2019 Quarter 3 Provider Packet
Provider Visit Form

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

PCP____ Specialist____ CBAS____ Home Health____ SNF____ Ancillary____ Other____

PACKET INCLUDES:

- 2019 Quarter 3 Provider Packet – Provider Visit Form
- Vendor Disclosure of Ownership Form
- Provider Demographic Attestation Form
- Required: 2 Question/5-Minute Survey
- Electronic Funds Transfer (EFT) for Provider Payments
- EFT Authorization Form
- Electronic Data Interchange (EDI) Enrollment Form & Network Access Request for Secure File Transfer Protocol (SFTP) Form
- Electronic Remittance Advice (ERA) Enrollment Form & Questionnaire
- 2019 Pay-for-Performance (P4P) Program Quarterly Opioid Education
- Member Responsibilities and Rights
- Preventive Guidelines Update 2019
- Important Notice on Measles
- Important Notice on Pertussis
- Conversations with Parents about Vaccines
- Cultural Sensitivity Training 2019

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

Comments: ____

____

____

Provider/Office Staff Signature: ____

Provider/Office Staff Print: ____

Vendor Disclosure of Ownership Form

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.

Important Note: 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		

ALAMEDA **Alliance** FOR HEALTH

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.					
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:

Please print single-sided and fax the completed form to the Alliance Provider Services Department:
Fax: **1.855.891.7257**

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: **1.510.747.4510**
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

Date Update Completed *(MM/DD/YYYY)*: _____ / _____ / _____

Notes:

Questions? Please call the Alliance Provider Services Department
Monday – Friday, 7:30 am – 5 pm
Phone Number: **1.510.747.4510**
www.alamedaalliance.org

Required: 2 Question/5-Minute Survey

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

From **May to December of 2019**, the Alliance will be conducting the **2019 Provider Appointment Availability Survey (PAAS)**. All health plans in California are required to survey providers to assess the availability of routine and urgent appointments.

The Alliance will *first* fax/email the survey. If we do not receive a fax or email response, we will *follow* with a phone call.

Specifically, we will be asking:

1. When is your next available appointment date and time for **urgent** services?
2. When is your next available appointment date and time for **non-urgent** services?

Your provider office is **contractually obligated** to complete the survey. Please note that refusal to comply with the survey may result in a corrective action plan.

The required appointment availability timeframes are outlined in the table on the next page.

Thank you for your attention and assistance in completing this survey.

TIMELY ACCESS REGULATION*

All Providers are required to offer appointments within the following timeframes:

PRIMARY CARE PHYSICIAN (PCP) APPOINTMENT	
Appointment Type:	**Appointment Within:**
Non-Urgent Appointment	10 Business Days of Request
Initial OB/Gyn Pre-natal Appointment	2 Weeks of Request
Urgent Appointment that *requires* PA	96 Hours of Request
Urgent Appointment that *does not* require PA	48 Hours of Request

SPECIALTY/OTHER APPOINTMENT	
Appointment Type:	**Appointment Within:**
Non-Urgent Appointment with a **Specialist** Physician	15 Business Days of Request
Non-Urgent Appointment with a **Behavioral Health** Provider	10 Business Days of Request
Non-Urgent Appointment with an **Ancillary Service**	15 Business Days of Request
Initial OB/Gyn Pre-natal Appointment	2 Weeks of Request
Urgent Appointment that *requires* PA	96 Hours of Request
Urgent Appointment that *does not* require PA	48 Hours of Request

ALL PROVIDER WAIT TIME/TELEPHONE/LANGUAGE PRACTICES	
Appointment Type:	**Appointment Within:**
In-Office Wait Times	60 Minutes
Call Return Time	1 Business Day
Time to Answer Call	10 Minutes
After-Hours Telephone Access – Provide 24 Hours Coverage	
Emergency Instructions – Ensure Proper Emergency Instructions	
Language Services – Provide 24 Hour Interpretive Services	

*** DMHC Regulations, Title 28 §1300.67.2.2(c)(5)**

PA = Prior Authorization

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.

This notification shall serve 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 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, Saving.

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:

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

SECTION B:

<table>
<tr><td>1. FINANCIAL INSTITUTION ROUTING NUMBER</td><td>2. PROVIDER'S ACCOUNT NUMBER (include leading zeros)</td><td>3. TYPE OF ACCOUNT AT FINANCIAL INSTITUTION
☐ CHECKING ☐ SAVINGS</td></tr>
<tr><td colspan="3">4. FINANCIAL INSTITUTION NAME</td></tr>
<tr><td colspan="3">8. PROVIDER ADDRESS</td></tr>
</table>

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: _________________________

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.

Electronic Data Interchange (EDI) Enrollment Form

Thank you for your interest in transmitting information electronically to Alameda Alliance for Health (Alliance). The first step in the EDI onboarding process is the completion of the EDI Enrollment Form and Trading Partner Agreement below. Please complete the forms and mail, fax or email it to:

Alameda Alliance for Health
Attn: IT Department – EDI Enrollment
1240 South Loop Road
Alameda, CA 94502
Fax: **1.510.747.4290**
Email: **edisupport@alamedaalliance.org**

For any questions, please call the Alliance Electronic Data Interchange Department at **1.510.373.5757**.
NOTE: If you are not a contracted provider with the Alliance, a copy of your W-9 may be required by the Alliance Provider Services Department. Please send a copy of your W-9 along with your Tax Identification Number (TIN) and National Provider Identifier (NPI) to **providerservices@alamedaalliance.org**.

