Alameda Alliance for Health (Alliance) New Provider Orientation for Enhanced Care Management (ECM) and Community Supports (CS)

ALAMEDA Alliance FOR HEALTH

Welcome to the Alliance Network!

ALAMEDA Alliance FOR HEALTH

ECM and CS Services Covered by the Alliance

- For members who have certain care needs and require ECM and CS services, such as:
  - Alliance Medi-Cal members who have certain health conditions; and
  - Who have been in the hospital or emergency room; or
  - Without stable housing.
- CS Services
  - Asthma remediation
  - Housing deposits
  - Housing navigation
  - Housing tenancy
  - Medical respite
  - Medically tailored meals

You can refer an Alliance Medi-Cal member to us by calling:

Alliance Case Management Department
Monday – Friday, 8 am – 5 pm
Phone Number: 1.510.747. 4512

Alliance ECM and CS Providers

- As a provider with the Alliance, you are contracted to provide services within the scope of your specialty and as defined in your contract to members for the following program:
  - Medi-Cal
    - → Health coverage for underserved individuals and families

Who We Are

- The Alliance has been in business since 1996.
- We are a local, not-for-profit Knox-Keene licensed health plan.
- Created by and for Alameda County residents.
- We hold open board meetings and are accountable to the community.
- We are committed to making high quality health care accessible and affordable to residents of Alameda County.
- Alliance Medi-Cal is comprehensive health coverage for Medi-Cal beneficiaries who have no share of cost and who live in Alameda County.
- Medi-Cal beneficiaries can choose between Alliance Medi-Cal and Anthem Blue Cross Medi-Cal. In some cases, they may have fee-for-service (FFS) Medi-Cal.
- Medi-Cal beneficiaries join the Alliance by completing the Medi-Cal Choice Form.

More About the Alliance (cont.)

- Some Medi-Cal beneficiaries must be enrolled in a health plan and may be automatically enrolled into the Alliance by the state.
- By enrolling in the Alliance for Medi-Cal, beneficiaries enjoy a large network of providers, assistance with care coordination, and a health plan that is local and accountable to the community.

Alliance Program Membership

- As an ECM/CS provider you will provide services to the Medi-Cal program. However, the Alliance provides comprehensive health care coverage to over 293,595 members through two programs:
  - Medi-Cal
    - → 287,715 members
  - Alliance Group Care
    - → 5,880 members

Source: Alameda Alliance for Health Board of Governors Regular Meeting – Operations Dashboard. December 2021

Alliance Medical Groups

- The Alliance is contracted with three medical groups:
  - Children First Medical Group (CFMG)
  - Community Health Center Network (CHCN)
  - Kaiser Permanente (Kaiser)
- Each group manages the non-ECM/CS authorizations, referrals, and claims of any Alliance member who chooses a PCP who belongs to that group – except for DME authorizations.
- For ECM/CS services, the Alliance manages authorizations, referrals, and claims/encounters for all Medi-Cal members including those that belong to CFMG and CHCN (excluding Kaiser).
  - Kaiser manages ECM and housing-related CS services for Alliance members assigned to Kaiser.
  - For members assigned to Kaiser, the Alliance manages CS services for medical respite, asthma remediation, and medically tailored meals.

Maintaining Your Alliance Contract

- Provide timely notification to Alliance Provider Services of all changes (organization name, phone, language capacity, address, TIN, etc.).
- Notify the Alliance Provider Services Department of new staff who provide ECM and CS services when they join or leave your organization. This is usually done through a roster.
- ECM and CS providers are credentialed at the organizational level. Please complete re-credentialing every three years.
- Please notify us of any changes in your ability to accept new referrals.

3 Easy Ways to Verify Member Eligibility

- Visit our Provider Portal (the best way!) through our website at **www.alamedaalliance.org**.
- Call the Alliance Provider Services Department at **1.510.747.4510**.
- Call the Alliance Member Services Department to speak with a friendly representative at **1.510.747.4567**.

Why It's Important to Verify Eligibility

- A member's eligibility can change from month-to-month.
- A referral or authorization doesn't guarantee that a member is eligible at the time of service.

