2019 1st Quarter Provider Packet
Provider Visit Form

Provider Name:_______________________________________ **Date of Visit:**________________

PROVIDER TYPE:

☐ Ancillary
☐ CBAS
☐ Home Health
☐ PCP
☐ SNF
☐ Specialist
☐ Other: ___________________________

SELECT ONE:

☐ Accepting New Patients
☐ Accepting Existing Patients
☐ Not Accepting Patients

PACKET INCLUDES:

- 2019 Q1 Provider Visit Form
- Vendor Disclosure of Ownership Form
- Provider Demographic Attestation Form
- Initial Health Assessment (IHA) and Staying Healthy Assessment (SHA)/ Individual Health Education Behavior Assessment (IHEBA) Presentation
- Protecting Member Confidentiality
- Timely Access Requirements
- Interpreter Services
- Electronic Funds Transfer (EFT)
- Alcohol Misuse Screening and Counseling (AMSC) Benefit Update
- Patient Health Education & Referral
- Wellness Programs & Materials – Provider Request Form
- Weight Watchers Rebranded as WW

Date: ____________________________

Comments:

Vendor Disclosure of Ownership

I. Instructions

This form must be completed and submitted to Alameda Alliance for Health (Alliance) by all providers and subcontractors. A new Disclosure Form is required and must be submitted in the event of renewal or extension of the contract or within 35 days after any information in your original form has changed. This Disclosure Form is to be completed to ensure compliance with government program requirements pertaining to: (1) disclosure of ownership, control and management; and (2) exclusions of individuals and entities from government programs as set forth in your contract with the Alliance and the Alliance's administrative requirements.

The disclosure, reporting, and exclusion requirements apply to partnerships on both non-profit and for-profit corporations, including without limitation limited liability companies. Governmental entities, such as counties organized as corporations are required to complete all sections of this Disclosure Form. Counties that are not organized as corporations are only required to complete Sections II, III, and VI of the Disclosure Form. The definitions are based on law, regulation, and instructions from regulatory authorities.

<u>Important Note</u>: For the purposes of this Disclosure Form, the term "Person with an Ownership or Control Interest" is not limited to persons or corporations with an ownership interest. For example, it also includes:

- **(I) Officers and individual board members of for-profit and non-profit corporations, including without limitation limited liability companies; and**
- **(II) Partners of a partnership, including without limitation limited liability partnerships.**

See Section VII for a complete definition of "Person with an Ownership or Control Interest" as well as definition of other key terms such as "Managing Employee," "Provider," and "Agent."

Please complete this Disclosure Form whether or not you have any information to report. If more space is needed, please attach additional information on a separate page.

For assistance in completing this Disclosure Form, please reference the Definitions provided under Section VII.

II. Identifying Information

LEGAL NAME ACCORDING TO THE IRS	DBA (Doing Business As), if applicable		
ADDRESS			NPI/UMPI
CITY	STATE	ZIP CODE	OFFICE PHONE NUMBER
FEDERAL EMPLOYER ID (FEIN)	TAX ID		

III. Structure

Check the entity type that describes your structure:

☐ Sole Proprietorship	☐ Partnership	☐ Other Partnership (i.e., LP, LLP, LLLP)	☐ Limited Liability Co.
☐ For Profit Corporation	☐ Non-Profit Corporation	☐ Public Corporation	☐ State
☐ Incorporated County	☐ Unincorporated County (You may advance to Section VI for Certification)		☐ Other

IV. Ownership, Control and Management Information

A. Please provide the following information for each **Managing Employee** and **Person or Entity with an Ownership or Control Interest** in your business, and any Sub-Subcontractor in which you have direct or indirect ownership of 5% or more. All applicable fields must be completed. The date of birth and social security number (SSN) are required if a *person's* name is provided, and the federal employer identification (FEIN) number is required if an *entity's* name is provided. A non-profit entity must disclose all required information applicable to the entity. Please review the definitions in Section VII.

No.	Full Legal Name and Title	Address Individuals – list home address Entities – list primary business address, every business location and P.O. Box	Date of Birth	SSN or FEIN	% Ownership Interest, if applicable
1.					
2.					
3.					

B. If any Person with an Ownership or Control Interest listed in subsection IV (A) is related to another Person with an Ownership or Control Interest listed in subsection IV (A) as a spouse, child or sibling, please provide the following information. If no such relationship exists, please indicate this with an "N/A."

No.	Full Legal Name and Title	SSN	Name of Person Related To	Related Person's SSN	Relationship
1.					
2.					
3.					

C. For each Person with an Ownership or Control Interest listed in subsection IV (A) who also has an ownership or control interest in a disclosing entity other than that indicated in subsection IV (A), please provide the following information. If no such ownership exists, please indicate this with an "N/A."

No.	Full Legal Name and Title	Address	Date of Birth	SSN or FEIN	% Ownership Interest
1.					
2.					

No.	Full Legal Name and Title	Address	Date of Birth	SSN or FEIN	% Ownership Interest
3.					