EDI ENROLMMENT INFORMATION		
TODAY'S DATE *(MM/DD/YYYY)*:	ANTICIPATED FREQUENCY OF TRANSMISSION *(select one)*: ☐ Daily ☐ Weekly ☐ Monthly ☐ Other: ______	
DESIRED PRODUCTION DATE *(MM/DD/YYYY)*:		
SUBMITTER INFORMATION *(Note: Exact name below should appear on inbound EDI claims)*		
COMPANY/PROVIDER NAME:		
TAX IDENTIFICATION NUMBER (TIN) **OR** UNIQUE PHYSICIAN IDENTIFICATION NUMBER (UPIN) *(if applicable)*:		
GROUP NPI *(if applicable)*:	INDIVIDUAL NPI:	
NPI Effective Date *(MM/DD/YYYY)*:		
ADDRESS:		
CITY:	STATE:	ZIP:
PHONE NUMBER:	FAX NUMBER:	
CONTACT INFORMATION		
NAME:		
PHONE NUMBER:	FAX NUMBER:	
EMAIL ADDRESS:		
INFORMATION SYSTEMS CONTACT NAME:		
PHONE NUMBER:	FAX NUMBER:	
EMAIL ADDRESS:		

TRANSMISSION/FORMAT INFORMATION
SUBMITTER PLANS TO TRANSMIT/RECEIVE THE FOLLOWING TRANSACTIONS *(select all that apply)*:
☐ Professional Health Claims (ASC X12N 837-005010X222A1)
☐ Institutional Health Claims (ASC X12N 837-005010X0223A2)
☐ Health Care Claim Payment Advice (ASC X12N 835-005010X0221A1)
☐ Health Care Eligibility Status Request and Response Transaction (ASC X12N 270/271-005010X279A1)
☐ Health Care Claim Status Request and Response Transaction (ASC X12N 276/277-005010X212)

CLEARINGHOUSE INFORMATION

The Alliance will receive files directly from a submitter or via the submitter's clearinghouse. All clearinghouse fees are the submitter's responsibility.

It is also the submitter's responsibility to secure a Business Associate Agreement (BAA) with its clearinghouse. If you indicate below that a BAA is not in place, the Alliance will not send any protected health information (PHI) to the clearinghouse on the submitter's behalf. The submitter must provide the Alliance a written notice 30 days prior to terminating an active BAA with its clearinghouse.

Do you currently use a clearinghouse for electronic transmissions?

☐ No ☐ Yes

If **yes**, what is your clearinghouse name? ________________________________

If **yes**, do you plan to use this clearinghouse for transmissions involving the Alliance?

☐ No ☐ Yes

If **yes**, do you have a BAA in place with your clearinghouse?

☐ No ☐ Yes

TRADING PARTNER AGREEMENT

(This should be signed by the provider)

This agreement is made between Alameda Alliance for Health ("Plan") and ________________________

("Trading Partner") as of _____________day of ____________________________, 20____. This agreement provides the terms and conditions governing electronic transfers of data between Plan and Trading Partner (collectively "Parties"). Both Parties acknowledge and agree that the privacy and security of data held by or exchanged between them is of utmost priority. Both Plan and Trading Partner agree to take steps reasonably necessary to ensure that electronic transactions between them conform to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Plan's Electronic Data Interchange (EDI) Enrollment Form, and the then current version of the Plan companion guides. This agreement will remain in effect until terminated according to the terms listed in this agreement. This agreement cannot be altered or amended without a written statement signed by both Parties.

I. Term and Termination

This agreement will remain effective indefinitely beginning on the effective date of this agreement. Either Party may voluntarily terminate this agreement by providing written notice to the other Party thirty (30) days in advance of the termination date. If a Party breaches any material obligation of this agreement, the other Party may terminate this agreement immediately upon providing written notice to the other Party.

II. Obligations of the Parties

1. Each Party will be responsible for and take reasonable care to ensure that the information submitted in each electronic transaction by itself, its employees, or its agents is accurate, complete and truthful.
2. Each Party will take reasonable precautions to limit the disclosure of the electronic data to authorized personnel on a need-to-know basis. Company and Trading Partner will notify the other Party of a termination of its relationship with a previously authorized employee or vendor (i.e., clearinghouse), that may require action to foreclose submission and receipt of transactions by person or vendor no longer authorized to act on its behalf.
3. Parties will not disclose the electronic data to any other person or organization without the express written permission of the subject of the data (i.e., the Plan's member or the Trading Partner's patient/customer) unless such disclosure is permissible by State or Federal law. Plan and Trading Partner will notify the other Party if it becomes aware of any use or disclosure that is not expressly permitted by this agreement.
4. Each Party will treat the information sent and received electronically as proprietary and will not use the information for any purpose or in a manner that would violate any privacy, security, or confidentiality laws or regulations including, but not limited to, the HIPAA law. Each party will put appropriate safeguards in place to protect patient specific data from improper access and will maintain the confidentiality of any security access codes.
5. Both Parties must agree that adequate testing has been completed before "live," production submissions will be transmitted or accepted to or from the other Party.
6. Plan and Trading Partner will not consider the other Party's electronic submission "received" (and will not "date stamp" the transaction) until the file has passed the Plan's initial edits.
7. Each Party will pay its own costs, charges, or fees it may incur as a result of transmitting electronic transactions to, or receiving electronic transactions from, the other Party.
8. Each Party will retain all original source documentation that supports the electronic data submission for at least six years and as required by applicable state and federal laws. Plan and Trading Partner shall have access to the other Party's original source documentation for auditing and verification purposes. Both Parties will research and correct any data discrepancies at its own expense. If a discrepancy is identified in either Party's original source documentation, both Parties agree to implement corrective action that will ensure an accurate and prompt resolution which may include adjusting any incorrect payments identified as a result of such audit. Anyone who misrepresents or falsifies information relating to a claim may, upon conviction, be subject to fines and/or imprisonment under Federal law.
9. Plan and Trading Partner will notify the other Party promptly if any transmitted data is received in an unintelligible or garbled form. Both Parties agree to retransmit the original transmission if a data transmission is lost or indecipherable.
10. Plan agrees to provide an acknowledgement of receipt of the Trading Partner's electronic data submission.

III. Indemnification

Plan and Trading Partner shall hold harmless and indemnify the other Party from any and all claims, liabilities, judgments, damages or judgments asserted against, imposed upon or incurred due to its own negligence, intentional wrongdoing, or violation of this agreement.

IV. Authorized Signature

I am authorized to sign this agreement on behalf of said Trading Partner. I have read and agree to the foregoing provisions and acknowledge the same by signing below.

Alameda Alliance for Health Trading Partner

Printed Name: ____

Printed Title: ____

Date: ____

Network Access Request for Secure File Transfer Protocol (SFTP) Form – External

Thank you for your interest in transmitting information electronically to Alameda Alliance for Health (Alliance). The Alliance has implemented a secure, Health Insurance Portability and Accountability Act (HIPAA) compliant file transfer website. This website will allow our trading partners to securely send and receive protected health information (PHI) to the Alliance.