Timely Access Requirements

Timely Access Requirements	
Appointment Type:	**Appointment Within:**
Non-Urgent Appointment	10 Business Days of Request
First 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
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** Provider	15 Business Days of Request
First OB/GYN Pre-natal Appointment	2 Weeks of Request
In-Office Wait Time	60 Minutes
Call Return Time	1 Business Day
Time to Answer Call	10 Minutes
Telephone Access – Provide coverage 24 hours a day, 7 days a week.	
Telephone Triage and Screening – Wait time not to exceed 30 minutes.	
Emergency Instructions – Ensure proper emergency instructions.	
Language Services – Provide interpreter services 24 hours a day, 7 days a week.	

Timely Access Standards Exceptions

Exceptions to the Appointment Availability Standards
Preventive Care Services and Periodic Follow Up Care: Preventive care services and periodic follow up care are not subject to the appointment availability standards. These services may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of their practice. Periodic follow-up care includes but is not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological monitoring for recurrence of disease.
Extending Appointment Waiting Time: The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the patient.
Advanced Access: The primary care appointment availability standard in the chart may be met if the primary care physician (PCP) office provides "advanced access." "Advanced Access" means offering an appointment to a patient with a primary care physician (or nurse practitioner or physician's assistant) within the same or next business day from the time an appointment is requested (or a later date if the patient prefers not to accept the appointment offered within the same or next business day).

After Hours Access to Care

- All PCPs are required to have after-hours phone coverage 24 hours a day, 7 days a week.
- After-hours access must include triage and screening (waiting time does not exceed 30 minutes) for emergency care and direction to call **9-1-1** for an emergency medical condition.
- A physician or mid-level provider must be available for contact after-hours, either in-person or via telephone.

Emergency Services

- Alliance members may seek care at any hospital Emergency Room(ER) for an emergency medical condition without authorization.
- ER services also include an evaluation to determine if a psychiatric emergency exists.
- Any prudent layperson may determine if an ER visit is warranted. An emergency medical condition (including labor and delivery) is defined by Title 22, CCR, Section 51056 and Title 28, CCR, Section 1300.71.4.(b)(2) as one that is manifested by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:
  - Placing the member's health in serious jeopardy
  - Serious impairment to bodily function
  - Serious dysfunction of any bodily organ or part
  - Death

Cultural and Language Services

- 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.
- To access telephonic interpreters at any time, 24 hours a day, 7 days a week, please call **1.510.809.3986**.
- For communication with a patient who is deaf, hearing or speech impaired, please call the California Relay Service (CRS) at **7-1-1.**
- Providers can request in-person interpreter services for ASL, complex and sensitive services. Find the guidelines and request form at **www.alamedaalliance.org**, and search for "Language Access". Please request **five (5) business days** in advance.
- Document in the health record if a patient refuses professional interpreter assistance.
- Keep on file documentation of language proficiency for any office staff who communicates with members in non-English languages.
- Update the Alliance on any changes in your office's language capacity.
- Members can request interpreter assistance or plan information in their preferred language by calling the Alliance Member Services Department at **1.510.747.4567**.

Cultural & Linguistic Services (cont.)

The Alliance is committed to providing quality healthcare to its culturally diverse membership. To ensure access for members of all cultures we:

- Offer providers cultural sensitivity training
  - Training available on our website and through bulletins and faxes.
  - Training covers use of language services, cultural impact on healthcare, working with members with disabilities, LGBT, aging, refugees & immigrants and more.
  - Providers are required to complete cultural sensitivity training upon joining the Alliance network and regularly thereafter.
- Communicate updates on our membership population noting changes in language, ethnicity, age, and gender.
- Provide plan materials and education in our members primary languages
  - English, Spanish, Chinese and Vietnamese (Medi-Cal) and English Spanish and Chinese (Group Care)
  - Content and images reflect the diversity of our membership
- Promote culturally sensitive care that recognizes use of home remedies, cultural preferences, health literacy challenges, privacy concerns and the complex nature of health care structure.

