Welcome to the Alliance Provider Network! This document provides key information about the Alliance's programs and requirements. More information is available in your Alliance contract, the Alliance's on-line Provider Manuals, and on our website www.alamedaalliance.org.

SUMMARY OF KEY INFORMATION FOR PROVIDERS

HEALTHCARE YOU CAN COUNT ON
SERVICE YOU CAN TRUST

This document provides an overview of the Alameda Alliance for Health's programs and requirements.

Please contact the Provider Service Department if you have any questions or would like the most recent version for your records.

Document version: January 2018

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ALAMEDA ALLIANCE FOR HEALTH

Healthcare you can count on

Service you can trust

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ALAMEDA ALLIANCE FOR HEALTH

Healthcare you can count on

Service you can trust

This document highlights some of Alameda Alliance for Health's (Alliance) programs and requirements. More information is available in your Alliance contract, the Alliance's Provider Manuals and on our web site www.alamedaalliance.org. The policies and procedures described herein are subject to change. Please check the Alliance Provider Manual available online or contact the Alliance Provider Services Department at 510-747-4510 for the most up to date information.

Welcome to the Alliance Provider Network!

As a provider with Alameda Alliance for Health (Alliance), you are contracted to provide services within the scope of your specialty and as defined in your contract to members for our two programs:

Medi-Cal: Health coverage for low-income individuals and families

Alliance Group Care: Health coverage for Alameda County In-Home Supportive Services (IHSS) workers

Alameda Alliance for Health (Alliance) is a Knox-Keene licensed health plan providing affordable health care coverage to low income Alameda County residents. We have been in business since 1996 and are a local not-for-profit health plan, designed for and by the members and providers we serve. We hold open board meetings and are accountable to the community.

We are committed to making high quality health care accessible and affordable to lower-income residents of Alameda County.

Our Plans

The Alliance is proud to offer two comprehensive health plans for residents of Alameda County. By enrolling in the Alliance for Medi-Cal or Group Care beneficiaries enjoy a large network of providers, assistance with care coordination, interpreter services, and a health plan that is local and responds to the needs of the community.

The Alliance provides comprehensive health care coverage to over 265,260* members through two programs:

Medi-Cal

≈ 259,516 members

Alliance Group Care

≈ 5,744 members

*Source: Alliance eligibility data for January 2018

• **Alliance Medi-Cal** is comprehensive health coverage for Medi-Cal beneficiaries who don't have a share of cost and who live in Alameda County. Medi-Cal beneficiaries can choose between Alliance Medi-Cal, Regular Medi-Cal, and Blue Cross Medi-Cal. Some Medi-Cal beneficiaries are required by the State Medi-Cal program to be enrolled in a health plan and may be automatically enrolled into the Alliance by the State. Medi-Cal Managed Care through the Alliance includes coverage for medical, vision, and pharmacy services. Coverage for mental health/chemical dependency and dental services is provided by the State Medi-Cal program. Eligibility for enrollment is determined by the State Medi-Cal program. Beneficiaries can contact Health Care Options at **1-800-430-4263** or complete the Medi-Cal Choice Form to apply for enrollment in the Alliance Medi-Cal program.

• **Alliance Group Care** provides coverage to In-Home Supportive Services (IHSS) who work in Alameda County. This plan includes coverage for medical, mental health/chemical dependency and pharmacy services. Dental and vision coverage is provided to IHSS workers by the IHSS Public Authority (PA). Eligibility for enrollment is determined by the PA. IHSS workers can contact the PA at **510-577-3551** to apply for enrollment in the Alliance Group Care plan.

Our Provider Network and Medical Groups

The Alliance network includes over 800 directly contracted PCPs, specialists, and ancillary providers, including durable medical equipment providers, home health agencies, and physical/speech/occupational therapists. The Alliance is also contracted with most of the hospitals within Alameda County and three medical groups (Children's First Medical Group, Community Health Center Network, and Kaiser). A list of the Alliance's network providers and hospitals can be found on the Alliance's website. Each of the Alliance's three medical groups also maintains a list of their providers on their websites.

Each medical group manages the authorizations, referrals, and claims of any Alliance member who chooses a PCP who belongs to that group – **except for DME authorizations**.