The first step in the SFTP onboarding process is the completion of the Network Access Request for Secure File Transfer Protocol (SFTP) form below. Please complete the form and fax or email it to:

Alliance EDI Department
Fax: **1.510.747.4290**
Email: **edisupport@alamedaalliance.org**

NOTE: This form must be completed the provider; third party requestors are not allowed. Fields with a (*****) must be completed. Once the form has been reviewed and approved, the Alliance Service Desk team will send a confirmation email with instructions on how to use the website. Please allow 5 to 10 business days for a response. For any questions, please call the Alliance Service Desk at **1.510.747.4520**.

REQUESTOR INFORMATION*		
FIRST NAME:	LAST NAME:	
TITLE:	COMPANY NAME:	
BUSINESS ADDRESS:		
CITY:	STATE:	ZIP:
PHONE NUMBER:	FAX NUMBER:	
EMAIL ADDRESS:		
NATURE OF WORK:	SUBMISSION DATE *(MM/DD/YYYY)*:	
REQUEST TYPE *(select one)*: ☐ New SFTP Folder Set-Up ☐ Access Existing SFTP Folder		
FOLDER NAME *(if known)*:		
EXTERNAL IP ADDRESS *(www.whatismyip.com)*:		
USE TYPE *(select one)*: ☐ One-Time ☐ Reoccurring		
REQUESTOR'S MANAGER INFORMATION*		
FIRST NAME:	LAST NAME:	
TITLE:	PHONE NUMBER:	
EMAIL ADDRESS:		
REQUESTOR'S IT CONTACT INFORMATION*		
FIRST NAME:	LAST NAME:	
TITLE:	PHONE NUMBER:	
EMAIL ADDRESS:		

ALLIANCE CONTACT *(referred by)*
PRIMARY CONTACT NAME:
SECONDARY CONTACT NAME: Cindy Rogers

CONFIDENTIALITY STATEMENT

I agree not to share my password, leave terminal sessions logged in under my name for others to use, or otherwise share access under my privileges. I understand that my logon name and password constitutes an electronic signature under California law.

I agree to access only members for whom I am providing assistance or for whom I can demonstrate a need to know.

I agree to maintain the confidentiality of medical information and will abide by the Alameda Alliance for Health security and confidentiality policies.

Requestor's Signature: ______________________________

Alliance Supervising Manager Signature: ______________________________

Date: ______________________________

ALLIANCE USE ONLY	
FILE TYPE:	AUTOMATION: ☐ Yes ☐ No
STAGING LOCATION:	SCHEDULE: ☐ Daily ☐ Weekly ☐ Monthly
FTP ACCOUNT NAME:	PROCESS TYPE: ☐ In ☐ Out ☐ Both

Electronic Remittance Advice (ERA) Enrollment Form

Thank you for your interest in receiving ERA from Alameda Alliance for Health (Alliance). The first step in the ERA onboarding process is the completion of the ERA Enrollment Form and Trading Partner Agreement below. Please complete the forms and mail, fax or email them to:

Alameda Alliance for Health
Attn: IT Department – EDI Enrollment
1240 South Loop Road
Alameda, CA 94502
Fax: **1.510.747.4290**
Email: **edisupport@alamedaalliance.org**

For any questions, please call the Alliance Electronic Data Interchange Department at **1.510.373.5757**.
NOTE: ERA testing cannot be initiated until the Alliance has received your completed ERA Enrollment Form and Trading Partner Agreement.

PROVIDER INFORMATION		
COMPANY/PROVIDER NAME:		
DOING BUSINESS AS (DBA) *(Trade name, or fictitious business name, under which the business or operation is conducted and not the legal name of the legal person(s) who own/and are responsible for it)*:		
TAX IDENTIFICATION NUMBER (TIN):		
NATIONAL PROVIDER IDENTIFIER(S) (NPI)*:*		
GROUP NPI: ☐ Yes ☐ No	INDIVIDUAL NPI: ☐ Yes ☐ No	
ADDRESS:		
CITY:	STATE:	ZIP:
PHONE NUMBER:	FAX NUMBER:	
PROVIDER CONTACT INFORMATION		
NAME *(Name of a contact in provider office for handling ERA issues)*:		
PHONE NUMBER/EXT:	FAX NUMBER:	
EMAIL ADDRESS:		
PREFERENCE FOR AGGREGATION OF REMITTANCE DATA *(e.g., Account Number Linkage to Provider Identifier) (Provider preference for grouping (bulking) claim payment remittance advice – must match preference for EFT payment. Select one.)*: ☐ NPI ☐ TIN		
METHOD OF RETRIEVAL: ▣ Download from Alliance SFTP site *(only option)*		
REASON FOR ENROLLMENT SUBMISSION *(select one)*: ☐ New Enrollment ☐ Change Enrollment ☐ Delete Enrollment		

TRADING PARTNER AGREEMENT

(This should be signed by the provider)

This agreement is made between Alameda Alliance for Health ("Plan") and ________________________

("Trading Partner") as of ____________day of ___________________________, 20____. This agreement provides the terms and conditions governing electronic transfers of data between Plan and Trading Partner (collectively "Parties"). Both Parties acknowledge and agree that the privacy and security of data held by or exchanged between them is of utmost priority. Both Plan and Trading Partner agree to take steps reasonably necessary to ensure that electronic transactions between them conform to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Plan's Electronic Data Interchange (EDI) Enrollment Form, and the then current version of the Plan companion guides. This agreement will remain in effect until terminated according to the terms listed in this agreement. This agreement cannot be altered or amended without a written statement signed by both Parties.