Services that Require a PCP Referral*

Services that Require a Referral from a Member's PCP	Documentation Requirements

• Diagnostic imaging studies at any facility contracted with the Alliance
• Outpatient elective surgery at any facility contracted with the Alliance
• Second opinions provided by specialists contracted with the Alliance
• Specialty care referrals to Alliance contracted specialists, including consults and in-office procedures
• Sweet Success services for prenatal diabetic care
	• PCP may refer the member to specialty care in writing or by phone
	• Once the initial referral is made, additional referrals to the same specialist are not required for care related to that condition
	• PCPs may make standing referrals for specific conditions and diseases
	• The specialist is required to:
	  • Verify the member's eligibility at the time of service
	  • Verify the referral from the PCP
	  • Provide feedback to the PCP
	  • Document the referring PCP's name in Box 17 of the CMS 1500 or Box 82 of the UB-92 for ALL consults and procedures related to the referred condition
	  • Claims that do not contain this information will be denied

*** Referral requirements may vary depending on the member's assigned Alliance medical group. Please contact the member's assigned medical group to find out if a referral is required for a particular service.**

Non-ECM and CS Services that Require Authorization

- To access the most up-to-date grid, please visit **www.alamedaalliance.org/providers/authorizations**
- The authorization process described in this presentation applies to members assigned to PCPs who are contracted directly with the Alliance or for members who have not yet been assigned to a PCP.
- The Alliance processes authorization requests in a timely manner and in accordance with state and federal requirements.
- Medical providers submit an authorization request, by using the Alliance Authorization Request form (AAR), attach supporting clinical documentation, and fax it to the Alliance Authorizations Department.
- Medical providers may contact the Alliance Authorizations Department to request a copy of the criteria used to make a decision about an authorization request at **1.510.747.4540**.

Inpatient Admission Authorization Process for Hospitals*

- Emergent inpatient admissions *do not* require prior authorization. However, hospitals must notify the Alliance Authorizations Department of an emergency inpatient admission within **one (1) working day**.
- The Alliance Authorization Department clinical staff will concurrently review the hospital stay and coordinate care with the facility to determine the appropriate level of care and assist with discharge planning.
- Hospitals and treating providers are reimbursed by the Alliance as long as timely notification of an admission has been received and meets medical necessity.

***Hospitals must notify the appropriate Alliance medical group of admissions for their members.**

ECM and CS Authorization Process

- The authorization process described in this presentation applies to ECM and CS services currently offered by the Alliance.
- There is an authorization form for each ECM and CS service offered by the Alliance (5 forms available):
  - 1 authorization form for ECM
  - 1 authorization form for housing services (Hosing navigation, deposits, and
  - 1 authorization form for medically tailored meals
  - 1 authorization form for asthma remediation
  - 1 authorization form for medical respite
- A completed copy of Approval Request form is required to be submitted to the Alliance.
- The Alliance processes authorization requests in a timely manner and in accordance with state and federal requirements.
- Providers may contact the Alliance Case Management Department for any questions or once the form has been submitted at **1.510.747.4512**.
- Authorization forms will be posted to our website.

Authorization Turnaround Times

Request Type	Authorization Processing Timeframes for Medi-Cal and Group Care
Medically Urgent	A decision is made within 72 hours of receipt. Written or verbal notification of the Alliance's decision to approve, deny, modify, or defer is provided to the requesting provider within 24 hours of the decision.
Routine Pre-Authorization	A decision is made within 5 business days of receipt. Written or verbal notification of the Alliance's decision to approve, deny, modify, or defer is provided to the requesting provider within 24 hours of the decision.
Inpatient Hospice Care	Written or verbal notification of the Alliance's decision to approve, deny, modify, or defer is provided to the requesting provider within 24 Hours of receipt.
Retrospective*	A decision is made within 30 calendar days of receipt. Written or verbal notification of the Alliance's decision to approve, deny, modify or defer is provided to the requesting provider within 30 calendar days of receipt. * Submissions within 30 days from the date of service, (when there is no claim on file) will be processed through the UM Department. Submissions >30 days with be processed with claim submission via the Retrospective Claims Review Process.

Contacts for ECM and CS Authorizations

Health Plan/ Medical Group	Address	Authorization Department Numbers	Alliance Program
Alameda Alliance for Health (Alliance)	1240 South Loop Road, Alameda, CA 94502 www.alamedaalliance.org	Phone: **1.510.747.4512** Fax: **1.510.995.3725** Main Number: **1.510.747.4500**	Medi-Cal
Kaiser Permanente	www.kaiserpermanente.org	Main Number: **1.800.464.4000**	Medi-Cal

Direct Access to OB/GYN Services

- Female members of the Alliance may self-refer for covered obstetrical and gynecological services from OB/GYNs participating within the Alliance or their medical group's network.