PCP assignment determines the medical group to which an Alliance member is assigned. The medical group is responsible for managing the care of their assigned members, including Utilization Management and Claims processing. Providers must follow the referral and authorization guidelines of the member's assigned medical group (please refer to the Referrals and Authorizations section for more information).

The Alliance supplies members with ID cards which list their PCP/medical group assignment. It is, however, imperative to verify member eligibility before providing care. Eligibility and PCP/medical group assignment can change from month to month (please refer to the Eligibility section for more information).

• Alliance Directly Contracted Providers

The Alliance is directly contracted with over 800 PCPs, specialists, and ancillary providers. The Alliance is responsible for Utilization Management (authorizations) and Claims processing for members who choose PCPs within the Alliance's direct network.

• Children's First Medical Group

Children's First Medical Group (CFMG) is contracted with the Alliance to provide primary and specialty care to children 0-20 years of age. The CFMG network is composed of approximately 700 primary, ancillary, and specialty care providers. CFMG is responsible for managing the care of Alliance members who choose PCPs within the CFMG network.

• Community Health Center Network

Community Health Center Network (CHCN) is contracted with the Alliance to provide primary and specialty care to Alliance members of all ages and its network includes over 700 primary, ancillary, and specialty care providers. CHCN is responsible for Utilization

Management and Claims processing for members who choose PCPs within the CHCN network.

• Kaiser Permanente

Alliance Medi-Cal members assigned to Kaiser receive their primary, specialty, hospital, vision, and pharmaceutical care from Kaiser.

If you receive a referral for an Alliance member assigned to one of the Alliance's medical groups, please:

1. Contact the member's assigned medical group before providing care to the member, OR

2. Refer the member back to his/her PCP for a referral to a provider within the medical group

Maintaining Your Alliance Contract

• Demographic Changes

Please inform us promptly about changes to your practice, such as a new address or suite number, phone, fax, tax identification number (TIN), ownership or group name change, provider additions or deletions, or any new practice limitations. A W-9 form is required for any changes to a group name, new ownership, or TIN. Notification can be made in writing, by fax, letter, or email and be sent to the Alliance Provider Services Department.

• Credentialing and Re-credentialing

To participate in the Alliance's network, PCPs, mid-level practitioners, and specialists are credentialed by the Alliance at the onset of their contractual relationship and again once every three years. The Alliance Credentialing unit manages this process and notifies providers of the documents needed and the criteria that must be met. The Alliance's credentialing criteria comply with all applicable federal and State regulatory requirements.

• Facility Site Review

The Alliance is required by the California Department of Health Care Services (DHCS) to conduct facility site reviews (FSR) of primary care provider and obstetrician/gynecologist (OBGYN) sites. An initial FSR is required at the initiation of a contract and every three years, thereafter. A site review need not be repeated as part of the initial credentialing process if a new PCP or OBGYN is added to a site that has a current passing site review score. The Alliance Quality Management Unit manages this process.

• Contract Terminations

Providers must promptly notify the Alliance if they plan to terminate their relationship with the Alliance. It is especially important for a PCP to provide at least 90 days' notice of termination to the Alliance, as the Alliance is required by law to re-assign patients to another PCP and to provide 30-day advance notification to members of this transition. Written notification by fax, letter, or email can be sent to the Alliance Provider Services Department.

Quality Improvement

• **Health Effectiveness Data Information Set (**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 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. Alliance HEDIS® study methodology and results are also validated and audited by an external agency.

HEDIS® studies use claims and encounter data submitted by Alliance 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 only once each year.

• Potential Quality of Care and Service Issues (PQI)

The Alliance maintains a mechanism to identify, analyze, and resolve PQI's to ensure that services provided to members meet established quality of care and service standards. The Alliance Quality Management unit reviews and resolves PQI's in a timely manner and may request information from Alliance providers to assist with the review process.
PQI's can be identified in several ways, including:

- Encounter data, including medical and pharmacy claims
- Member or provider complaints

Member Eligibility

• Determining Eligibility and PCP/Medical Group Assignment

Although Alliance members are issued ID cards, member eligibility and the benefits currently available to members should always be verified prior to providing care. Eligibility and PCP/Medical Group assignment can change from month to month. **A referral or authorization does not guarantee that a member is eligible at the time of service.**

It's important to note the medical group (CFMG, CHCN, Kaiser) to which a member is assigned because providers must follow the referral and authorization guidelines of the member's assigned medical group. If you receive a referral for an Alliance member assigned to one of the Alliance's medical groups, please:

1. Contact the member's assigned medical group before providing care to the member, or
2. Refer the member back to his/her PCP for a referral to a provider within the medical group

The Alliance provides four easy ways to verify eligibility:

1. Visit our website and log on to the secure provider portal at www.alamedaalliance.org
2. Call our Automated Eligibility Verification System at **510-747-4505**
3. Call the Alliance Provider Services department at **510-747-4510**

• Enrollment, Disenrollment and PCP Changes

Alliance members who wish to change their medical group and/or PCP or who wish to dis-enroll completely from the Alliance should be referred to Member Services at **510-747-4567**. Members can ask to change PCPs at any time; PCP change effective date will be:

The first day of the current month if the member:

- Is staying within the same medical group, or
- Has not received services during the current month

The first day of the following month if the member
Has utilized services during the current month.

• Newborn Coverage

For the Alliance Medi-Cal program the Alliance covers newborns during the month of birth and the month following.

For the Group Care program, the Alliance covers newborns for 30 days following birth.

Access

• 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) within the United States 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

• Interpreter and Translation Services

Professional interpreter services for medical encounters must be offered to Alliance members with limited English proficiency. The Alliance provides access to telephonic and face-to-face interpretation, including face-to-face interpretation for American Sign Language (ASL). The Alliance also provides document translations of Alliance-provided member materials.
The Alliance provides interpreter services for appointments in non-hospital settings, as long as the provider is contracted with the Alliance. Hospitals are required to provide interpreter services to patients accessing care at their facilities.

Face-to-face interpretation can be arranged by contacting Alliance Member Services at 510-747- 4567 at least 72 hours in advance of an appointment. For telephonic interpretation, please call the Alliance's interpreter vendor, IEC, at 1- 866-948-4149.

Referrals and Prior Authorization

• Referrals and Authorization Process Overview

The Alliance processes authorization requests in a timely manner and in accordance with State and Federal requirements. Authorization department staff is available by telephone every business day from 8:30a.m. – 5p.m. at **510-747-4540**. Please leave a message including your phone number and you will receive a call back from a department member within one (1) business day.

To submit an authorization request, please complete the Alliance Authorization Request form (AAR), attach supporting clinical documentation, and fax it to the Alliance Authorizations department at **1-855-891-7174**. This fax number can be used to send authorization and utilization inquiries and requests to the Authorizations department during and outside of business hours.

The authorization process described in this section 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 authorization requirements may be different for members assigned to one of the Alliance's medical groups (CFMG, CHCN, Kaiser). Please contact the member's assigned medical group to find out if authorization is required for a particular service.

• Services that Require Prior Authorization from the Alliance*

The following services require prior authorization from the Alliance:

1. Cancer Clinical Trials
2. Cataract Spectacles and Lenses
3. Chiropractic Services – Line of Business Limits May Apply
4. Durable Medical Equipment (DME) and Supplies
5. Elective Inpatient Admissions
6. Enteral or Nutritional Formulas
7. EPSDT Supplemental Services
8. Hearing Aids and Repairs
9. Home Health Care or Home Infusion Services
10. Hospice Services – Inpatient Services
11. In-Office Injectable and Oncology Drugs (specific drugs)
12. Non-emergent Medical Transportation
13. Nutrition or Dietician Assessment/Counseling *(except Sweet Success)*
14. Orthotics and Prosthetics
15. Organ Transplants
16. Out-of-Network Services
17. Perinatologist's Care of Pregnancy *(excludes consultation)*
18. Physical, Occupational, Speech and Respiratory Therapy
19. Podiatry care for Alliance Medi-Cal members aged 21 and over
20. Radiology (ST, MRI, PET, Nuclear Medicine)
21. Second Opinions (if the provider is not contracted with the Alliance)

Prior authorization requests should be accompanied by medical records to assist the Alliance's clinical reviewers with determining whether the requests meet the Alliance's criteria for coverage.

*The authorization requirements are different for members assigned to one of the Alliance's medical groups (CFMG, CHCN, and Kaiser). Please contact the member's assigned medical group to find out if authorization is required for a particular service.