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II. Obligations of the Parties

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2. Each Party will take reasonable precautions to limit the disclosure of the electronic data to authorized personnel on a need-to-know basis. Company and Trading Partner will notify the other Party of a termination of its relationship with a previously authorized employee or vendor (i.e., clearinghouse), that may require action to foreclose submission and receipt of transactions by person or vendor no longer authorized to act on its behalf.
3. Parties will not disclose the electronic data to any other person or organization without the express written permission of the subject of the data (i.e., the Plan's member or the Trading Partner's patient/customer) unless such disclosure is permissible by State or Federal law. Plan and Trading Partner will notify the other Party if it becomes aware of any use or disclosure that is not expressly permitted by this agreement.
4. Each Party will treat the information sent and received electronically as proprietary and will not use the information for any purpose or in a manner that would violate any privacy, security, or confidentiality laws or regulations including, but not limited to, the HIPAA law. Each party will put appropriate safeguards in place to protect patient specific data from improper access and will maintain the confidentiality of any security access codes.
5. Both Parties must agree that adequate testing has been completed before "live," production submissions will be transmitted or accepted to or from the other Party.
6. Plan and Trading Partner will not consider the other Party's electronic submission "received" (and will not "date stamp" the transaction) until the file has passed the Plan's initial edits.
7. Each Party will pay its own costs, charges, or fees it may incur as a result of transmitting electronic transactions to, or receiving electronic transactions from, the other Party.

8. Each Party will retain all original source documentation that supports the electronic data submission for at least six years and as required by applicable state and federal laws. Plan and Trading Partner shall have access to the other Party's original source documentation for auditing and verification purposes. Both Parties will research and correct any data discrepancies at its own expense. If a discrepancy is identified in either Party's original source documentation, both Parties agree to implement corrective action that will ensure an accurate and prompt resolution which may include adjusting any incorrect payments identified as a result of such audit. Anyone who misrepresents or falsifies information relating to a claim may, upon conviction, be subject to fines and/or imprisonment under Federal law.
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10. Plan agrees to provide an acknowledgement of receipt of the Trading Partner's electronic data submission.

III. Indemnification

Plan and Trading Partner shall hold harmless and indemnify the other Party from any and all claims, liabilities, judgments, damages or judgments asserted against, imposed upon or incurred due to its own negligence, intentional wrongdoing, or violation of this agreement.

IV. Authorized Signature

I am authorized to sign this agreement on behalf of said Trading Partner. I have read and agree to the foregoing provisions and acknowledge the same by signing below.

Alameda Alliance for Health Trading Partner

Signature: ____

(This must be signed by the ultimate Trading Party, not a third party representative.)

Printed Name: ____

Printed Title: ____

Date: ____

Are you a Candidate for Electronic Remittance Advice (ERA)?

What is ERA?

Alameda Alliance for Health (Alliance) offers both paper remittance advices (RAs), and electronic remittance advices (ERAs) to our contracted providers. ERAs are formatted in a standard computer language (ANSIx12835/835 format). ERAs are designed to load directly into an EMR/HealthCare software that supports the standard 835 format. ERAs are received more quickly, and saves you processing time.

How does ERA work?

The Alliance currently sends ERAs directly to a provider's Secure File Transfer Protocol (SFTP) location. **However, providers are welcome to directly share ERAs with their clearinghouse.**

Is your practice a candidate for ERA?

In order to receive ERAs, you must meet certain system/software requirements. Please answer following questions to ensure that your practice is a candidate to receive ERA's.

1. Does your EMR/Medical Software support electronic 835s in-house, and reconcile with submitted claims?

   ☐ **YES** ☐ **NO** *(If* ***NO****, your practice is* ***NOT*** *a candidate for ERA)*

2. Do you receive electronic 835s from other payers?

   ☐ **YES** ☐ **NO**

   If **YES**, how do you process them?

3. If your clearinghouse is processing electronic 835s for you, would you be able to share the electronic 835s from the Alliance directly with them?

   ☐ **YES** ☐ **NO**

Questions? Please call the Alliance Electronic Data Interchange Department
Monday – Friday, 9 am – 5 pm
Phone Number: **1.510.373.5757**
www.alamedaalliance.org

July 1, 2019

Re: Alliance Substance Abuse Stewardship Program

Dear Provider,

Alameda Alliance for Health (Alliance) values our dedicated provider partners, and we appreciate the care you provide to our patients and community.

The Alliance has implemented a substance abuse stewardship program that closely complements the Centers for Disease Control and Prevention (CDC) treatment guidelines. Our **Pay-for-Performance (P4P) Program incentivizes the review of quarterly opioid education**.

Please review the attached:

- Calculating Total Daily Dose of Opioids
- CDC Opioid Guideline Mobile App

The table below details the **current and planned** opioid/benzodiazepine allowance.

PROGRAM	DEC 2018	JUNE 2019
"New Start" SAO Limits	14 days	14 days
SAO Quality Limit/Month	90 pills/30 days	60 pills/30 days
PA for All LAOs	Yes	Yes
LAO Increase Limit	Yes	Yes

Key Points:

- Short acting opioids (**SAO**) have a **14-day limit** on their **initial** start.
- All long acting opioids (**LAO**) require prior authorization (**PA**).
- **LAO** require the concurrent prescription of **naloxone**.
- Concurrent prescription of **benzodiazepines and opioids** require a **PA**, and the prescription of **naloxone**.

As a community partner, we value your efforts and need your support as we ensure the safe and appropriate use of opioids. Thank you for the care that you provide to your patients and our community.

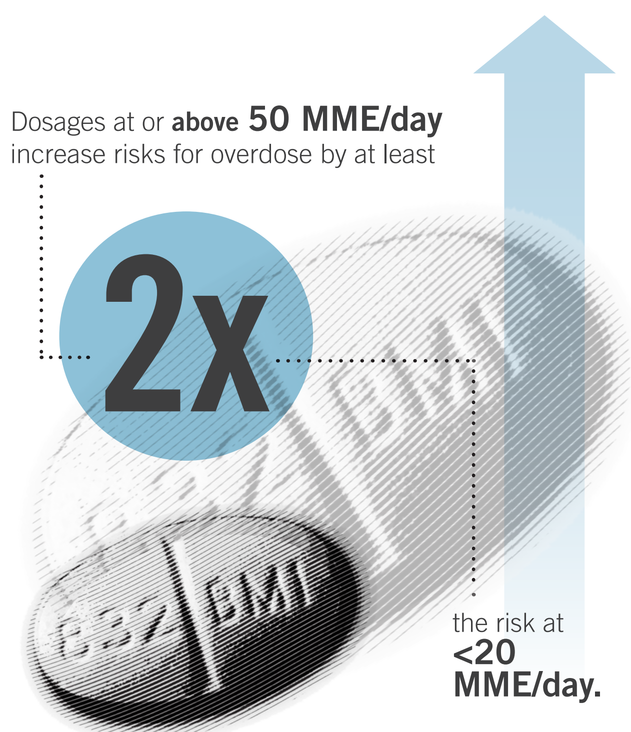
Sincerely,

Sanjay Bhatt, MD MS MMM
Medical Director – Quality Improvement
Alameda Alliance for Health

CALCULATING TOTAL DAILY DOSE OF OPIOIDS FOR SAFER DOSAGE

Higher Dosage, Higher Risk.