*** Referral requirements may vary depending on the member's assigned Alliance medical group. Please contact the member's assigned medical group to find out if a referral is required for a particular service.**

Sensitive Services

- Sensitive services are those services designated by the State Medi-Cal program as available to members without a referral or authorization in order to protect patient confidentiality and promote timely access.
- Sensitive services include family planning, screening and treatment for sexually transmitted diseases, HIV testing, and abortions.
- All Alliance Medi-Cal members may go outside of their medical group's network for sensitive services, which does not include prenatal care.
- Authorization is not required for prenatal care, but members must stay within their medical groups.

Sensitive Services (cont.)

Abortion

- In-network abortion services are available to all Alliance members without referral or authorization.
- Abortion services from non-Alliance providers are also available to all Alliance members without referral or authorization.
- Group Care members are encouraged to use abortion services provided within the Alliance's or their medical group's network before seeking authorization to be seen by an out of network provider.
- Alliance Medi-Cal members may obtain abortion services from any Medi-Cal provider without a referral or authorization.

Member Benefits

All Alliance members receive:

- Regular medical exams & visits
- Durable medical equipment (DME)
- Home health & hospice
- Immunizations
- Specialist care
- Inpatient hospital care
- Emergency services
- No-cost interpreter services
- No-cost health education materials and classes
- Major organ transplants
- More information can be found in our Provider Manual

Member Benefits: Behavioral Health

- All Alliance members have access to outpatient and inpatient behavioral health care, which includes substance abuse treatment.
- PCPs and specialists can encourage members in need of behavioral health care to access this free and confidential benefit.
- **Access**: Alliance Medi-Cal members behavioral health services are provided by Alameda County Behavioral Health Care Services (BHCS). (moderate to high severity) Members can self-refer for most services and can contact BHCS toll-free at **1.800.491.9099**.
- **Beacon:** Behavioral services provided by Beacon Health Strategies for Medi-Cal (mild to moderate and autism services) and Group Care members (all services). Members can self-refer for most services and can contact Beacon toll-free at **1.855.856.0577**.

Member Benefits: Lab Services

- Alliance members must receive **outpatient** lab services and specimen readings from Quest Diagnostics, except for:
  - HIV testing
  - Renal tests performed at dialysis centers
  - Genetic, chromosomal and alpha-feto protein prenatal testing
  - Lab services performed at one of the following Alliance-contracted hospitals:
    - Alameda County Medical Center (Fairmont and Highland Campuses)
    - UCSF Benioff Children's Hospital Oakland
    - Summit Medical Center
- Members who are assigned to Alameda Health System (AHS) as their PCP must use an AHS lab.
- Providers may contact Quest Client Services toll-free at **1.800.288.8008** to find a Quest lab.
- For Courier Services, STAT pickup, or Will Call, providers may contact Quest toll-free at **1.800.288.8008**, **Option 3**.

Member Benefits: Vision Services

- March Vision Care (MARCH) administers vision benefits for Alliance Medi-Cal members.
- Alliance Medi-Cal members may self-refer to MARCH providers or a PCP can refer a member to a participating MARCH provider.
- For questions regarding vision benefits or to find a MARCH provider, please contact MARCH at **1.844.336.2724** or visit **www.marchvisioncare.com**.
- Vision services for Alliance Group Care members are administered by the IHSS Public Authority (PA), which can be reached at **1.510.577.3552**.
- Please note that ophthalmology care is a medical benefit through the Alliance and there is no age restriction for these services for either of our plans. PCP referral is required, and the care must be provided by Alliance contracted ophthalmologists.

Medi-Cal Carve-out Benefits

These benefits are covered directly by Medi-Cal:

- Outpatient pharmacy called Medi-Cal Rx is covered by Magellan
- Dental is covered by Denti-Cal
- Moderate-to-severe mental health is covered through ACCESS

Initial Health Assessment (IHA)

- PCP's must provide each new Alliance members with an initial health assessment (IHA) as soon as possible after enrolling with the Alliance.
- The State Medi-Cal program mandates that all new Medi-Cal members have an IHA within 120 days from the member's enrollment date.
- Pregnant women must have their IHA as soon as an appointment can be scheduled.
- The IHA should follow appropriate preventive health guidelines and should include a physical examination with referrals for lab work and tests as indicated, immunizations, and a nutritional assessment.