V. Excluded Individuals or Entities

A. Are there any of your employees, Persons or Entities with an Ownership or Control Interest in your business, or any of your Managing Employees, Affiliates, or agents who are or have ever:

- Been excluded from participation in Medicare, any of the State health care programs, or Federal health care program under sections 1128 and 1128A of the Social Security Act?

  ☐ Yes ☐ No

- Been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Title XX, or Title XXI in California or any other state or jurisdiction since the inception of these programs?

  ☐ Yes ☐ No

- Had civil money penalties or assessments imposed under Section 1128A of the Social Security Act (that is, federal fraud and abuse law civil monetary penalty provisions)?

  ☐ Yes ☐ No

- Entered into a settlement in lieu of conviction involving fraud or abuse of any government program?

  ☐ Yes ☐ No

- Been debarred, suspended, or otherwise excluded for participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

  ☐ Yes ☐ No

B. Do you have any agreements for the provision of items or services related to the Alliance's obligations under its contracts with the State or the Centers for Medicare and Medicaid Services (CMS) with an individual or entity who: (i) has been excluded from participation in Medicare or any of the State health care programs; (ii) has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Title XX, or Title XXI in California or other state or jurisdiction since the inception of those programs; or (iii) had civil money penalties or assessments imposed under Section 1128A of the Social Security Act?

☐ Yes ☐ No

If you answered "Yes" to any of the above questions, list the name and the social security number (SSN) or federal employer identification number (FEIN) of the individual or entity, and reason for answering "Yes" (i.e., conviction of a criminal offense related to involvement in, or exclusion from participation in, Medicare, Medicaid, or other federally funded government health care programs, or imposition of civil money penalties or assessments under Section 1128A of the Social Security Act).

No.	Full Legal Name	SSN or FEIN	Reason
1.			
2.			
3.			
4.			

VI. Certification

I am authorized to bind the entity named in this document and I certify that the above information is true and correct. I will notify the Alliance of any changes to this information as outlined in Section I.

NAME (print)	TITLE
SIGNATURE	DATE
EMAIL ADDRESS	

Return a completed, signed Disclosure Form to the Alliance as follows:

Fax the completed form to the Alliance Provider Services Department:
Fax: **855.891.7257**

You may also mail the form to:
Alameda Alliance for Health
ATTN: Provider Services Department
1240 South Loop Road
Alameda, CA 94502

If you have any questions, please contact the Alliance Provider Services Department:
Phone Number: **510.747.4510**
Email: **deptproviderrelations@alamedaalliance.org**

VII. Definitions

For the purpose of this disclosure, the following definitions apply:

1. **Act** means the Social Security Act.

2. **Affiliate** means associated business concerns or individuals if, directly or indirectly:
   A) Either one controls or can control the other; or
   B) A third party controls or can control both.

3. **Agent** means any person who has been delegated the authority to obligate or act on behalf of the Provider or Subcontractor.

4. **Disclosing Entity** means a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent. For purposes of this Disclosure Form, Disclosing Entity shall also include Provider, Other Disclosing Entity, Subcontractor, and Sub-Subcontractor.

5. **Other Disclosing Entity means** any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes:

   A) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (Title XVIII);
   B) Any Medicare intermediary or carrier; and
   C) Any entity (other than an individual practitioner or group of practitioners) that furnishes or arranges, for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

6. **Managing Employee** means an individual (including a general manager, business manager, administrator, or director) who exercises operational or managerial control over the Provider or Subcontractor, or part thereof, or who directly or indirectly conducts the day-to-day operations of the Provider or Subcontractor, or part thereof.

7. **Person or Entity with an Ownership or Control Interest** means a person or corporation that:
   A) Has an ownership interest, directly or indirectly, totaling 5% or more in the Provider or Subcontractor;
   B) Has a combination of direct and indirect ownership interests equal to 5% or more in the Provider or Subcontractor;
   C) Owns an interest of 5% or more in any mortgage, deed of trust, note, or other obligation secured by the Provider or Subcontractor, if that interest equals at least 5% of the value of the property or assets of the Provider or Subcontractor;
   D) Is an officer or director of Subcontractor or a Provider organized as a corporation (this includes officers and individual board members of for-profit and non-profit corporations, including without limitation limited liability companies); or
   E) Is a partner in a Provider organized as a partnership, including without limitation limited liability partnerships.

8. **Provider** means an individual or entity that: A) is engaged in the delivery of health care services and is legally authorized to do so by the state in which the individual or entity delivers services; and B) has entered into an agreement with the Alliance to provide health care services to Alliance members, including members enrolled through the Alliance's contracts with the State. For purposes of this disclosure, "Provider" also means a vendor providing non-health care services through an agreement with the Alliance to members enrolled through the Alliances' government program contracts with the State, provided those services are significant and material to the Alliance's obligations under the respective government program contract.

9. **State** means the California Department of Health Care Services (DHCS).

10. **Subcontractor** means an individual, agency, or organization that has a contract with the Alliance that relates directly or indirectly to the performance of the Alliance's obligations under its contract with the State. A network provider is not a subcontractor by virtue of the network provider agreement with the Alliance.

