form then

click the  icon.

The Specialist's **Servicing Provider/Facility Info** address and phone number will populate on the form as additional verification.

Diagnosis code is required in the first Dx1 box, with following diagnostic codes as needed. You may also search by clicking on the  icon and you can search for a list of diagnosis codes.

#	Date(s) of Service*	Service Code	Modifier	Units	Qty*	Charge
1	to		Q	▼		
2	to		Q	▼		
3	to		Q	▼		
4	to		Q	▼		
5	to		Q	▼		
6	to		Q	▼		

Line Items will populate for the 50-1 Medical TAR form which requires Date(s) of Service, Service Code (procedure code or CPT code), Modifier, Units, Quantity, and Charge (billed charges).

To **submit your authorization**, click on the  icon, and if submitted successfully, the authorization # will populate on the top line in green, and will be placed on the first line item within the home.

Upload Attachments

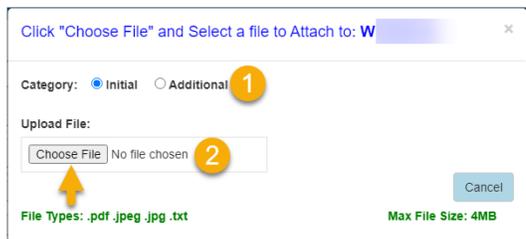
Once you save the details within your authorization, you have the ability to upload attachments for medical justification and supporting documentation so CenCal Health's Medical Management Department can further review.

Follow the steps below to attach your supporting documentation to new authorization requests.

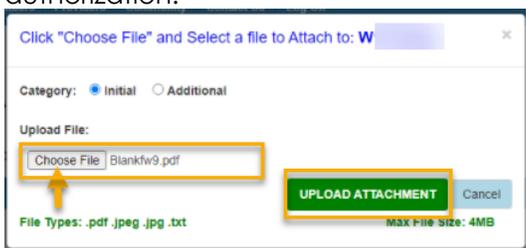
1. Enter all pertinent information to your Authorization Form (TAR, RAF, FORM 18-1, 20-1), then click  icon button. If all information submitted is valid, the Attach Button(s) will become visible via the  Attach button icon. If the authorization was not successfully submitted, the Attach Button(s) will not be visible

Click on the  Add Attachment icon to upload your supporting documents.

The submitted authorization number will appear on the attachment function. Follow the steps to indicate the Category type (Initial, or Additional), and then **Choose File** to upload documents from your file data source.



Once the document is chosen, the screen will indicate file name, and the **UPLOAD ATTACHMENT** icon button will appear once a file has been selected for upload. Click **UPLOAD ATTACHMENT** to save the document to the authorization.



The document(s) will then be connected to your authorization.

Attachments for Auth#: W [redacted]

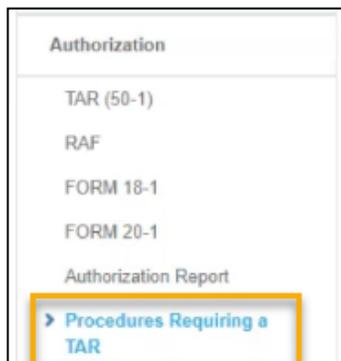
CATEGORY	SUB CATEGORY	SOURCE	FILENAME	DESCRIPTION	CREATED_BY	CREATED_DATE	
		Portal	2019_W-2_CenCal_Health.pdf			12/15/2020	Download
Initial		Portal-INI	Blank_Form.pdf	Member Notes		12/15/2020	Download

Page 1 of 1

- Use the **Download** button to get a copy of the attached document.
- Use the **+** button to add additional documents.
- Use the browser **←** back button to return to previous page.

All files will only be accessible for download for 30days from the created date, and will show as 'Not Available' on the list above once it hits the 30 day mark. CenCal Health staff will still have access to view internally.

Procedures Requiring a Tar



Certain procedures require prior authorization (i.e. Treatment Authorization Request (TAR)) before the procedure is rendered and reimbursement can be made. An authorization is needed to ensure that requested benefits are medically necessary, do not exceed benefit limits, and are the lowest cost item or service covered by the program which meets the member's medical needs.

The search tool can be used to determine whether a procedure code requires a prior authorization. The tool also provides additional information regarding the procedure code age, service, frequency, and diagnosis code limits/requirements upon claim submission. This additional information is displayed as billable units based on the procedure code description.

HCPCS/CPT Procedure Code - Prior Authorization Requirement Search Tool

Certain procedures require prior authorization (i.e. Treatment Authorization Request (TAR)) before the procedure is rendered and reimbursement can be made. An authorization is needed to ensure that requested benefits are medically necessary, do not exceed benefit limits, and are the lowest cost item or service covered by the program which meets the member's medical needs.

The search tool can be used to determine whether a procedure code requires a prior authorization. The tool also provides additional information regarding the procedure code age, service, frequency, and diagnosis code limits/requirements upon claim submission. This additional information is displayed as billable units based on the procedure code description.

Enter the Procedure Code and Date of Service you are searching, then click Submit. If you do not know the Procedure Code click the magnifying glass to search by procedure code description.

Prior Authorization tool is for TAR requirement only and not Referral Authorization Forms (RAF)s. For RAF requirements, please refer to this [site](#) or contact Medical Management at 805-562-1082.

Plan: Medi-Cal | Procedure Code: | Date of Service: 06/11/2021 | **SUBMIT** **RESET**

Enter the Procedure Code and Date of Service you are searching, then click [Submit](#). If you do not know the Procedure Code click the magnifying glass to search by procedure code description.