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 (Auth required for certain diagnostic codes) ▪ Outpatient elective surgery at any facility contracted with the Alliance (Auth required for certain CPT Codes) ▪ 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 ▪ The specialist is required to: o Verify the member's eligibility at the time of service o Verify the referral from the PCP o Provide feedback to the PCP o 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 o Claims that do not contain this information will be denied

*Referral requirements are different for members assigned to one of the Alliance's medical groups. Please contact the member's assigned medical group to find out if a referral is required for a particular service.

• Prior Authorization Exceptions

The following services do not require prior authorization:

1. Emergency care (within the United States)
2. Obstetrical and gynecological services, including basic prenatal care and support services available through the member's medical group (see paragraph below)
3. Preventive care (in network)
4. Sensitive services (see paragraph below regarding Sensitive Services)
5. Standing referrals to specialty care (in network)

- Direct Access to OB/GYNs

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.

- Inpatient Admission Notification Process*

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's clinical staff is responsible for concurrent review of hospital stays and for assisting with discharge planning. Hospitals and treating providers are reimbursed by the Alliance as long as timely notification of an admission has been received.

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

- Contacts for Authorization

All requests for authorization must be sent to the Alliance or the member's medical group.

Health Plan/ Medical Group	Address	Authorization Department Numbers	Alliance Programs
Alameda Alliance for Health (Alliance)	1240 South Loop Road, Alameda, CA 94502 www.alamedaalliance.org	Phone: (510) 747- 4540 Fax: 1-855-891-7174 Main Number: (510) 747-4500	Medi-Cal, Group Care
Children First Medical Group (CFMG)	6425 Christie Ave #110 Emeryville, CA 94608 www.children-first-medical-group.com	Phone: (510) 428- 3489 Fax: (510) 428-5868 Main Number: (510) 428-3154	Medi-Cal
Community Health Center Network (CHCN)	101 Callan Ave, 3rd Floor San Leandro, CA 94577 www.chcn-eb.org	Phone: (510) 297-0220 Fax: (510) 297-0222 Main Number: (510) 297-0200	Medi-Cal, Group Care
Kaiser Foundation Health Plan (Kaiser)	www.kaiserpermanente.org	Main Number: (800) 464-4000	Medi-Cal

Timeframes for Authorization Processing

The Alliance processes authorization requests within the following timeframes:

Request Type	Authorization Processing Timeframes for Medi-Cal and Group Care
Medically Urgent	Written or verbal notification of the Alliance's decision to approve, deny, modify, or defer is provided to the requesting provider within **72 Hours** of receipt
Routine Pre-Authorization	Written or verbal notification of the Alliance's decision to approve, deny, modify, or defer is provided to the requesting provider within **14 Business Days** of receipt
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	The Alliance is no longer accepting retroactive authorizations for outpatient and facility medical services. Authorization requests submitted post the date of service will be issued an administrative denial. Additionally, providers must submit all retroactive authorizations to the Grievances and Appeals Department for further consideration.

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.

Group Care members are encouraged to use family planning, HIV testing, and sexually transmitted disease services provided by the Alliance or their medical group, and referral or authorization may be required to access these services outside of the network.

• Sterilization Services

California law (Title 22, Sections 51305.1 and 51305.4) requires that Medi-Cal beneficiaries who request sterilization (surgery that will end their ability to have children) complete a form (PM-330) attesting that they are giving informed consent for the procedure. These forms must be completed and signed 30 days prior to the surgery and filed in the medical record. Medi-Cal members may not waive the 30-day waiting period. A copy of the form must be attached to the primary surgeon's claim when submitted for payment.

• Abortion

In-network abortion services are 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.

• Minor Consent Services

California law (California Family Code, Sections 6920 – 6929) gives minors the right to access some services without parental consent. Medical records and/or information regarding medical treatment specific to these services cannot be released to parents and guardians, without the minor's consent.

Minors of any age may consent to and receive:

- Family planning services and medical care related to the care or prevention of pregnancy, except sterilization
- Abortions performed under emergent medical conditions
- Medical care after a sexual assault

Minors aged 12 years and older may consent to and receive:

- Diagnosis and treatment of sexually transmitted diseases
- Outpatient mental health care services, including drug and alcohol abuse treatment

Benefits

• Medical Benefits

For Alliance Medi-Cal and Group Care members, the Alliance covers medical services that are medically necessary and covered by the Medi-Cal program at the time of service. Benefits include primary care, specialty care, durable medical equipment, home health, inpatient care, and skilled nursing care. A complete list of covered services can be found in the Alliance Provider Manual.