11. **Sub-subcontractor** means:
    A) An individual, agency, or organization to which a Disclosing Entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
    B) An individual, agency, or organization with which a fiscal agent or Disclosing Entity has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

Provider Demographic Attestation Form

INSTRUCTIONS:

1. Please print clearly.
2. Please return form by fax to Alameda Alliance for Health (Alliance)
   Fax Number: **1.855.891.7257**

For questions, please call the Alliance Provider Services Department at **1.510.747.4510**.

PROVIDER INFORMATION	
PROVIDER/CLINIC NAME	PROVIDER TAX ID
SITE ADDRESS	
MAIN PHONE NUMBER	FAX NUMBER
HOURS OF OPERATION	
CLINIC EMAIL ADDRESS	
LANGUAGES SPOKEN	ACCEPTING PATIENTS ☐ YES ☐ NO ☐ ONLY EXISTING

PROVIDER NAME	**PROVIDER NPI**	**IS THIS PROVIDER STILL AFFILIATED WITH THIS PRACTICE?**
		☐ YES ☐ NO
		☐ YES ☐ NO
		☐ YES ☐ NO
		☐ YES ☐ NO

Notes:

Questions? Please call the Alliance Provider Services Department
Monday – Friday, 7:30 am – 5 pm
Phone Number: **510.747.4510**
www.alamedaalliance.org

C&O Reviewed 12/18

Initial Health Assessment (IHA) and Staying Healthy Assessment (SHA)/ Individual Health Education Behavior Assessment (IHEBA)

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Initial Health Assessments (IHA)

- To comply with Medi-Cal Managed Care Health Plan Policy Letter 08-003
- IHA completed within 120 days of members' enrollment with the plan
- Must be documented in the member's medical record
- Must include a Staying Healthy Assessment (SHA)
- ***Alliance Quality Improvement Department will conduct quarterly audits of randomly selected medical records***

Procedure for Missed Scheduled Appointments

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- For members that miss their scheduled appointments and two additional documented attempts to reschedule have been unsuccessful, the documentation must include at least the following:
  - One attempt to contact the member by telephone with the telephone number provided by the plan; and
  - One attempt to contact the member by letter or postcard sent to the address provided by the plan; and
  - The plan or PCP has made a good faith effort to update the member's contact information, including updating information received from the Post Office for any change in address and from dialing Directory Assistance for any new telephone number; and
  - Attempts to perform the IHA at any subsequent member office visit(s), even if the deadline for IHA completion has elapsed, until the IHA is completed or the member is disenrolled from the plan.

Alameda Alliance for Health

Staying Healthy Assessment

- To comply with the Medi-Cal Managed Care Health Plan Policy Letter 13-001

	Periodicity	Administer	Administer/ Re-Administer		Review
DHCS Form #	**Age Groups**	**Within 120 Days of Enrollment**	**1st Scheduled Exam** (after entering new age group)	**Every 3-5 Years**	**Annually** (Intervening years)
DHCS 7098 A	0-6 Months	X	X		
DHCS 7098 B	7-12 Months	X	X		
DHCS 7098 C	1-2 Years	X	X		X
DHCS 7098 D	3-4 Years	X	X		X
DHCS 7098 E	5-8 Years	X	X		X
DHCS 7098 F	9-11 Years	X	X		X
DHCS 7098 G	12-17 Years	X	X		X
DHCS 7098 H	Adult	X		X	X
DHCS 7098 I	Senior	X		X	X

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Links to APL letters and SHA forms

- DHCS - Initial Comprehensive Health Assessment
  - www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL%202008/PL08-003.PDF
- DHCS – Individual Health Education Behavioral Assessment
  - www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL1999/MMCDPL99007.pdf
- DHCS – Staying Healthy Assessment Questionnaires (SHA)
  - www.dhcs.ca.gov/formsandpubs/forms/Pages/StayingHealthyAssessmentQuestionnaires.aspx

Thank you

ALAMEDA Alliance FOR HEALTH

Protecting Member Confidentiality

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 mandated the establishment of national standards to protect members' health care information. Additionally, federal and California laws have been enacted to cover the release of information, sharing member information, new HIPAA incident notification rules, and set civil/criminal penalties and fines for inappropriate release of member information.

Please ensure that you are protecting our members and their confidential health care information when sending information to Alameda Alliance for Health (Alliance).

Below are key practices to be aware of when sending information to the Alliance:

1. When mailing paper claims and billing information, secure the envelope or box to ensure that it is closed and information will not come out or get lost in the mail.
2. Email exchanges with member information should be sent and received securely.
3. Shred documents that contain member identifiers when no longer needed.
4. Provide ongoing training of HIPAA protection procedures and reporting methods to office staff.
5. Notify the Alliance Compliance Department of any suspected incidents within 24 hours of discovery.
   Toll-Free: **855.747.2234**
   Email: **compliance@alamedaalliance.org**

For more information about HIPAA compliance, please visit **www.hhs.gov** or the Alliance website at **www.alamedaalliance.org/providers/resources**.