Plan: Medi-Cal | Procedure Code: 27447 | Date of Service: 06/11/2021 | **SUBMIT** **RESET**

Code: 27447
Description: Arthroplasty, Knee, Condyle And Plateau; Medial And Lateral Compartment W/Wo Patella Resurfacing
Age Range: N/A
Service Limit: N/A
Frequency Limit: N/A
Diagnosis List: N/A

Result: PROCEDURE CODE REQUIRES PRIOR AUTHORIZATION.

Additional Information: None

Notes:
 1) All efforts are made to provide the most current information on the Prior Authorization Search Tool. The results of this tool does not guarantee coverage, payment, or authorization
 2) Prior authorization is not a guarantee of payment for services. Payment is made in accordance with a determination of the member's eligibility on the date of service, benefit limitations/exclusions, evidence of medical necessity, and other applicable standards during the claim review, including the terms of any applicable provider agreement
 3) A Referral Authorization Form/Approval does not eliminate the need for a prior authorization
 4) For additional information on prior authorization submission please visit: [Cancel Health](#) or contact Medical Management at 805-562-1082
 5) Procedure codes available for purchase and rental, will only show the frequency limit for the purchase, when applicable. Rental limits are based on a rental period of one calendar month unless otherwise stated in the additional information section for that code.

Plan: Medi-Cal | Procedure Code: 99213 | Date of Service: 06/10/2021 | **SUBMIT** **RESET**

Code: 99213
Description: Office Or Other Outpatient Visit For The Evaluation And Management Of An Established Patient, Which Requires A Medically Appropriate History And/Or Examination And Low Level Of Medical Decision Making. When Using Time For Code Selection, 20-29 Minutes Of Total Time Is Spent On The Date Of The Encounter
Age Range: 0-999
Service Limit: 1 per day
Frequency Limit: N/A
Diagnosis List: N/A

Result: PROCEDURE CODE DOES NOT REQUIRE PRIOR AUTHORIZATION.

Additional Information: None

Notes:
 1) All efforts are made to provide the most current information on the Prior Authorization Search Tool. The results of this tool does not guarantee coverage, payment, or authorization
 2) Prior authorization is not a guarantee of payment for services. Payment is made in accordance with a determination of the member's eligibility on the date of service, benefit limitations/exclusions, evidence of medical necessity, and other applicable standards during the claim review, including the terms of any applicable provider agreement
 3) A Referral Authorization Form/Approval does not eliminate the need for a prior authorization
 4) For additional information on prior authorization submission please visit: [Cancel Health](#) or contact Medical Management at 805-562-1082
 5) Procedure codes available for purchase and rental, will only show the frequency limit for the purchase, when applicable. Rental limits are based on a rental period of one calendar month unless otherwise stated in the additional information section for that code.

REPORTS

Reports

- Capitation
- PCP Mid-Month
- Case Management
- Patient Profile
- Claim Status
- Claim Report
- Explain Codes
- Authorization Report
- PCP 834 Download
- Submitter Report
- ER Report

[Daily Claims](#) – Please refer to the Claims Entry section of guide.

[Capitation](#) - This PCP monthly capitation report shows member aid codes, ages, and guaranteed payment amount per member per month. Below will reflect payment of summary per PCP practice. This report can be downloaded or printed by clicking on the icon.

[Pcp Mid-Month](#) – This report outlines a PCPs new or deleted assigned members per month. This reflects changes that are made prior to the middle of each month.

[Case Management](#) – This report will show a PCPs Case Management List. You may query by plan on any month of any year.

[Patient Profile](#) – This report shows all services performed for a particular member during a specified time period by the provider. Enter a valid member ID number, program, from/thru dates, then click on **Submit Form** for a member claim report which shows all claims you have submitted on behalf of that member. To do another report, simply click on the **Reset Form** button.

[Claim Status](#) – Allows a provider to review all claims that have been submitted to date that are payable, deniable, or pending. You select which program you wish to run the report on and the provider number.

[Claim Report](#) – Allows a provider to review large volumes of claims at once. The maximum date span is 200 days. This report shows the same information as the Daily Claims Report but on a larger scale.

[Explain Codes](#) – This is a list of the Explain Codes which appear on the Claims Editor, Daily Claims Report, Patient and Provider Profiles, and EOBs.

[Pcp 834 Download](#) -This is a HIPAA compliant Case Management file which generates an online report. Benefit Enrollment and Maintenance documents objective is to clarify what segments CenCal Health's 834 will contain, along with clarifying the definition of "generic fields" (i.e., group policy number). Please click on the '[Download the SBRHA 834 Companion Guide](#)' for more information.

Note: HIPAA is clear that member information that is sent in a file to a payer or provider must be in HIPAA format

[Submitter Report](#) – Displays a report of claims submitted through a clearinghouse by a provider and gives the claim status w/ link to edit minimal service line data and ability to reedit.

[Er Report](#) – This is an online tool for Primary Care Provider to assist in the care of their assigned members by monitoring ER usage.

COORDINATION OF CARE



This is an online tool for Primary Care Providers to review their practice and manage the care their members are receiving.

Each report is grouped with appropriate member data and allow for individual 360 member information upon clicking on individual Member ID#.