Higher dosages of opioids are associated with higher risk of overdose and death—even relatively low dosages (20-50 morphine milligram equivalents (MME) per day) increase risk. Higher dosages haven't been shown to reduce pain over the long term. One randomized trial found no difference in pain or function between a more liberal opioid dose escalation strategy (with average final dosage 52 MME) and maintenance of current dosage (average final dosage 40 MME).



WHY IS IT IMPORTANT TO CALCULATE THE TOTAL DAILY DOSAGE OF OPIOIDS?

Patients prescribed higher opioid dosages are at higher risk of overdose death.

In a national sample of Veterans Health Administration (VHA) patients with chronic pain receiving opioids from 2004–2009, **patients who died** of opioid overdose were prescribed an average of **98 MME/day**, while **other patients** were prescribed an average of **48 MME/day**.

Calculating the total daily dose of opioids helps identify patients who may benefit from closer monitoring, reduction or tapering of opioids, prescribing of naloxone, or other measures to reduce risk of overdose.

HOW MUCH IS 50 OR 90 MME/DAY FOR COMMONLY PRESCRIBED OPIOIDS?

50 MME/day:

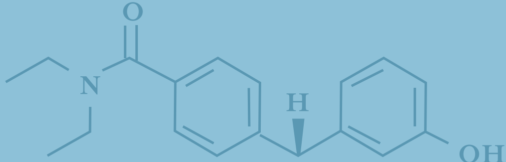
- 50 mg of hydrocodone (10 tablets of hydrocodone/ acetaminophen 5/300)
- 33 mg of oxycodone (~2 tablets of oxycodone sustained-release 15 mg)
- 12 mg of methadone (<3 tablets of methadone 5 mg)

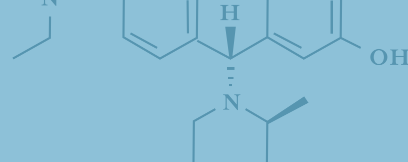
90 MME/day:

- 90 mg of hydrocodone (9 tablets of hydrocodone/ acetaminophen 10/325)
- 60 mg of oxycodone (~2 tablets of oxycodone sustained-release 30 mg)
- ~20 mg of methadone (4 tablets of methadone 5 mg)

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html





HOW SHOULD THE TOTAL DAILY DOSE OF OPIOIDS BE CALCULATED?

1. **DETERMINE** the total daily amount of each opioid the patient takes.
2. **CONVERT** each to MMEs—multiply the dose for each opioid by the conversion factor. (*see table*)
3. **ADD** them together.

Calculating morphine milligram equivalents (MME)

OPIOID (doses in mg/day except where noted)	**CONVERSION FACTOR**
Codeine	0.15
Fentanyl transdermal (in mcg/hr)	2.4
Hydrocodone	1
Hydromorphone	4
Methadone	
1-20 mg/day	4
21-40 mg/day	8
41-60 mg/day	10
≥ 61-80 mg/day	12
Morphine	1
Oxycodone	1.5
Oxymorphone	3

These dose conversions are estimated and cannot account for all individual differences in genetics and pharmacokinetics.

CAUTION:

- Do not use the calculated dose in MMEs to determine dosage for converting one opioid to another—the new opioid should be lower to avoid unintentional overdose caused by incomplete cross-tolerance and individual differences in opioid pharmacokinetics. Consult the medication label.

USE EXTRA CAUTION:

- **Methadone:** the conversion factor increases at higher doses
- **Fentanyl:** dosed in mcg/hr instead of mg/day, and absorption is affected by heat and other factors

HOW SHOULD PROVIDERS USE THE TOTAL DAILY OPIOID DOSE IN CLINICAL PRACTICE?

- Use caution when prescribing opioids at any dosage and prescribe the lowest effective dose.
- Use extra precautions when increasing to ≥50 MME per day* such as:
  - Monitor and assess pain and function more frequently.
  - Discuss reducing dose or tapering and discontinuing opioids if benefits do not outweigh harms.
  - Consider offering naloxone.
- Avoid or carefully justify increasing dosage to ≥90 MME/day.*

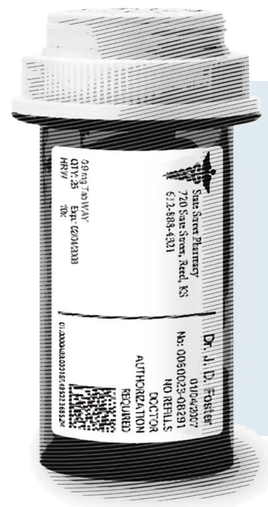
* These dosage thresholds are based on overdose risk when opioids are prescribed for pain and should not guide dosing of medication-assisted treatment for opioid use disorder.

CDC OPIOID PRESCRIBING GUIDELINE MOBILE APP

Safer Opioid Prescribing at Your Fingertips

THE OPIOID GUIDE APP

Opioids can have serious risks and side effects, and CDC developed the CDC Guideline for Prescribing Opioids for Chronic Pain to encourage safer, more effective chronic pain management. CDC's new Opioid Guide App makes it easier to apply the recommendations into clinical practice by putting the entire guideline, tools, and resources in the palm of your hand.



Since 1999, the amount of prescription opioids sold in the U.S. has nearly quadrupled.

FEATURES INCLUDE:

MME Calculator

Patients prescribed higher opioid dosages are at higher risk of overdose death. Use the app to quickly calculate the total daily opioid dose (MME) to identify patients who may need closer monitoring, tapering, or other measures to reduce risk.

Prescribing Guidance

Access summaries of key recommendations or link to the full Guideline to make informed clinical decisions and protect your patients.