Timely Access Requirements

Alameda Alliance for Health (Alliance) values our dedicated provider partner community. We are committed to continuously improving our provider customer satisfaction.

We have received some recent inquiries regarding what standards are measured related to **Timely Access** so we wanted to provide you with the state mandated standards for which you are evaluated. All providers contracted with the Alliance are required to offer timely access to care based on the appointment availability and wait time standards below:

Appointment Type:	Offer the Appointment Within:
Initial OB/Gyn Prenatal Appointment	2 weeks of request
Non-urgent appointment with a Primary Care Physician	10 business days of request
Urgent care appointment that *does not* require prior authorization	48 hours of request
Urgent care appointment that *requires* prior authorization	96 hours of request
Non-urgent appointment with a **Specialist Physician**	15 business days of request
Non-urgent appointment for **Ancillary Services**	15 business days of request
Non-urgent appointment with a Mental Health Care Provider	10 business days of request
Wait time in a provider's office	Less than 60 minutes*
Returning member's phone calls	1 business day*

*Updates effective 11/15/18

Optimizing Your Performance

Every year, the Alliance conducts a variety of surveys to measure compliance with the standards above. To ensure that your practice is meeting the standards, we suggest the following:

- Internally review your policies and procedures
- Educate clerical staff about the purpose and importance of these standards

If you do not complete the above standards, the Alliance will follow-up with your office regarding planned steps to improve appointment availability.

Questions? Please call the Alliance Quality Improvement Department
Monday – Friday, 8 am – 5 pm
Phone Number: **510.747.6229**
www.alamedaalliance.org

Interpreter Services Guide

The Alliance provides no-cost interpreter services including American Sign Language (ASL) for all Alliance covered services, 24 hours a day, 7 days a week. Please confirm Alliance member's eligibility before requesting services.

How to Access Telephonic Interpreter Services

- For Telephonic Interpreter Services, please call **510.809.3986**, available 24 hours a day, 7 days a week.
- Inform the operator you are an Alliance provider.
- Provide the operator with the member's nine-digit Alliance ID number.
- For communication with patients who are deaf, hearing impaired or speech impaired, please call the California Relay Service (CRS) at **711**.

How to Order In-Person Interpreter Services

- Please fax the *Interpreter Services Appointment Request* form to the Alliance at **855.891.7172**.
- Schedule in-person interpreter services at least **five (5) working days** prior to the appointment.
- Requests made less than **five (5) working days** prior to the appointment may need to be filled with a telephonic interpreter.
- If needed, please cancel interpreter services at least 48 hours prior to the appointment by calling **510.747.4510**.

Please Note

The Alliance highly discourages the use of adult family or friends as interpreters. Children cannot interpret unless there is a life-threatening emergency and no qualified interpreter is available.

If a patient declines interpreter services, please document the refusal in the medical record. This is required by the California Department of Health Care Services (DHCS) and the California Managed Risk Medical Insurance Board.

Questions? Please call the Alliance Provider Services Department
Monday – Friday, 7:30 am – 5 pm
Phone Number: **510.747.4510**
www.alamedaalliance.org

C&O Reviewed 12/18

Interpreter Services Appointment Request Form

INSTRUCTIONS:

1. Please print clearly.
2. Fields with a (*) must be completed.
3. Forms must be submitted by fax at least **five (5) working days** prior to the date of the appointment.
4. Please return form by fax to Alameda Alliance for Health (Alliance)
   Fax Number: **855.891.7172**

For questions, please call the Alliance Provider Services Department at **510.747.4510**.

PATIENT INFORMATION		
*MEMBER NAME		*MEMBER DOB _____ / _____ / _____
*MEMBER ID NUMBER		MEMBER CONTACT PHONE NUMBER
INTERPRETER SERVICE TYPE (PLEASE CHECK ONLY ONE)		
☐ TELEPHONE INTERPRETING *(scheduling is optional)* ☐ VIDEO INTERPRETING *(if available at clinic location)* ☐ IN-PERSON INTERPRETING		*LANGUAGE PREFERENCES ☐ FEMALE ☐ MALE
APPOINTMENT DETAILS		
*APPOINTMENT DATE _____ / _____ / _____	*APPOINTMENT START TIME	*APPOINTMENT DURATION
PROVIDER/FACILITY NAME		PROVIDER SPECIALTY
PROVIDER ADDRESS (INCLUDE DEPARTMENT/FLOOR/SUITE)		
PLEASE DESCRIBE THE NATURE OF THE VISIT (CHEMO, RADIOLOGY, ETC.) AND JUSTIFICATION FOR INTERPRETER SERVICE TYPE.		
*NAME OF PERSON REQUESTING INTERPRETER		*PHONE NUMBER
*DATE SUBMITTED _____ / _____ / _____		

Telephonic Interpreter Services are available 24/7 without an appointment by calling **510.809.3986**.

Electronic Funds Transfer (EFT) for Provider Payments Reminder

Alameda Alliance for Health (Alliance) values our dedicated provider partner community. We are committed to continuously improving our provider and member customer satisfaction.