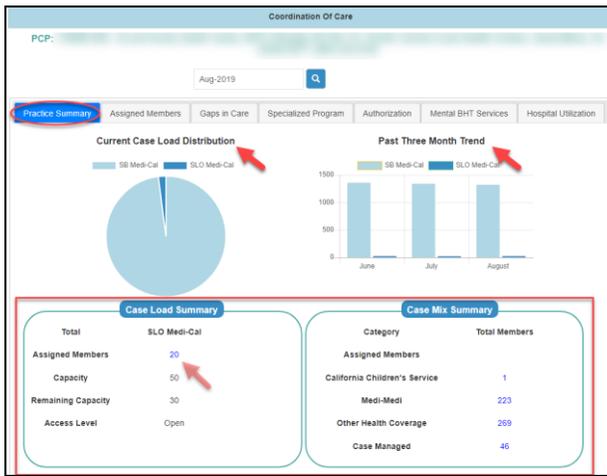
Indicate your provider number and Month/Year in which you would like your practice reports to appear.

[Practice Summary](#)

The cover screen will automatically start with the  tab.

[Current Case Load Distribution & Past Three Month Trends](#)

Here you can see how many members your practice has under the SB Medi-Cal & SLO Medi-Cal program, and the past three month trends under each program assigned to your practice.



Case Load Summary

Assigned Members: Indicates the quantity of assigned members, under each plan ID (SB Medi-Cal, and SLO Medi-Cal) assigned to your practice within that date range.

Capacity: Indicates the total amount of members, under each plan ID (SB Medi-Cal, and SLO Medi-Cal), you want to manage within that date range.

Remaining Capacity: Indicates how many additional members your practice can add to your capacity list.

Access Level: EPO (Established Patients Only) & Auto Assign, under each plan ID (SB Medi-Cal, and SLO Medi-Cal) assigned to your practice within that date range.

Case Mix Summary

This box indicates a total amount of members the practice is assigned to, in the California Children's Services (CCS) program, Medi-Medi members, have Other Health Coverage, and are under Case Management.

- ❖ **Helpful Tip:** You can click additional Member Assigned details if a number on this screen is indicated in blue.
- ❖ **Helpful Top:** The additional tabs below allows the user to export to CSV report by clicking on  icon

Assigned Members

Displays all of your assigned members with 'Continuous' care, 'New' assigned members in green. This report also identifies which members are due for their IHA visits.

Member ID	Member No.	Plan	Language	Eligibility St.	Special Care	CHC	Address	IHA (Due by)
2		SB Medi-Cal	English	Continuous		N		
2		SB Medi-Cal	English	Continuous		N		
2		SB Medi-Cal	English	Continuous		N		
2		SB Medi-Cal	Spanish	Continuous		N		
2		SB Medi-Cal	English	Continuous		N		
2		SB Medi-Cal	English	Continuous		Y		
2		SB Medi-Cal	English	Continuous		N		
2		SB Medi-Cal	Spanish	Continuous		Y		
2		SB Medi-Cal	English	Continuous		Y		
2		SB Medi-Cal	Spanish	Continuous		N		
2		SB Medi-Cal	English	Continuous		N		
2		SB Medi-Cal	Spanish	Continuous		Y		
2		SB Medi-Cal	English	Continuous		N		
2		SB Medi-Cal	Spanish	Continuous		N		
2		SB Medi-Cal	English	Continuous		Y		
2		SB Medi-Cal	Spanish	Continuous		N		
2		SB Medi-Cal	English	Continuous		Y		
2		SB Medi-Cal	Spanish	Continuous		N		
2		SB Medi-Cal	English	Continuous		Y		
2		SB Medi-Cal	English	Continuous		N		