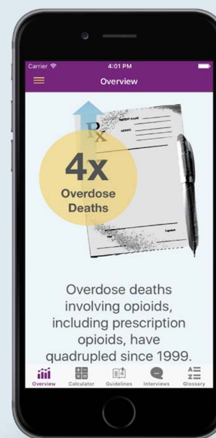
Motivational Interviewing (MI)

To provide safer, more effective pain management, talk to your patients about the risks and benefits of opioids and work together towards treatment goals. Use the interactive MI feature to practice effective communication skills and prescribe with confidence.

MANAGING CHRONIC PAIN IS COMPLEX, BUT ACCESSING PRESCRIBING GUIDANCE HAS NEVER BEEN EASIER.

Download the free Opioid Guide App today!

www.cdc.gov/drugoverdose/prescribing/app.html



Available on the App Store

ANDROID APP ON Google play

This App, including the calculator, is not intended to replace clinical judgment. Always consider the individual clinical circumstances of each patient.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

WE ARE A PART OF YOUR HEALTH CARE FAMILY AND WE EACH HAVE A ROLE TO PLAY

Alliance Member Responsibilities and Rights

If you need help reading this document or would like a different format, please call Member Services at 510.747.4567

Si necesita ayuda para leer este documento, llame a Servicios al Cliente al 510.747.4567

假如您看不懂本文件，需要協助或其他語文版本，請致電會員服務部，電話 510.747.4567

Nếu quý vị cần giúp đỡ đọc tài liệu này, xin gọi ban Dịch Vụ Hội Viên tại số 510.747.4567

As a member of Alameda Alliance for Health (Alliance), you have certain responsibilities.

ALLIANCE MEMBERS HAVE THESE RESPONSIBILITIES:
To treat all the Alliance staff and health care staff with respect and courtesy.
To give your doctors and the Alliance correct information.
To work with your doctor. Learn about your health, and help to set goals for your health. Follow care plans and advice for care that you have agreed to with your doctors.
To always present your Alliance Member Identification Card to receive services.
To ask questions about any medical condition, and make sure you understand your doctor’s reasons and instructions.
To help the Alliance maintain accurate and current records by providing timely information regarding changes in address, family status, and other health care coverage.
To make and keep medical appointments and inform your doctor at least twenty-four (24) hours in advance when you need to cancel an appointment.
To use the emergency room only in case of an emergency or as directed by your doctor.

Alliance Member Responsibilities and Rights

As a member of Alameda Alliance for Health (Alliance), you have certain rights.

ALLIANCE MEMBERS HAVE THESE RIGHTS:
To receive information and advice about the Alliance, its programs, its doctors, the health care network, Advance Directive, and your rights and responsibilities.
To receive services and care without discrimination of race, color, ethnicity, national origin, religion, immigration status, age, disability, socioeconomic status, gender identity, or sexual orientation.
To be treated with respect at all times.
To keep your health information private, receive a copy, review and request changes to your health records.
To choose a doctor [Primary Care Provider (PCP)] within the Alliance's network and help make choices about your health care with your doctor. This includes the right to refuse treatment.
To talk freely with your doctors about treatment options for your health and help make choices about your health care with your doctor, this includes the right to refuse treatment.
To voice complaints (grievance) about the Alliance, its doctors, or the care we provide, or ask for a State Medi-Cal Fair Hearing.
To receive translation and interpreter services, and written information in other formats (audio, braille, large size print, etc.).
To access covered Federally Qualified Health Centers, American Indian Health Programs, sexually transmitted disease services, emergency services and family planning services outside the Alliance's network, Minor Consent Services, and specialty services (i.e., Durable Medical Equipment (DME)).
To leave the Alliance upon request at any time, subject to any restricted disenrollment period.
To continue to see your doctor if you are no longer covered by the Alliance under certain circumstances.
To be free from any form of restraint or rejection used as a means of pressure, discipline, convenience, or retaliation.
To use these rights freely without changing how you are treated by the Alliance, doctors, the health care network, or the State.
To access the Alliance Nurse Line, 24/7 at 1.888.433.1876.
To access telephone Triage or Screening 24/7 by calling your Primary Care Provider (PCP).

Alliance Member Responsibilities and Rights

As a member of Alameda Alliance for Health (Alliance) you also have the right to receive timely access to care.

California Law requires the Alliance to provide timely access to care. This means there are limits on how long our members have to wait to receive health care appointments, and telephone advice. The Alliance will do our best to ensure that you are best cared for and treated in a timely manner.

APPOINTMENT WAIT TIMES:
Health plan members have the right to appointments within the following time frames:

EMERGENCY CARE	WAIT TIME
Emergency Care (life-threatening)	Immediately, 24/7
Emergency Care (non-life-threatening)	Within 6 hours
URGENT APPOINTMENTS	**WAIT TIME**
For services that do not need prior approval	48 hours from request
For services that need prior approval	96 hours from request
NON-URGENT APPOINTMENTS	**WAIT TIME**
Primary care appointment	10 business days
Specialist appointment	15 business days
Appointment with a mental health care provider (who is not a physician)	10 business days
Appointment for ancillary services to diagnose or treat a health condition	15 business days

Questions? Call the Alliance Member Services
Monday – Friday, 8 am – 5 pm
Phone Number: 510.747.4567 • Toll-Free: 1.877.932.2738 • CRS/TTY: 711/1.800.735.2929
www.alamedaalliance.org