This notification serves as a reminder that the Alliance offers Electronic Funds Transfer (EFT) as an option to receive provider payments. The EFT payment option is available to all contracted providers. Providers who enroll in EFT will have fee-for-service (FFS) payments deposited directly into their bank account.

Providers can enroll to receive EFT provider payments for fee-for-service (FFS) payments by:

- Returning a completed **Electronic Funds Transfer Authorization Form** available at **www.alamedaalliance.org/providers**
- Providers with more than one (1) National Provider ID (NPI) will need to include a separate attached list of NPI numbers to the enrollment form. Any attachments to the EFT authorization form must have an original authorized signature.
- Provider Groups that receive payments under the Group ID only need to complete one (1) single enrollment form for the Group NPI.
- Provider Group Members, who also bill individually, can enroll in EFT as an individual provider by submitting a separate enrollment form with their individual Provider NPI.

Included with this notification are an instruction guide, and enrollment and EFT authorization form for completion.

Questions? Please call the Alliance Provider Services Department
Monday – Friday, 7:30 am – 5 pm
Phone Number: **510.747.4510**
www.alamedaalliance.org

Electronic Funds Transfer (EFT) for Provider Payments

Alameda Alliance for Health (Alliance) values our dedicated provider partner community. We are committed to continuously improving our provider and member customer satisfaction.

We are pleased to announce the availability of Electronic Funds Transfer (EFT). Providers who enroll in EFT will have fee-for-service (FFS) payments deposited directly into their bank account. The EFT option is available to all contracted providers.

To enroll in EFT, providers must complete the **Electronic Funds Transfer Authorization Form** that can be found at the end of this document. Prior to completing the form, please read the **Instruction Sheet** carefully and follow the directions.

Providers with more than one National Provider ID (NPI) should attach a list of NPI numbers to the application. Please note that any attachments to the Electronic Funds Transfer Authorization Form must have an authorized original signature.

Provider Groups that receive payments under the Group ID only need to complete one (1) single enrollment form for the Group NPI. Provider Group Members, who also bill individually, can enroll in EFT as an individual provider by submitting a separate enrollment form using their individual Provider NPI. Only one (1) TIN can be used per form.

ONE (1) of the following items must be attached to your enrollment form:

- A voided check from your checking account; OR
- If you have a deposit-only checking account (and do not have checks) or you choose to have the EFT deposited into a savings account, you may submit a letter from a bank officer verifying your account information. The letter must be on bank letterhead and include the bank's name, address and routing number, the type of account, the account number, and the account owner's name, address and tax ID number. The letter also must be signed by a bank officer and notarized.

EFT enrollment applications that do not meet these requirements will be rejected.

After sending the Electronic Funds Transfer Authorization Form to the Alliance, please allow a minimum of four (4) weeks for processing.

The EFT transactions will be transmitted to the Alliance's bank on Thursday. Due to normal banking procedures, the transferred funds may not be available at your bank for up to three (3) business days after the transfer. Please contact your banking institution regarding the availability of your funds.

If you have any questions about the EFT process, please call the Alliance Provider Services Department at **510.747.4510**.

Electronic Funds Transfer Authorization Form - Instructions

Providers wishing to request **Electronic Funds Transfer (EFT)** of Alameda Alliance for Health (Alliance) fee-for-service (FFS) funds must complete and return an **Electronic Funds Transfer Authorization Form**, along with one (1) of the following attached to your form:

- A voided check from the checking account to which the funds are to be transferred. The check must contain the name and address of the provider or provider organization and the word "VOID" must be written across its face; OR
- If you have a deposit-only checking account (and you do not have checks) or you choose to have the EFT deposited into a savings account, you may submit a letter from a bank officer. The letter must be on bank letterhead and include the bank's Name, address and routing number, the type of account, the account number, and the account owner's name, address and tax ID number. The letter also must be signed by a bank officer and notarized.

Sections A and B of the EFT form must be complete and legible, otherwise, the request will not be processed and will be returned.

Section A: Provider Information

Step 1 – Enter **NAME OF PROVIDER** – Complete legal name of the institution, corporate entity, practice, or individual provider as it is filed with the Alliance.

Step 2 – Enter **PROVIDER IDENTIFIER NPI NUMBER** (or Group NPI if payment is made to a Group Practice).
Providers with more than one NPI, attach a list of NPI numbers to the application. **Provider Groups that receive payments under the Group number only need to complete one (1) single enrollment form for the Group NPI.** Provider Group Members, who also bill individually, can enroll in EFT as an individual provider by submitting a separate enrollment form using their **individual Provider NPI**.

Step 3 – Enter **DOING BUSINESS AS (DBA) NAME** – A fictitious business name, under which the business or operation is conducted and presented to the world and is not the legal name of the legal person (or persons) who actually own it and are responsible for it.

Step 4 – Enter **PROVIDER IDENTIFIER** – Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN).

Step 5 – Enter **PROVIDER CONTACT NAME** – Name of contact in provider office for handling EFT issues.

Step 6 – Enter **PHONE NUMBER** – Associated with contact person.

Step 7 – Enter **EMAIL ADDRESS** – An electronic mail address in which the Alliance may contact the provider.