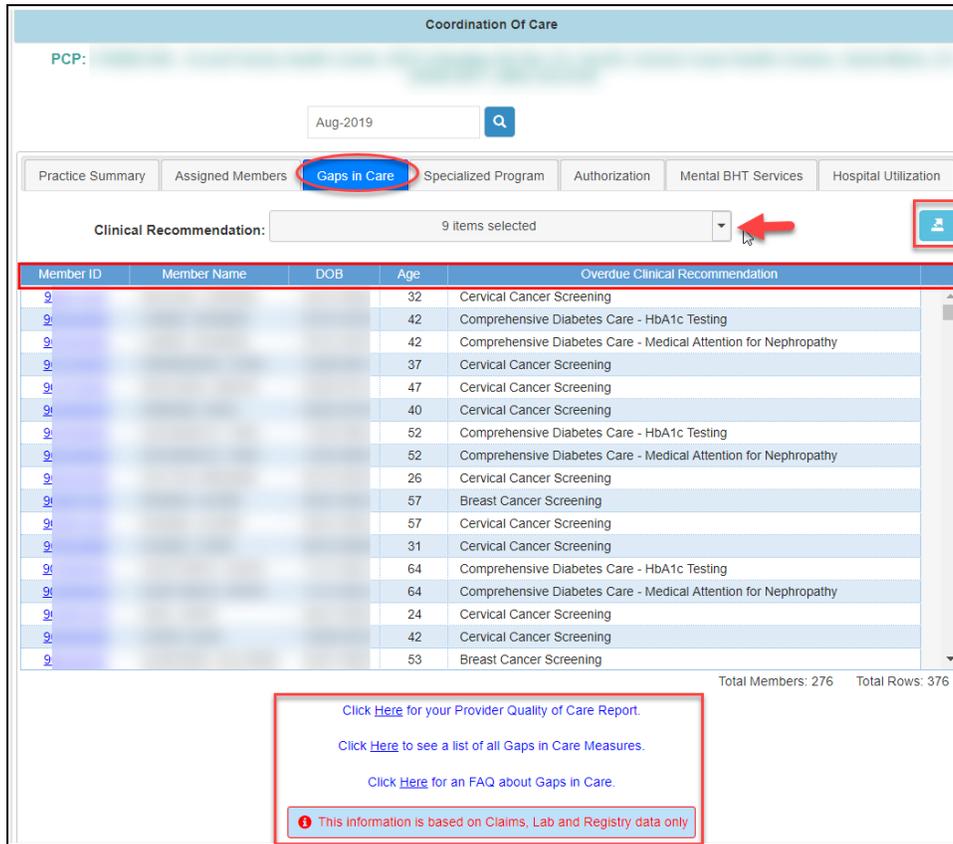
IHA (Due by)
12/30/2019

Click on the 'Show Reassigned only' button for a list of members that are no longer assigned to your practice and to see a list of ineligible members indicated in red.

All columns can be filtered per your needs, and export to a csv download by clicking on the  icon.

Gaps In Care

Identifies members who are due for clinically recommended services to help Primary Care Providers continue providing high quality health care for members who are due for one or more aspects of care.



Coordination Of Care

PCP:

Aug-2019

Practice Summary Assigned Members **Gaps in Care** Specialized Program Authorization Mental BHT Services Hospital Utilization

Clinical Recommendation: 9 items selected

Member ID	Member Name	DOB	Age	Overdue Clinical Recommendation
9			32	Cervical Cancer Screening
9			42	Comprehensive Diabetes Care - HbA1c Testing
9			42	Comprehensive Diabetes Care - Medical Attention for Nephropathy
9			37	Cervical Cancer Screening
9			47	Cervical Cancer Screening
9			40	Cervical Cancer Screening
9			52	Comprehensive Diabetes Care - HbA1c Testing
9			52	Comprehensive Diabetes Care - Medical Attention for Nephropathy
9			26	Cervical Cancer Screening
9			57	Breast Cancer Screening
9			57	Cervical Cancer Screening
9			31	Cervical Cancer Screening
9			64	Comprehensive Diabetes Care - HbA1c Testing
9			64	Comprehensive Diabetes Care - Medical Attention for Nephropathy
9			24	Cervical Cancer Screening
9			42	Cervical Cancer Screening
9			53	Breast Cancer Screening

Total Members: 276 Total Rows: 376

[Click Here for your Provider Quality of Care Report.](#)

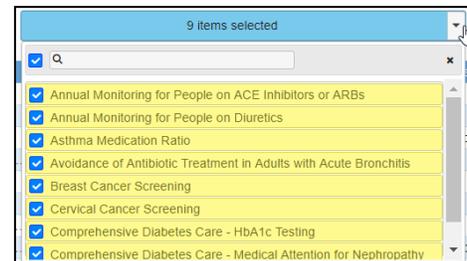
[Click Here to see a list of all Gaps in Care Measures.](#)

[Click Here for an FAQ about Gaps in Care.](#)

This information is based on Claims, Lab and Registry data only

Click on the 'Clinical Recommendation' drop down to filter your 'Overdue Clinical Recommendation' member report.

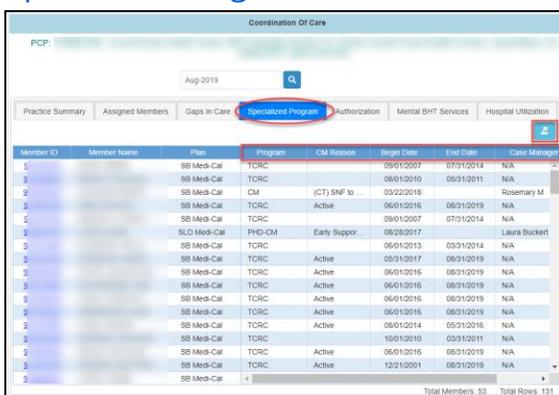
Additional information on Quality of Care Reports, Gaps in Care Measures, and FAQ is available via the links on this tab.



9 items selected

- Annual Monitoring for People on ACE Inhibitors or ARBs
- Annual Monitoring for People on Diuretics
- Asthma Medication Ratio
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
- Breast Cancer Screening
- Cervical Cancer Screening
- Comprehensive Diabetes Care - HbA1c Testing
- Comprehensive Diabetes Care - Medical Attention for Nephropathy

Specialized Program



Coordination Of Care

PCP:

Aug-2019

Practice Summary Assigned Members Gaps in Care **Specialized Program** Authorization Mental BHT Services Hospital Utilization