Alliance Member Responsibilities and Rights

WORDS TO KNOW
Ancillary Services – Health care services to support the work of a doctor. Services can be classified into three categories: diagnostic, therapeutic, and custodial. Services can include diagnostic laboratory and X-ray services, chiropractic services, and hospice care.
Emergency – The sudden start/onset of a medical condition or illness that is an immediate threat to the well-being of the patient. Conditions include but are not limited to chest pains, seizure or loss of consciousness, severe abdominal pain, sudden paralysis, uncontrolled bleeding, and active labor. If you have an emergency medical condition or psychiatric emergency, call 911 or go to the nearest hospital with an emergency room.
Emergency Care – An exam performed by a doctor (or other appropriate staff under the direction of a doctor as allowed by law) to find out if an emergency medical condition exists. Medically necessary services needed to make you clinically stable within the capabilities of the facility.
Durable Medical Equipment (DME) – Certain medically necessary equipment that is for repeated use, for medical purpose, and/or generally not useful for someone who is not ill or hurt.
Expedited – To speed up the review process.
Grievance – An official written or verbal complaint filed with your medical provider if you are not happy with the behavior or actions of your plan or its representative (e.g., poor customer service, when an appeal process extends past the written date, etc.).
Life-threatening – Fatal or lethal illness or condition, if not attended to immediately, the likelihood of death is high. Conditions include but are not limited to difficulty breathing, shortness of breath, electrocution, gunshot wound, stabbing, sudden fainting, and severe allergic reactions.
Medical Interpreter/Translator – Individual who can help communicate spoken or signed language between the patient and the healthcare provider. The interpreter does not add, omit or change meaning or offer an opinion.
Medically Necessary – Services that are reasonable and needed to protect life, to prevent illness or disability, or to relieve severe pain, through the diagnosis or treatment of disease, illness, or injury.
Non-life-threatening – Illness or injury that does not require immediate attention/help (e.g., common cold, broken fingers or toes).
Non-Urgent Appointments – Request if you would like to schedule a routine care, check-up, or periodic health examination with your primary care doctor or would like to set up an appointment with a diagnostic specialist.
Nurse Line – The Alliance Nurse Line is offered 24/7 to all members to help answer your health questions in regards to common illnesses and conditions, healthy lifestyle tips, health screenings and shots. The Nurse Line links you to a Registered Nurse who will discuss your health and wellbeing. The Registered Nurse will also help you decide what kind of care to seek, including: if your health problem can be treated at home, if you should see a doctor, or if you might need to get urgent or immediate care.
Primary Care/Routine Care – Medically necessary services that are not urgent and help keep you healthy, such as check-ups, Well Child visits, and services to keep you from getting sick. The goal of routine care is to prevent health problems.
Triage Line – The Alliance Triage line is offered 24/7 to all members to answer your health concerns and symptoms via communication, with a physician, registered nurse, or other qualified health professional to help determine the urgency of the member's need for care.
Urgent Appointments – Schedule if not condition or illness is attended to, could harm the patient's health in the future. Conditions include but are not limited to fever, ear/eye infection, minor cuts, broken bones, simple fractures).
Urgent Care – Medical care that is necessary to prevent serious deterioration of the health of a member, often resulting from an unforeseen illness, injury, or complication of an existing condition.

Preventive Guidelines Update – April 2019

Alameda Alliance for Health (Alliance) values our dedicated provider partner community. We are committed to continuously improving the quality of care and wellbeing of our members.

The Alliance recommends that our provider network follow the most current versions of the following preventive guidelines. We recognize that these guidelines are continuously updated and we understand that providers may need time to implement changes. For a complete list of the preventive guidelines, please visit **www.alamedaalliance.org/providers/medical-management/clinical-guidelines**

Children and Adolescents

Preventive Care
For members 21 years of age and under, the Alliance adheres to the most recent Bright Futures/ American Academy of Pediatrics (AAP) Recommendations for Preventive Pediatric Health Care. This is a schedule of screenings and assessments recommended at each well-child visit from infancy through adolescence. To view the full periodicity schedule, please visit **www.aap.org/periodicityschedule**.

Immunizations
The Alliance covers immunizations according to the immunization schedule recommended by the Advisory Committee on Immunization Practices (ACIP) and approved by the Centers for Disease Control and Prevention (CDC), American Academy of Pediatrics (AAP), American Academy of Family Physicians (AAFP), and American College of Obstetricians and Gynecologists (ACOG). To view the immunization schedule, please visit **www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html**.

Adults and Pregnant Women

Preventive Care
For asymptomatic healthy adults and pregnant women, the Alliance follows the current U.S. Preventive Services Task Force (USPSTF) A and B Recommendations for providing clinical preventive services. To view the recommendations, please visit **www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations**.

Immunizations
The Alliance provides immunizations according to the immunization schedule recommended by the Advisory Committee on Immunization Practices (ACIP) and approved by the Centers for Disease Control and Prevention (CDC), American College of Physicians (ACP), American Academy of Family Physicians (AAFP), American College of Obstetricians and Gynecologists (ACOG), and American College of Nurse-Midwives (ACNM). To view the adult immunization schedule for adults (19 years of age and older), please visit **www.cdc.gov/vaccines/schedules/hcp/imz/adult.html**.

Questions? Please call Alliance Health Programs
Monday – Friday, 9 am – 5 pm
Phone Number: **1.510.747.4577**
www.alamedaalliance.org

Important Notice on Measles

Alameda Alliance for Health (Alliance) values our dedicated provider partner community. We are committed to continuously improving our provider and member customer satisfaction. We have an important notice that we would like to share with you.

Measles in Alameda County

The City of Berkeley has confirmed one (1) case of measles in an adult resident. This person visited public venues during May 5, 2019 to May 13, 2019, including Berkeley Bowl. Earlier this year, an infectious individual visited a Livermore restaurant on March 23, 2019.

Actions Requested of Healthcare Professionals

1. **Watch** for measles symptoms. Consider measles in patients of any age who have a fever ≥ 101°F (38.3°C) and a maculopapular rash, regardless of their travel history or exposure history. Mask anyone with fever and rash.
2. **Immediately report** suspect measles cases. Call while the patient is in the office. Do not wait for lab confirmation to call.
3. **Test** in consultation with the Alameda County Public Health Department (ACPHD). Do not send specimens to a commercial lab or send the patient to the lab for testing.
4. **Implement** airborne precautions immediately.
5. **Advise** patient to stay home until contacted by ACPHD.
6. **Ensure** your staff and patients are up to date on their vaccinations against measles.

Prevent Measles

Protect your patients against measles by following the Centers for Disease Control and Prevention (CDC) vaccination guidelines. One (1) dose of the measles, mumps, and rubella (MMR) vaccine is about 93% effective at preventing measles; two doses are about 97% effective.

International travelers, college or trade school students, health care workers, and people who work with babies, children, pregnant women, or people with weak immune systems are recommended to receive two (2) doses of the MMR vaccine.