Step 8 – Enter **PROVIDER ADDRESS** – The number and street name where a person or organization can be found, include **CITY**, **STATE** and **ZIP CODE**.

Step 9 – Enter **PROVIDER AGENT NAME** – Name of provider's authorized agent.

Step 10 – Enter **PROVIDER AGENT PHONE NUMBER** - Associated with provider agent.

Step 11 – Enter the **PROVIDER AGENT ADDRESS** – The number and street name where a person or organization can be found, include **CITY**, **STATE** and **ZIP CODE**.

Step 12 – Enter **PROVIDER AGENT EMAIL ADDRESS** – An electronic mail address in which the Alliance may contact the provider agent.

Section B: Banking Information

Step 1 – Enter the Financial Institution Routing Number: A 9-digit identifier of the financial institution where the provider maintains an account to which payments are to be deposited. Numbers can be found at the bottom of your check.

Step 2 – Enter the Provider's Account Number with Financial Intuition: Provider's account number at the financial institution to which EFT payments are to be deposited.

Step 3 – Type of Account at Financial Institution: The type of account the provider will use to receive EFT payments, e.g. Checking, Savings.

Step 4 – Financial Institution Name: Official name of the Provider's financial institution.

Step 5 – Financial Institution Address: Street Address associated with receiving depository financial institution name field, City, State, Zip Code.

Section C: EFT Authorization or Cancellation

Providers should complete and sign this section. All documents received will be processed and placed in the provider's file. Please note: For providers who have claims paid within a particular payment cycle, FFS funds are normally scheduled to be transferred on Thursdays. Due to normal banking procedures, the transferred funds may not be available at your bank for up to three (3) business days after the transfer. Please contact your banking institution regarding the availability of your funds.

Please allow a minimum of four (4) weeks for your Electronic Funds Transfer Authorization Form request to be processed.

To change banking information, providers must send the following:

- A new Electronic Funds Transfer Authorization Form indicating the new banking information. The enrollment form must be signed with an original signature and a title must be indicated.
- A voided check with the new account and routing numbers must be attached to the new enrollment form. If the account is a "deposit only" account, attach a signed, notarized letter from your banking institution indicating the new account and routing numbers. Regardless of what is being updated, both the account and routing numbers must always be indicated.

- A letter indicating changes to your account is required. The letter must be on company letterhead and include any provider number(s) (tax ID and NPI), new account and routing numbers and a brief explanation for the change. The letter must have an original signature and a title should be indicated.

Note: If you are changing your EFT from one banking institution to another banking institution, your payments will automatically transfer back to paper for a minimum of two (2) weeks while your EFT is being set up on your new account.

To cancel EFT transactions, providers must send an Electronic Funds Transfer Authorization Form, including the provider number(s), applicable Tax ID and/or NPIs, to the address below. Please allow a minimum of four (4) weeks to transition to a paper check.

Please email, fax or mail the completed form with the voided check and attachments (if applicable) to:

Email
finance@alamedaalliance.org
ATTN: Alameda Alliance for Health – [DBA/Provider Name]

Mail
Alameda Alliance for Health
ATTN: EFT Processing – Finance Department
1240 South Loop Road
Alameda, California 94502

Fax
Alameda Alliance for Health – Finance Department
ATTN: Alameda Alliance [DBA/Provider Name]
Fax Number: **510.995.3709**

For questions regarding the Electronic Funds Transfer Authorization Form, please contact:
Alliance Provider Services Department
Phone Number: **510.747.4510**

Electronic Funds Transfer (EFT) Authorization Form

This authorization remains in full force and effect until Alameda Alliance for Health (Alliance) receives written notification from the provider of its termination, or until the Alliance or an appointing authority deems it necessary to terminate the agreement.

DIRECTIONS: An original pre-imprinted voided check for checking accounts, or an original bank letter for savings accounts, must be submitted with this form. The provider name, routing number and account number on either of those documents must match what is entered on this form. Photocopied documents will not be accepted. Please print or type legibly. Use ink for signatures, including notary.

SECTION A:

1. NAME OF PROVIDER (Name must match name on bank account and name registered with the Alliance)		2. PROVIDER IDENTIFIER NPI NUMBER (Attach the providers with more than one NPI form below if multiple NPI's)	
3. DOING BUSINESS AS NAME (DBA)		4. PROVIDER IDENTIFIER (TIN OR EIN, only one TIN/EIN per form)	
5. PROVIDER CONTACT NAME	6. PHONE NUMBER	7. EMAIL ADDRESS	
8. PROVIDER ADDRESS	CITY	STATE	ZIP CODE
9. PROVIDER AGENT NAME (Name of provider's authorized agent)		10. PROVIDER AGENT PHONE NUMBER	
8. PROVIDER AGENT ADDRESS	CITY	STATE	ZIP CODE
12. PROVIDER AGENT EMAIL ADDRESS			

SECTION B:

1. FINANCIAL INSTITUTION ROUTING NUMBER	2. PROVIDER'S ACCOUNT NUMBER (include leading zeros)	3. TYPE OF ACCOUNT AT FINANCIAL INSTITUTION ☐ CHECKING ☐ SAVINGS
4. FINANCIAL INSTITUTION NAME		
8. PROVIDER ADDRESS		

SECTION C:

Please check the appropriate box.