Member ID	Member Name	Plan	Program	CM Reason	Begin Date	End Date	Case Manager
9	SB Med-Cal	TCRC			09/12/2007	07/31/2014	N/A
9	SB Med-Cal	TCRC			28/01/2010	09/31/2011	N/A
9	SB Med-Cal	CM	(CT) SNF to		03/22/2018		Rosemary M
9	SB Med-Cal	TCRC	Active		06/01/2016	08/31/2019	N/A
9	SB Med-Cal	TCRC			09/01/2007	07/31/2014	N/A
9	S/O Med-Cal	PHD-CM	Early Suppor		08/28/2017		Laura Buckert
9	SB Med-Cal	TCRC			06/01/2013	03/31/2014	N/A
9	SB Med-Cal	TCRC	Active		20/31/2017	08/31/2019	N/A
9	SB Med-Cal	TCRC	Active		06/01/2016	08/31/2019	N/A
9	SB Med-Cal	TCRC	Active		06/01/2016	08/31/2019	N/A
9	SB Med-Cal	TCRC	Active		06/01/2016	08/31/2019	N/A
9	SB Med-Cal	TCRC	Active		06/01/2016	08/31/2019	N/A
9	SB Med-Cal	TCRC	Active		06/01/2016	08/31/2019	N/A
9	SB Med-Cal	TCRC	Active		06/01/2016	08/31/2019	N/A
9	SB Med-Cal	TCRC	Active		06/01/2016	08/31/2019	N/A
9	SB Med-Cal	TCRC	Active		06/01/2016	08/31/2019	N/A
9	SB Med-Cal	TCRC	Active		06/01/2016	08/31/2019	N/A
9	SB Med-Cal	TCRC	Active		12/21/2001	08/31/2019	N/A
9	SB Med-Cal						

Total Members: 53 Total Rows: 131

The purpose of this tab is to view all members assigned to them and see which program the member is case Managed under. The report indicates the CM Reason, Begin Date, End Date, and Case Manager Name.

Authorization Utilization

Member ID	Member Name	Auth #	Status	Claim	Referral Provider Name	Start Date	End Date	Plan
9		Rf	Approved	N	Arroyo Grande Commu...	06/07/2019	09/04/2019	SB Medi-...
9		Rf	Approved	N	Dignity Health	06/07/2019	09/04/2019	SB Medi-...
9		Rf	Approved	N	Marian Regional Medica...	06/07/2019	09/04/2019	SB Medi-...
9		W	Approved	N	Pacific Central Coast H...	06/25/2019	09/25/2019	SB Medi-...
9		W	Approved	N	Santa Maria Speciality H...	06/25/2019	09/25/2019	SB Medi-...
9		A	Approved	N	USC University Hospital	01/25/2019	01/24/2020	SB Medi-...
9		A	Approved	N	USC Kenneth Norris Jr ...	01/25/2019	01/24/2020	SB Medi-...
9		A	Cancel	N	USC Kenneth Norris Jr ...	01/25/2019	01/24/2020	SB Medi-...
9		A	Approved	N	USC Care Medical Group	01/25/2019	01/24/2020	SB Medi-...
9		A	Approved	N	USC University Hospital	07/09/2019	12/31/2019	SB Medi-...
9		Rf	Modified	N	USC University Hospital	07/09/2019	10/06/2019	SB Medi-...
9		W	Approved	N	House Ear Clinic	03/21/2019	09/21/2019	SB Medi-...
9		W	Approved	Y	Best Care Pharmacy	05/21/2019	09/16/2019	SB Medi-...
9		W	Approved	N	Sims Physical Therapy Inc	07/24/2019	08/31/2019	SB Medi-...
9		A	Approved	N	Ventura Transit System ...	07/03/2019	07/01/2020	SB Medi-...
9		Rf	Approved	N	Pueblo Radiology Medic...	07/03/2019	09/30/2019	SB Medi-...

Purpose is to allow Primary Care Physicians (PCP) to manage their assigned members referral visit and check the status of each authorization, and provide follow-up care as needed. 'Visit Complete' is pulled from claims data received by CenCal Health.

Mental BHT Services

Member ID	Member Name	Plan	Auth #	Category	Provider	Requested Date	Total Approvals
1		SB Medi-Cal	MHC	RET	Eduardo G.	01/22/2019	01/22/2019
1		SB Medi-Cal	MHC	RET	Eduardo G.	04/29/2019	04/29/2019
1		SB Medi-Cal	MHC	ROU	Elizabeth S.	11/16/2018	11/27/2018
1		SB Medi-Cal	MHC	ROU	Elizabeth S.	11/16/2018	11/27/2018
1		SB Medi-Cal	MHC	RET	Elizabeth S.	01/23/2019	02/06/2019
1		SB Medi-Cal	MHC	RET	Elizabeth S.	05/24/2019	05/28/2019
1		SB Medi-Cal	MHC	ROU	Pamela Jor.	01/15/2019	01/25/2019
1		SB Medi-Cal	MHC	RET	Pedro Gut.	01/11/2019	01/11/2019
1		SB Medi-Cal	MHC	ROU	Clark Elliott	05/20/2019	05/21/2019
1		SB Medi-Cal	MHC	ROU	Clark Elliott	05/20/2019	05/21/2019
1		SB Medi-Cal	MHC	RET	Jasmin Fra	04/10/2019	04/10/2019
1		SB Medi-Cal	MHC	ROU	Jasmin Fra	06/26/2019	07/06/2019
1		SB Medi-Cal	MHC	ROU	Jasmin Fra	06/26/2019	07/06/2019
1		SB Medi-Cal	MHC	ROU	Karen Hold	12/28/2018	01/03/2019
1		SB Medi-Cal	MHC	ROU	Karen Hold	12/28/2018	01/03/2019
1		SB Medi-Cal	MHC	ROU	Pamela Jor.	12/28/2018	01/03/2019

Mental/BHT referrals, authorization and coordination of services will be managed by the CenCal Health Behavioral Health delegate- The HOLMAN Group to ensure that members have access to services according to expected standards and that duplicative services are not being provided. Through this tab, Providers can View the authorization data received from The HOLMAN Group, the information of the qualified BHT provider, and the First Date of service, and data on the approval (number of days).