Child Health & Disability Program (CHDP)

- The CHDP program oversees the screening and follow-up components of the federally mandated Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program for Medi-Cal children and youth.
- The CHDP Program is responsible for ensuring that high quality preventative services are delivered and available to eligible children and youth.
- For Alliance Medi-Cal members, pediatric clinical preventive service encounters must be documented using the CHDP Confidential Screening/Billing Report (PM-160).

Child Health & Disability Program (CHDP) (cont.)

- Data submitted on PM-160 forms is used to develop an administrative data set for HEDIS® (Healthcare Effectiveness and Data Information Set).
- The form is then forwarded to the local CHDP Program on a monthly basis. Providers should attach the PM-160 forms to claims for pediatric preventative services and send them to:

  Alameda Alliance for Health
  Claims Department
  P.O. Box 2460
  Alameda, CA 94501-4506

Staying Healthy Assessment (SHA)

- Alliance PCP's are required to ask Alliance members to complete the Staying Healthy Assessment.
- (IHEBA) at age-specific intervals.
- PCP's use the completed form to assess, inform and refer members on healthy living topics like tobacco use and nutrition.
- PCPs must complete a one-time training on the SHA.
- The Alliance covers extended counseling, intervention and referral for members who respond "yes" for tobacco or alcohol use.
- Find training webinars and links, forms, requirements and instructions at **www.alamedaalliance.org** for the Staying Healthy Assessment, AMSC (for alcohol use disorders) and Tobacco Cessation.

Services Covered by Other Organizations That Work With Medi-Cal

- California Children's Services (CCS) provides medical care for children younger than 21 years of age who have physical disabilities and complex medical conditions.
- Early Start who provides services to members with significant developmental delays in cognitive, physical (motor, vision, and hearing), communication, social/emotional, and adaptive/self-help functions.
- Regional Center of the East Bay (RCEB), a private, non-profit agency that assist mentally disabled persons, individuals who are substantially handicapped by cerebral palsy, epilepsy or autism, and their families in locating services in their communities.
- WIC is a nutrition/food program that helps pregnant, breastfeeding or postpartum women, and children less than 5 years of age to eat well and stay healthy.
- In most cases, PCPs and specialists are responsible to refer members.
- The Alliance is not financially responsible for these services.

Claims & Encounter Overview

- Submit claims/encounter data using the following forms:
  - CMS 1500 (HCFA)
  - UB-92 (Facility Claims)
  - PM-330 (Sterilization Consent form)
- Claims are considered timely if they are submitted within 180 calendar days post-service, or post-EOB if other coverage exists.
- To file an appeal, please complete a Notice of Provider Dispute (NOPD) form and submit it to the Alliance Claims Department.

Claims & Encounter Overview (cont.)

- Use CPT and HCPCS Codes covered by Medi-Cal to bill for services provided to Alliance Medi-Cal and Group Care members.
- Please refer to our Provider Manual for more detailed and helpful information about our claims policies.
- Please refer to the Medi-Cal billing guidelines for appropriate place of services codes, NDC codes, and if codes are split billable.
- ECM and CS providers receive specific claim and encounter trainings through the Alliance IT staff when onboarding as a new provider. Providers should refer to the document and training material provided by Alliance IT.

Electronic Billing and RA

- You can sign up to bill electronically (EDI), Electronic Fund Transfer (EFT), and Electronic Remittance Advise (ERA).
- The forms can be found at **www.alamedaalliance.org/providers/billing/electronic-data-interchange-edi-services/**
- This will speed up claim processing and get you paid faster.
- Contact the Alliance Provider Services Department at **1.510.747.4510** to learn how to submit claims electronically.

Complaint and Grievance Process

Member Complaints/Grievances/Appeals

- Members may report complaints/grievances/appeals by calling Alliance Member Services at **1.510.747.4567**.
- Contracted providers, offices, or facilities are required to make member grievance forms and assistance readily available and provide them promptly to members in accordance with California Code of Regulations, Title 28 §1300.68 (b)(7).
- Once the member's complaint/grievance/appeal is logged by Member Services, our Grievances and Appeals Unit will investigate the situation and provide the member with a resolution.
- In some cases, the Alliance Grievance and Appeals Unit may request information from our providers to assist with reviewing a member's complaint/grievance.

Complaint and Grievance Process (cont.)