Unless specifically indicated, the Alliance does not cover services that are not covered by Medi-Cal, including cosmetic services, infertility treatment, and experimental and investigational procedures.

• Podiatry Services

The State Medi-Cal program no longer covers podiatry care for Medi-Cal members aged 21 and over starting July 1, 2009. However, the Alliance continued to cover podiatry services for Alliance Medi-Cal members aged 21 and over. Prior authorization must be obtained from the Alliance for Medi-Cal members and the podiatry benefit is limited to the following conditions:

1. Disorders of the feet secondary to or complicated by chronic disease
2. Disorders of the feet, which significantly impair the ability to walk

The podiatry benefit for Alliance Medi-Cal members aged 0-20 and all Group Care remains unchanged. Members in these 4 groups who are managed by the Alliance may access this benefit by obtaining a referral from their PCP.

For members assigned to one of the Alliance's medical groups, prior authorization may be required. Please contact the assigned medical group for additional information.

• Pharmacy Benefits

Alliance Pharmacy benefits are administered by PerformRx, the Alliance's Pharmacy Benefit Manager. PerformRx is responsible for pharmacy claims processing, pharmacy contracting and oversight, processing drug authorization requests in a timely manner, and formulary management.

PerformRx also processes prior authorization requests for specialty drugs dispensed by Diplomat Specialty Pharmacy (Diplomat). Diplomat is the only pharmacy that can dispense certain specialty drugs for Alliance Medi-Cal and Group Care members. A complete description of the Alliance's specialty pharmacy program and drugs covered under the program can be found on the Alliance's website.

ePOCRATeS

The Alliance maintains one formulary for Alliance Medi-Cal and Group Care. Providers should consult the Alliance's formularies when prescribing medication for Alliance members. Both formularies include the list of drugs covered by the Alliance and can be found at www.epocrates.com. The Alliance's formularies are also available on our web site at www.alamedaalliance.org.

Providers can reduce the need to request prior authorization for non-formulary drugs by prescribing drugs on the Alliance's formularies. For Medi-Cal & Group Care, Prior authorization requests must be sent to PerformRx via their confidential fax at **1-855-811-9329**. PerformRx can be reached at **1-855-508-1713**, Monday through Friday, 8:00am – 6:00pm.

• Behavioral Health Services

All Alliance members have access to outpatient and inpatient behavioral health care, which includes substance abuse treatment. PCPs and specialists can encourage any member who appears to be in need of behavioral health care to access this free and confidential benefit.

For Alliance Medi-Cal members behavioral health services (moderate to high severity) are provided by Alameda County Behavioral Health Care Services (BHCS). Members can self-refer for most services and can contact BHCS at **1-800-491-9099**.

Behavioral health services (mild to moderate and autism services) are provided by Beacon Health Strategies for Medi-Cal and Group Care members. Members can self-refer for most services and can contact Beacon at **1-855-856-0577**.

• Laboratory Services

The Alliance contracts with Quest Lab to provide most outpatient laboratory services. Providers must use Quest for most laboratory services, including specimen reading, except for:

1. Genetic, chromosomal and alpha-fetal protein prenatal testing
2. HIV testing
3. Renal tests performed at a dialysis center
4. Lab services performed at one of the following Alliance-contracted hospitals:
   - Alameda County Medical Center (Fairmont and Highland Campuses)
   - Children's Hospital Oakland
   - Summit Medical Center

Alliance members assigned to any of the Alameda Health System Campus Highland Hospital Fairmont Rehab and Wellness, Hayward Wellness, Newark Wellness and Etc. will use the Alameda Health System campus for any lab request from your provider.

Providers can contact Quest Client Services at **1-800-288-8008** to find a Quest lab. For Courier Services, STAT pickup, or Will Call, providers can contact Quest at **1-800-288-8008, Option 3**.

• Dental Services

For Alliance Medi-Cal members who are pregnant, living in a skilled nursing facility or under age 21, dental services are provided by Denti-Cal. Members can self-refer for dental services and should call **1-800-322-6384** for assistance. A dental screening by the PCP is part of the Initial Health Assessment and CHDP check-ups. PCPs should encourage adult Medi-Cal members to seek dental care from low-cost dental providers.