Hospital Utilization

Member ID	Member Name	Plan	# of ER Visits	Primary Diagnosis	Admit Type	Admit Date	Provider
2		SB Medi-Cal	0	Interventrolal dpc.	Emergency	07/09/2019	Marian
2		SB Medi-Cal	0	Spiral stairnals, c.	Elective	06/23/2019	Charm
2		SB Medi-Cal	0	Schizoaffective d.	Urgent	01/08/2019	Sherm
2		SB Medi-Cal	0	Displaced commi.	Trauma Center	04/24/2019	Marian
2		SB Medi-Cal	0	Transient cerebra.	Emergency	02/12/2019	Marian
2		SB Medi-Cal	0	Single sylvom inf.	Newborn	08/01/2019	Marian
2		SB Medi-Cal	0	Mild hypertension.	Urgent	01/16/2019	Marian
2		SB Medi-Cal	0	Morbid (severe) o.	Elective	11/20/2018	Marian
2		SB Medi-Cal	0	Gram-negative se.	Emergency	02/23/2019	Marian
2		SB Medi-Cal	0	Matern care for is.	Elective	11/15/2018	Marian
2		SB Medi-Cal	0	Single sylvom inf.	Newborn	11/15/2018	Marian
2		SB Medi-Cal	0	Other chest pain	Urgent	12/16/2018	Marian
2		SB Medi-Cal	0	Throat (postobstr.	Emergency	03/27/2019	Marian
2		SB Medi-Cal	0	Hypertensive urg.	Emergency	04/20/2019	Santa F
2		SB Medi-Cal	0	Disease of intest.	Elective	12/13/2018	Marian
2		SB Medi-Cal	0	Displaced commi.	Emergency	12/16/2018	Marian

Emergency Room (ER) Utilization data is based on what is reported to CenCal Health through the real-time ER data feeds by only the following in-network hospitals: Cottage Health System, Catholic Healthcare West, and Lompoc District Hospital and claims feed. As a result, this report may not reflect all ER visits for your assigned members.

PROCEDURE PRICER



CenCal Health hopes you find this reimbursement rate information for various procedure codes useful. The reimbursement rates are the latest in CenCal Health's database for contracted providers who do not have special contracts covering the procedure codes.

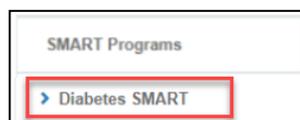
The use of modifiers with the procedure codes will affect the reimbursement rates. In some cases, the member's age and status can also influence the rate. In addition, CenCal Health reserves the right to retroactively or prospectively change the rates, and the rates may be affected retroactively or prospectively by State changes to the basic Medi-Cal rates.

After completing the necessary fields, click the button **Price It** or press the **Enter** key, and a price will appear in the field labeled **Allowable**, which is the current allowable for that particular procedure on that date of service. You may also receive messages like "not a benefit", "modifier required", or "manual pricing" in that field.

IMPORTANT REMINDER: Providers should always bill CenCal Health with their usual and customary charged amounts and not the allowable that appears on this screen or their EOBs. We are constantly changing and updating our data, including reimbursement rates, and you could short-change yourself.

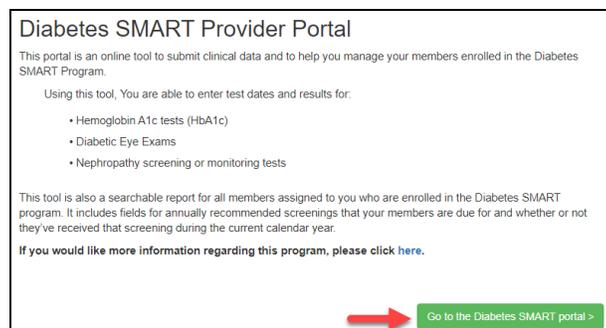
SMART PROGRAMS

Diabetes Smart



CenCal Health identifies members with certain chronic conditions and develops and implements network-based Disease Management Programs to address their health care needs. These programs work with PCPs and specialists to improve

clinical outcomes, reduce or delay long-term complications, and manage the member's care in a cost-effective manner.



This online tool allows our providers to view and submit clinical data to help you manage your members enrolled in the Diabetes SMART Program.

Using this tool, you are able to enter test dates and results for:

- Hemoglobin A1c tests (HbA1c)
- Diabetic Eye Exams
- Nephropathy screening or monitoring tests

In addition, it can be used as a report for all members assigned to you and/or who are enrolled in the Diabetes SMART program. It includes fields for annually recommended screenings that your members are due for and whether or not they've received that screening during the current calendar year.

The Diabetes SMART Clinical tool is where you will enter clinical test results for a specific member enrolled in the Diabetes SMART program, and have the ability to export to a CSV file for your own clinical reports.

Export to CSV/ Save Changes/ Cancel

Newly Enrolled Members Members with No Results

Member Id	Name	DOB	Test Date	Test Type	Test Result	Test Value	Rendering#	Rendering Name
9			08/07/2019	NEPH	Pos			
9			08/06/2019	HbA1c		12		
9			08/05/2019	NEPH	Pos			
9			08/04/2019	HbA1c		21		
9			08/01/2019	HbA1c		13		
9			04/17/2019	EYE	DR			

*Member Id: grey="Continuous" green="New" red="Disenrolled" Total Members without any Test Results: 67

This interactive form will allow you to filter 'Newly Enrolled Members', and 'Members with No Results' by clicking the check box.

Eligible members and non-eligible members (indicated in red) are listed.