Additional Information and Resources

- Alameda County and City of Berkeley – Public Health Alerts and Advisories **www.cityofberkeley.info/Alerts_and_Advisories.aspx**
- Alameda County Public Health Department – Measles Prevention **www.acphd.org/measles/prevention.aspx**
- CDC – Measles Outbreak Toolkit for Healthcare Providers: **www.cdc.gov/measles/toolkit/healthcare-providers.html**
- Provider guidance and clinic waiting room posters **www.eziz.org/resources/measles**

Important Notice on Pertussis

At Alameda Alliance for Health (Alliance) we value our community of dedicated provider partners. We have an important notice that we would like to share with you.

Whooping Cough Infant Death Reported

The California Department of Public Health (CDPH) recently reported that the first 2019 infant pertussis death occurred in Orange County.

Immunize Pregnant Women to Prevent Infant Pertussis

In response, to the recent infant death, CDPH has issued a Clinician Health Advisory urging providers to ensure that **all pregnant patients between 27 and 36 weeks of gestation receive the Tdap vaccine. This vaccine is covered by Medi-Cal.**

Please encourage your pregnant patients and their families to receive the Tdap vaccination to protect their infants.

For more information please visit:

- Clinician Health Advisory: http://eziz.org/assets/docs/Prenatal/PertussisClinicianLetterApril2019.pdf
- CDPH Pertussis page: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Immunization/pertussis.aspx

Pregnancy Tdap Efforts at the Alliance

In an effort to improve Tdap vaccination rates, the Alliance has partnered with the Alameda County Public Health Department. To request free educational material or learn about best practices, please visit the Alameda County Public Health Department's Immunization Projects website at: http://www.acphd.org/iz/projects.aspx

If you are interested in knowing your Alliance member patient Tdap vaccination rates, please email Theresa Cereno, LVN at tcereno@alamedalliance.org.

Questions? Please call Alliance Health Programs
Monday – Friday, 9 am – 5 pm
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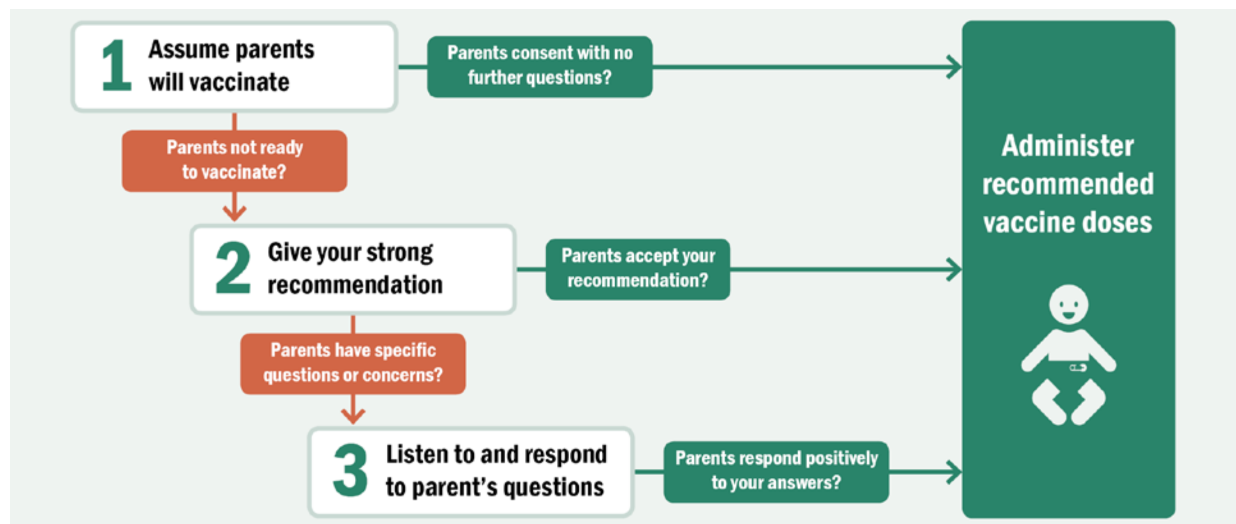
www.alamedaalliance.org

Conversations with Parents about Vaccines

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

When it comes to vaccines, your recommendation can make a difference! According to the Center for Disease Control and Prevention (CDC)[i] parents consider their child's doctor to be their most trusted source of information when it comes to vaccines.

Consider using the guide below to discuss vaccines with parents.



Additional Information and Resources

- Conversations with parents about vaccines – **www.cdc.gov/vaccines/hcp/conversations/conv-materials.html**
- Conversations with adults about vaccines – **www.cdc.gov/vaccines/hcp/adults/for-practice/standards/recommend.html**
- Conversations with women about vaccines – **immunizationforwomen.org/providers/practice-management/communicating-with-patients.php**

[i] Content and graphic are from **www.cdc.gov/vaccines/hcp/conversations/talking-with-parents.html**. June 7, 2019.

Cultural Sensitivity Training 2019

Alameda Alliance for Health (Alliance) values our community of dedicated provider partners. We are committed to continuously improving our provider and member customer satisfaction. We have an important notice that we would like to share with you.

Updated Alliance Cultural Sensitivity Training Now Available!

Ongoing cultural sensitivity training is an important way to help ensure our provider partners meet the diverse needs of their Alliance member patients. We have created a training that complies with cultural and linguistic regulations for Medi-Cal Managed Care. Our goal is to support you in advancing your expertise in providing quality health care through cultural sensitivity and communication. The training is updated annually.

The Alliance Cultural Sensitivity Training takes one (1) hour to complete and includes:

- State and federal laws and regulations regarding cultural, and linguistic services
- Current Alliance membership demographics
- Why culture is important in health care
- Practical tips for cultural sensitive practices
- Best communication practices for sub-groups, including:
    - Refugee and immigrant members
    - Limited-English speaking members
    - LGBTQ members
    - Senior and Persons with Disabilities
- Accessible communications: interpreters, translation, and alternate formats
- Case studies on providing culturally sensitive care

To view the training slide deck and webinar, as well as access other cultural resources, please visit: **www.alamedaalliance.org/providers/provider-training**

Questions? Please call Alliance Health Programs
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www.alamedaalliance.org