The IHSS Public Authority (PA) contracts with Delta Dental to provide dental care for Alliance Group Care members. Group Care members can contact the IHSS PA if they have questions regarding their dental coverage or need to enroll in the dental plan. Members can contact Delta Dental at **1-888-335-8227** to find a participating dental provider.

• Vision Benefits

March Vision Care (MARCH) administers vision benefits for Alliance Medi-Cal members.

The benefit packages are:

1. Alliance Medi-Cal Kids: 0 – 20 years old
   a. 1 eye exam every 24 months
   b. 1 pair of glasses every 24 months

2. Alliance Medi-Cal Adults: 21 years old and older
    a. 1 eye exam every 24 months
    b. no coverage for glasses or contacts

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 **844-336-2724** or visit www.marchvisioncare.com.

Vision services for Alliance Group Care members are administered by the IHSS Public Authority (PA). The PA contracts with EyeMed Vision Care to provide vision services for IHSS members. EyeMed can be reached at **1-866-723-0514**.

Please note that ophthalmology care is a medical benefit through the Alliance and there is no age restriction for these services for any of our plans. PCP referral is required and the care must be provided by contracted ophthalmologists.

• Chiropractic and Acupuncture Benefits

For Alliance Medi-Cal members who are pregnant, living in a skilled nursing facility, or younger than 21 years old, *chiropractic* benefits are provided through the State fee-for-service Medi-Cal program, not through the Alliance. Members can self-refer for these benefits.

For Alliance Medi-Cal the acupuncture benefits a limited to two (2) visits per calendar months, additional visits are available via prior authorization. Prior request will be reviewed based on medically necessity. The benefit must be requested by an practicing Medi-Cal Provider.

For Alliance Group Care, the Alliance covers *chiropractic* care as long as all services are obtained from participating Alliance chiropractors. The benefit is limited to 20 visits per Benefit year (July 1 – June 30). The Alliance covers *acupuncture* treatment as long as all services are obtained from participating Alliance acupuncturists. The benefit is limited to 10 visits per Benefit year (July 1 – June 30).

• Transplants

For Alliance Medi-Cal members, the Alliance covers kidney and corneal transplants. All other organ transplants are covered by Fee-For-Service Medi-Cal.

For Group Care the Alliance covers medically necessary organ and bone marrow transplants.

• Custodial Care

Custodial care is not covered by the Alliance for any of the Alliance's plans. The Fee-For-Service Medi-Cal program may cover custodial care for Alliance Medi-Cal members if they request and are granted enrollment back into Fee-For-Service Medi-Cal.

• Health Education

The Alliance offers health education services to all Alliance members. Providers can visit the "Provider: Health Education and Wellness Resources" section of our website at ***www.alamedaalliance.org*** for wellness information, handouts and programs available to Alliance members.

• Transportation Benefit (For Alliance Medi Cal Members

The Alliance offers non-emergency medical transportation and non-medical transportation that was effective on July 1, 2017. A provider or member can request transportation by calling logisticare at 1-888-457-3352 or completing the physician certification form. The PCS form can be found on the Alameda Alliance For Health website at http://www.alamedaalliance.org/providers/resource/forms.

• Case and Disease Management Program

Primary Care Providers (PCPs) are delegated the responsibility to provide basic comprehensive medical case management services to their assigned Alliance members. The Alameda Alliance for Health has a high risk case management program available for its Medi-Cal and IHSS members. Program objectives include providing an ongoing patient and family assessment and treatment plan to maximize quality of care while minimizing costs and providing support to both the member and the provider.

The Alliance Case and Disease Management Program is designed to assist in managing the care of medically complex members by coordinating services that will ensure the improvement of patient outcomes and overall member satisfaction.

PCPs may refer Alliance Medi-Cal and IHSS members to the Case & Disease Management Program. Contact the Case & Disease Management Department by phone **(1-877) 251-9612** or fax **510.747.4130** to request a referral form.

Health Assessments

• 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 mandate that all new Medi-Cal members have an IHA within 60 days (for members under the age of 18 months) and 120 days (for members 18 months of age and older) 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.

• Staying Healthy Assessment **(SHA)**

PCPs should also ask each Medi-Cal member to complete the Staying Healthy Assessment (SHA). The SHA is an age-specific risk assessment tool that is repeated at specific age intervals. PCPs use the SHA to assess, counsel and refer members regarding many issues, including nutrition, home safety, smoking, drug and alcohol use, and exposure to violence. The Alliance covers additional screening, Counseling and referrals alcohol misuse screening and counseling-AMSC.and Tobacco cessation benefit, forms, training and instructions for SHA and AMSC can be found on our website at www.alamedaalliance.org.