To add results for a listed member, click the  icon, and another line will appear with the member information auto populated in the fields.

Test Date	Test Type	Test Result	Test Value	Rendering#	Rendering Name
-----------	-----------	-------------	------------	------------	----------------

Enter the following:

1. Test Date (you can manually enter the date mm/dd/yyyy) or click from the calendar tool

Test Type

Select...

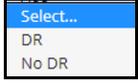
Select...

HbA1c

NEPH

EYE

2. Choose the 'Test Type'
3. Once you choose your 'Test Type' the following fields will indicate additional requirements, or 'N/A' for no additional entry required.

- o If you have an 'EYE' test type, the 'Test Result' selection of  will appear and the user is required to enter the rendering provider's NPI# and/or name that performed the eye exam.

ID: Name:

4. After entry is complete save changes by clicking  icon. To delete the line item, click  icon to delete that line item.

❖ **Helpful Tip:** You can enter more than one line item at a time, and then click save , and all items will save to this report. In addition, if a Member ID# is indicated in red as 'Disenrolled' data can't be entered.

After entering and saving  your data, the user can export to a report by clicking the 'Export to CSV'  icon.

Export to CSV/ Save Changes/ Cancel

Newly Enrolled Members Members with No Results

Member Id	Name	DOB	Test Date	Test Type	Test Result	Test Value	Rendering#	Rendering Name
9			Invalid date	EYE	DR	N/A		
9			08/07/2019	NEPH	Pos			
9			08/06/2019	HbA1c		12		
9			08/05/2019	NEPH	Pos			
9			08/04/2019	HbA1c		21		
9			08/01/2019	HbA1c		13		
9			04/17/2019	EYE	DR		SD010238C	

Pivot Mode

Filter...

- Member id
- Name
- DOB
- Test Date
- Test Type
- Test Result
- Test Value
- Rendering#
- Rendering Name
- Source

The user can also filter the rows for a personalized report for your records. These reports are useful in making sure that our members receive the correct health services during their next office visit.

PCP REASSIGNMENT REQUESTS



On occasion, a Primary Care Physician (PCP) may encounter a situation that warrants a request to have a patient reassigned to a new PCP.

CenCal Health has established a mechanism to address these issues. Please see the policy and procedure titled "PCP Request for Member Reassignment" in the PCP/Referral Provider Obligations section of the

Provider Manual for detailed instructions. Outlined below is the procedure that should be followed when submitting a request via the website.

A screenshot of the "CenCal Health Case Management Reassignment" form. It features a "Reset Form" button at the top left. Below it are two input fields: "Provider#" with the value "WEBPROV" and "Member#" with the value "WEBMEMB". At the bottom are "Submit Form" and "Reset Form" buttons.

Select "PCP Reassignment Requests" from the list of forms. Enter your provider ID# and the Member's Meds ID#. If the member is not currently eligible or is not assigned to you, you will receive an error message informing you of this.

A screenshot of the "CenCal Health Case Management Reassignment Form" showing advanced fields. It includes "Provider#" (WEBPROV), "Plan", "Provider Name" (John Doe), "Member#" (WEBMEMB), "DOB" (20000101), "Member Name" (Smith, Jennifer), "Requesting Date" (20080117), "Effective Date", and "Status". There is a section for "Reason for Discontinuing Case Management" and a "Provider Remarks" text area containing the text: "Member is not currently eligible and is not on your case management list. If this member becomes assigned to you in the future, you may resubmit your request at that time." A "Back" button is at the bottom left.

If the member is eligible and assigned to you, you will be taken to a different screen where you will choose the reason for your request from a drop-down list. All contractual and non-contractual reasons for requesting reassignment that meet CenCal Health's criteria are on this list.

You must enter supporting information in the "Provider Remarks" section, i.e. dates of member no shows, examples of how the member is non-compliant or abusive, etc. If left blank, the program will prompt you to enter your remarks.

When complete, click the "Submit" button on the form. Use the "Back" button to return to the previous screen to enter another request.

Requests will be approved if the documentation supports the request. If the documentation submitted was unclear or insufficient, the Provider Services QI Manager will contact the provider for clarification prior to reaching a decision. Requests submitted after the 10th of one month through the 10th of the next month are processed by the cut-off date (10th day of each month). PCPs may return to the website after the request has been processed to verify approval and the effective date by using the "Query" button on the PCP Reassignment Request form.

The member's new assignment becomes effective the first day of the following month. The PCP who requested the reassignment continues to be responsible for the member's care until the new assignment is in effect.

If you do not have Internet access, please call Provider Services at (805) 562.1677 for further instructions.

PHARMACY FORMS

Pharmacy Forms
CenCal Health Medical Request Form-MRF
Universal Prior Authorization Form
CenCal Health Pharmacy Authorization Form-PAF
Hepatitis C Medication Request Form
Synagis Medication Request Form
P & T Formulary Additions/Deletions Form

[CenCal Health Medical Request Form \(MRF\)](#)

Prior Authorization form for formulary exemption, please fax all supporting documents along with the form.