☐ I hereby authorize the Alliance to initiate credit entries to my bank account as indicated above, and the depository named above to credit the same to such account. For changes to existing accounts, do not close an existing account until the first payment has been deposited into the new account.

☐ I hereby **CANCEL** my EFT authorization

I understand that by signing this form, payments issued 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.

Authorized Signature:______________________________ Date: _____________________________________

Title:____ Print Name:_________________________

Signature must be owner, partner or corporate officer. Please send form and attachments (if applicable) via email, fax or mail.

Email
finance@alamedaalliance.org
ATTN: Alameda Alliance for Health [DBA/Provider Name]

Mail
Alameda Alliance for Health
ATTN: EFT Processing – Finance Department
1240 South Loop Road
Alameda, California 94502

Fax
Alameda Alliance for Health
ATTN: Alameda Alliance [DBA/Provider Name]
Fax Number: **510.995.3709**

Internal Use Only:
Reviewed By:
Finance Signatory: ____________________
Date Signed: _________________________
SR Number: _________________________

ALAMEDA Alliance FOR HEALTH

Providers with More Than One NPI

Providers with more than one NPI, attach a list of NPI numbers to the application. **Provider Groups that receive payments under the Group number only need to complete one (1) single enrollment form for the Group NPI.** However, members of Provider Groups who also bill individually may enroll by submitting a separate enrollment form using their individual provider number.

Provider Group/ Individual Name	Provider Group/ Individual NPI	Alameda Alliance for Health Use Only

Authorized Signature:______________________________ Date: ______________________________

Title:____ Print Name:_________________________

Signature must be owner, partner or corporate officer. Please send form and attachments (if applicable) via email, fax or mail.

Alcohol Misuse Screening and Counseling Benefit Update

Alameda Alliance for Health (Alliance) values our dedicated provider partner community. We are committed to working with our provider network to ensure that your patients receive Alcohol Misuse Screening and Counseling (AMSC). We would like to share the updated guidance for AMSC.

Key updates to the guidance for AMSC include:

1. Providers must annually screen adult members using one of three validated tools.
2. There are no longer requirements regarding who can provide AMSC services.
3. Providers must document alcohol misuse screening services.

Alcohol Misuse Screening

At least annually, primary care providers (PCPs) must screen Alliance members 18 years of age and older for alcohol misuse using one (1) of the following validated screening tools:

1. The Alcohol Use Disorders Identification Test (AUDIT)
2. The abbreviated AUDIT-Consumption (AUDIT-C)
3. A single-question screening, such as asking, "How many times in the past year have you had 4 (for women and all adults older than 65 years) or 5 (for men) or more drinks in a day?" This question is included in the Staying Healthy Assessment (SHA).

Behavioral Counseling for Alcohol Misuse

Offer at least one (1) and up to three (3) brief behavioral counseling intervention(s) to members that identify as having risky or hazardous alcohol use through the screening process.

Referral to Mental Health and/or Alcohol Use Disorder Services

Refer patients who screen positively for potential alcohol use disorder as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM), or whose diagnosis is uncertain, to the appropriate Alameda County Behavioral Health Care Services and Alliance contracted substance use providers**.** Alliance members can be referred by calling the following contacts:

For Alliance Medi-Cal Members
Alameda County Behavioral Health
ACCESS
Toll-Free: **800.491.9099**

For Alliance Group Care Members
The Alliance Mental Health Provider
Beacon Health Strategies
Toll-Free: **855.856.0577**

Billing for AMSC Services

Screening Reimbursement: Screening can be billed using HCPCS code H0049.

- Each Alliance member is allowed at least one (1) screening per year.
- Additional screenings may be provided when medically necessary.

Brief Counseling Interventions Reimbursement

The following HCPCS codes may be used to bill for these services:

- G0442 (annual alcohol misuse screening, 15 minutes)
- G0443 (brief face-to-face behavioral counseling for alcohol misuse, 15 minutes)

Code G0442 is limited to one screening per year, any provider, unless otherwise medically necessary.

Code G0443 may be billed on the same day as code G0442. Code G0443 is limited to 3 sessions per recipient per year, any provider, unless otherwise medically necessary.

Please remember to document the alcohol misuse screening of patients. If the patient transfers from one PCP to another, the receiving PCP must obtain the patient's prior medical records. If no documentation is found, the new PCP must provide and document the service.

Patient Health Education & Referral

Alameda Alliance for Health (Alliance) values our dedicated provider partner community. We are committed to continuously improving our provider and member customer satisfaction.

Health education is an important part of primary care visits. As a provider, you are a critical and influential source of health information for your patients. When you conduct an Initial Health Assessment (IHA) or review a patient's Staying Health Assessment (SHA), you uncover the key concerns of your patients. The Alliance offers member patient handouts and program referrals that can enhance your ability to address these concerns. You can find details on the IHA and SHA at on our website at: **www.alamedaalliance.org/providers/medical-management**.