Provider Complaints/Grievances/Appeals

- Appeals of claims decisions must be submitted via the Notice of Provider Dispute (NOPD) process. Please complete the NOPD form, attach supporting documentation, and submit it to the Alliance Claims Department.
- Appeals of authorization decisions must be submitted to the Alliance Grievances and Appeals unit. Please include supporting clinical documentation with each appeal.
- Other provider complaints can be submitted to Alliance Provider Services.

Member Discharge Process Overview

- Another form of a provider grievance is a member discharge.
- Providers have the right to discharge members from their care due to unruly behavior, threatening remarks, frequently missed appointments, fraud, etc.
- Document the patient behavior in medical record progress notes.
- A member may **not** be discharged due to their medical condition, frequent visits, or high cost of care.
- Member discharge requests must be submitted in writing to the Alliance Provider Services Department **prior** to discharging a member.
- Please refer to Part One of the Alliance Provider Manual for a complete description of the member discharge process requirements.

Quality Improvement: PQI's

- The Alliance maintains a systematic mechanism to identify, analyze and resolve potential quality of care and service issues (PQI's) to ensure that services provided to members meet established quality of care and service standards.
- PQI's can be identified in several ways, including:
  - Encounter data, including medical and pharmacy claims
  - Inpatient notifications
  - Member or provider complaints
- The Alliance Quality Improvement Department reviews and resolves PQI's in a timely manner and may request information from Alliance providers to assist with the review process.

Quality Improvement: HEDIS®

- The California Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS) require that the Alliance participate in the annual Healthcare Effectiveness and Data Information Set (HEDIS) process.
- HEDIS® measures are developed by a national group of health care experts, issued annually and used as a standard across the country. Using HEDIS measures, the Alliance can compare its performance against other managed care plans. HEDIS study methodology and results are also validated and audited by an external agency.
- HEDIS® studies use claims and encounter data submitted by providers and may be supplemented with data retrieved from providers' medical records. The Alliance makes every effort to request records or schedule HEDIS data retrieval for all studies at the same time and only once each year.

Health Education

- The Alliance has health information, self-management tools and referrals to programs and classes for all members at no cost.
- Health topics include:
  - Conditions like diabetes, asthma and hypertension
  - Pregnancy, breastfeeding (lactation consultants) and parenting
  - Healthy weight, nutrition and exercise
  - Smoking cessation, Diabetes Prevention Program (DPP) and much more!
- The ***Provider Resource Directory**** lists classes, programs and community referrals available to at no cost to Alliance members.
- Members can complete the ***Wellness Request Form**** or call Health Programs at **1.510.747.4577** to request class listings and materials in our threshold languages (English, Spanish, Chinese, & Vietnamese).
- Providers can refer using the ***Wellness Provider Fax Request Form****.

*Directory and forms are available at **www.alamedaalliance.org** and with your orientation packet.

We Are here for you!

At www.alamedaalliance.org you can:

- View updates
- Download forms
- View our on-line provider manual
- View clinical practice guidelines
- Check our online provider directories
- And much more!

Sign up for the **Alliance Provider Portal** and you can:

- Verify member eligibility
- Submit an electronic authorization requests (For outpatient and elective inpatient services that require authorization).
- Check claim status and view remittance advice statements.
- Submit an electronic Provider Dispute Resolution (PDR) Request (Claim Dispute).

Contact Us

- Alliance Provider Services Department:

  Phone Number: **1.510.747.4510**

  Fax: **1.855.891.7257**

  Email: **providerservices@alamedaalliance.org**

- Alliance Case Management Department:

  Phone Number: **1.510.747.4512**

  Fax: **1.510.995.3725**

  Email: **ECM@alamedaalliance.org**

- Our Provider Call Center can also route directly to our Case Management Department for specific questions related to ECM, CS, and MOT services if you select the ECM, CS, and MOT prompt.

Attachments and Forms

1. Sample Member Identification Cards
2. Provider Portal Sign-Up Instructions
3. Interpreter Services Quick Guide
4. Interpreter Services Request Form
5. Alliance Authorization Request Form(s) (For ECM and CS services only)
6. Notice of Provider Dispute Form (Claim appeal form)
7. Member Grievance Forms (English, Spanish, Chinese, Vietnamese, Tagalog)
8. Member Rights & Responsibilities
9. Timely Access Standards
10. APL 21-009 with ICD-10 List for Social Determinants of Health (SDOH)
11. Nurse Advice Line for Medi-Cal and Group Care Members
12. Non-Emergent Ground Transport
13. Important Contact Information