Prescriptions for the following require a MRF:

- All non-formulary medications
- Brand name drugs when an equivalent generic is available except for those drugs listed as exemptions, Drugs not meeting the Code 1 restriction or Step Therapy criteria
- And/Or Drugs exceeding the member age, dosing limit, quantity or duration of treatment dispensing limits

[CenCal Health Pharmacy Authorization Form \(PAF\)](#)

Exemption from the Maximum benefit of 7 medications

[Hepatitis C Medication Request Form](#)

Specific MRF for Hepatitis C Medications

[Synagis Medication Request Form](#)

Specific MRF for fulfillment thru CenCal Health's Specialty Pharmacy, Diplomat

[P & T Formulary Additions/Deletions Form](#)

Requests for medication reviews by CenCal Health's P&T Committee

RADIOLOGY BENEFIT MANAGER (RBM)

RBM Forms
Provider Fact Sheet
RadConsult Procedure
RadConsult Helpful Tips
Clinical Information Form

The Radiology Benefit Manager (RBM) process enhances the quality of services delivered to patients and reduces unnecessary radiation associated with advanced diagnostic imaging.

CenCal Health has been focusing on provider consultations and patient safety as a means to control for appropriate utilization of high-tech imaging. CenCal Health selected Care to Care, a URAC accredited as our new partner effective June 1, 2015. The goal is to improve our Radiology Benefit Management (RBM) program for high-tech imaging to enhance the quality of services delivered to patients and reduce unnecessary radiation associated with advanced diagnostic imaging.

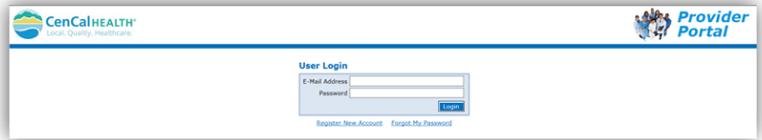
[Applicable Services](#)

This program applies to the following outpatient services:



- Positron Emission Tomography (PET)
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Computed Tomography (CT)
- Computed Tomography Angiography (CTA)
- Nuclear cardiology studies

The ordering physician's office must contact Care to Care to request an authorization prior to ordering a high-tech imaging service. Based on clinical information from the physician's office, Care to Care will then make consultative determinations using the clinical guidelines published on their website.



Requests can be submitted via phone, fax or through Care to Care's Care Portal

www.cencal.careportal.com

*Authorizations are valid for 90 days from the date of the consultation

Expectations

Imaging studies performed in conjunction with emergency room services, inpatient hospitalization, urgent care centers, or intra-operative procedures are excluded from the high-tech imaging consultation requirement. Imaging studies for members who have other health care coverage are excluded from the consultation process requirement.

Required Information

Consultation requests can be made to Care to Care via phone, fax or web:

Phone: 1 (888) 318-0276

Fax: 1 (888) 717-9660

Web: www.cencal.careportal.com and Care to Care's call center is open: M-F 5am – 5pm PST.

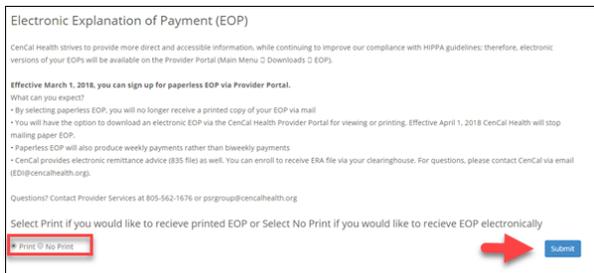
<p>What information is required when requesting prior authorization?</p>	<ul style="list-style-type: none"> ➤ Member (Patient) Name, Member DOB, Member ID number and ordering Physician Name and Address ➤ Name of Facility where services will be performed ➤ Radiological or Imaging Procedure to be performed ➤ Medical Indication(s) for requested procedure and ICD-9 code as available. Be sure to include: <ul style="list-style-type: none"> • Member's major complaint • What the referring physician is looking to rule out • Results of any lab findings, prior tests or imaging procedures • Outcome any prior treatment, including type and duration, for the same medical indication
--	---

ELECTRONIC EXPLANATION OF PAYMENT (eEOP) REPORT

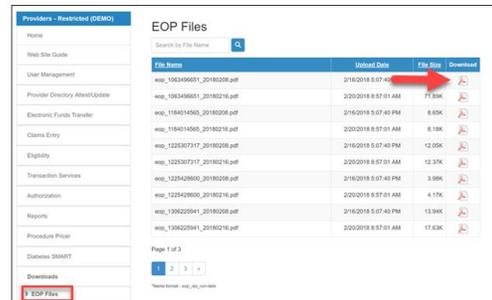


CenCal Health is trying to 'Go Green' and limit paper mailing and this process will allow providers to opt out of receiving paper EOP reports.

This form is only available to users that have the appropriate screen permission. Please contact your 'Physician/Administrator' if you need access to this section of the portal.



Providers who choose to sign up for electronic EOPs, the paper EOP will no longer be produced as it will be made available on the portal.



The EOP will be available on the provider portal for up to 18 months; therefore the Providers can access a copy of historical payment EOPs as needed.

Clicking on the  icon will prompt you to save and/or view the EOP as PDF.

CONTACT US

If you need to give access to a separate user that have multiple accounts with other provider groups (e.i. Billers that bill for multiple providers), have questions or would like additional training please reference our website at www.cencalhealth.org/providers/provider-portal/ or email CenCal Health's Web Master at webmaster@cencalhealth.org

Medical Management (805) 562-1082

- Authorization Questions/Concerns

Provider Services Department (805) 562-1676

- Portal Error Screen Issues
- Provider Information Changes
- Training

Pharmacy Services (805) 562-1080

- PAD & MRF Questions
- Medi-Cal Rx Transition

Member Services (877) 814-1861

- Member related general questions