Health Education Handouts
Looking for the right handout? Our handouts are in English, Spanish, Chinese and Vietnamese, and cater to our members.

Topics include:

- Asthma
- Baby & Breastfeeding
- Diabetes
- Injury Prevention
- Healthy Weight
- Mental Health
- Parenting
- Pregnancy
- Quit Smoking
- Sexual Health
- Substance and Alcohol Addiction

Health Education Program Referrals
Could your patient benefit from a healthy lifestyle program? Tobacco cessation? Breastfeeding classes? Diabetes self-management? Our Provider Health Education Resource Directory lists programs available at no cost to our members. You can refer members directly or fax us the Provider Wellness Request Form to make a request on behalf of your patient.

More Alliance resources can be found on our website at:
www.alamedaalliance.org/providers/health-education-and-wellness-resources

Thank you for all you do to improve the health and wellbeing of Alliance members!

Questions? Please call Alliance Health Programs
Monday – Friday, 8 am – 5 pm
Phone Number: **510.747.4577**
Email: **livehealthy@alamedaalliance.org**
www.alamedaalliance.org

ALAMEDA
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FOR HEALTH

PROVIDER REQUEST FORM - ALLIANCE WELLNESS PROGRAMS & MATERIALS

Please check off the topics that you want us to send your patients covered by Alameda Alliance for Health (Alliance). All Alliance wellness materials and programs are free for members. You can also request the materials in other formats. Many handouts can be downloaded at **www.alamedaalliance.org**.

BOOKS

- ☐ Cookbook:
  - ☐ Diabetes ☐ Healthy Eating
- ☐ What to do When Your Child Gets Sick

CLASSES & PROGRAM REFERRALS

- ☐ Asthma
- ☐ Alcohol and Other Substance Use
- ☐ Breastfeeding Support
- ☐ CPR/First Aid
- ☐ Diabetes
- ☐ Healthy Weight
- ☐ Heart Health
- ☐ Parenting
- ☐ Pregnancy and Childbirth
- ☐ Quit Smoking (*Member consents for Smoker's Helpline to call them*)
- ☐ Senior Centers/Programs
- ☐ Weight Watchers

MEDICAL ID BRACELETS OR NECKLACE

- ☐ Allergy
- ☐ Asthma
- ☐ Diabetes
- ☐ Other (list):________________________

WRITTEN MATERIALS

- ☐ Advanced Directive (medical power of attorney)
- ☐ Alcohol and Other Substance Use
- ☐ Asthma:
  - ☐ Adult ☐ Child
- ☐ Back Care
- ☐ Birth Control and Family Planning
- ☐ Breastfeeding
- ☐ Car Seat Safety
- ☐ Diabetes
- ☐ Domestic Violence
- ☐ Exercise:
  - ☐ General ☐ Resistance Bands
- ☐ Healthy Eating
- ☐ Heart Health
- ☐ Parenting and Discipline
- ☐ Pregnancy and Childbirth
- ☐ Quit Smoking
- ☐ Safety:
  - ☐ Adult ☐ Baby ☐ Child ☐ Senior
- ☐ Sexual Health
- ☐ Stress and Depression

Provider Name: ______________________________ Provider Clinic: ________________________

Provider Phone: ______________________________ Provider Fax: ___________________________

Member Name: ______________________________ Alliance ID Number: ____________________

Address to Mail Materials to: ____

City: ____ Zip: ____________

Language Preferred: ☐ Chinese ☐ English ☐ Spanish ☐ Vietnamese

To order, fax this form to:

Alliance Health Programs • 1240 South Loop Road, Alameda, CA 94502

Fax: **1.877.813.5151** • Phone Number: **510.747.4577**

Email: **livehealthy@alamedaalliance.org**

Weight Watchers Rebranded as WW

For many years Alameda Alliance for Health (Alliance) has offered Weight Watchers to our members. We continue to offer this program to members, and want to provide an update with you.

Weight Watchers Rebrand

Weight Watchers changed their name to WW with the tagline of "Wellness that Works" to reflect their new focus on wellness instead of weight. Their program is open to anyone who seeks to be healthier. Through weekly Wellness Workshops and digital tools, WW members track their food and activity and learn about successful behavior change. WW has also introduced a rewards program for participating and reaching nutrition and activity goals. For more information on the program, please visit their website at **www.weightwatchers.com**.

Continued WW Benefit

The Alliance will continue to offer vouchers to our members to attend Wellness Workshops. Alliance members will also have access to the digital tools. You can refer members who want support to make healthy lifestyle changes to WW, regardless of whether they want to lose weight. Workshops are held throughout Alameda County, and are held at different times of day. Members can even rotate locations. We will soon update our materials to reflect WW name change.

Thank you for your WW referrals and the critical role you play encouraging patients to participate in wellness programs like WW!

Questions? Please call Alliance Health Programs
Monday – Friday, 8 am – 5 pm
Phone Number: **510.747.4577**
Email: **livehealthy@alamedaalliance.org**
www.alamedaalliance.org