Child Health and Disability Program **(CHDP)** Reporting

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.

• California Children's Services **(CCS)**

California Children's Services (CCS) provides medical care for children younger than 21 years of age who have physical disabilities and complex medical conditions. Services provided under the CCS program are reimbursed through the CCS program. The Alliance is not financially responsible for CCS services provided to its members. An Alliance member who is eligible for CCS services remains enrolled with the Alliance. Physicians, the Alliance, and medical group staff are responsible for identification, referral, and case management of members with CCS eligible conditions. Until eligibility is established with the CCS program, the PCP, the Alliance, and medical group continue to provide medically necessary covered services related to the CCS eligible condition. Eligible conditions include medical conditions such as sickle cell anemia, cancer, diabetes, HIV, and major complications of prematurity.

Refer patients to CCS by contacting:
California Children's Services
1000 Broadway, Suite 500
Oakland, CA 94607
Telephone: **510-208-5970** I Fax: **510-267-3254** I www.dhcs.ca.gov/services.ccs

• Regional Center of the East Bay (RCEB)

Regional Center of the East Bay (RCEB) is a private, non-profit agency established to assist mentally disabled persons, individuals who are substantially handicapped by cerebral palsy, epilepsy or autism, and their families in locating services in their communities. To be eligible, a member must meet the following criteria:

- Disability is due to mental retardation, cerebral palsy, epilepsy, autism or a condition similar to mental retardation
- Disability began prior to the age of 18
- Disability is likely to continue indefinitely and is substantially handicapping for the individual

RCEB provides members with the services they need to function independently. Main areas of assistance include:

- Help finding housing
- School or adult day programs and social activities
- Transportation
- Providing respite services, including child care
- Durable medical equipment
- Speech or P.T./O.T. services

The Alliance is not financially responsible for the RCEB services provided to Alliance members. An Alliance member who is eligible for RCEB services remains enrolled with the Alliance, and the PCP, the Alliance, and medical group retain responsibility for coordination of services and for continued medical care.

Refer patients to RCEB by contacting:
Regional Center of the East Bay
76777 Oakport Street, Suite 300
Oakland, CA 94621
510-383-1200 or visit www.rceb.org

• Early Start

The Early Start program serves infants and toddlers three years old or younger who have:

- Significant developmental delays in cognitive, physical (motor, vision, and hearing), communication, social/emotional, and adaptive/self-help functions
- A diagnosed developmental disability that is expected to continue indefinitely
- A combination of biological and/or psychosocial factors which indicate a high risk for developmental disabilities

Early Start provides a wide range of services including speech and hearing evaluations and treatment. The Alliance is not financially responsible for the Early Start services provided to its members. The member's PCP is responsible for providing the initial evaluation and treatment. An Alliance member who is eligible for Early Start services remains enrolled with the Alliance, and the PCP, the Alliance, and medical group remain responsible for coordination of services and for continued medical care.

Refer patients to Early Start by contacting:
Regional Center of the East Bay
76777 Oakport Street, Suite 300
Oakland, CA 94621
510-383-1200 or visit www.rceb.org

• Women, Infants, Children Program **(WIC)**

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. WIC eligibility is determined by federal income guidelines. Services include free food vouchers, nutrition education, and breast-feeding support. Patients can call WIC at **1-888-942-9675** to find their local WIC office or visit www.calwic.org to receive assistance with applying for this service.

Claims

This section provides an overview of the Alliance's claim policies. Additional information can be found in the Alliance's Provider Manuals, which are available on our websites. The Alliance Claims department is available to provide assistance with claims questions and can be reached at **510-747-4530**. Providers can check the status of their claim submissions by calling the Claims Department or by using the Alliance's provider portal. Please visit our website to sign up for this free and convenient service.

• Claim Requirements

The Alliance has established requirements for filing a claim. Failure to comply with these requirements may jeopardize reimbursement. To be accepted as a valid claim, each claim must meet the following criteria:

- Be submitted on a standard current version of a CMS-1500, CMS-1450 (UB04), or the ANSI X12-837-4010A1 (current electronic format).

- Contain appropriate information in all required fields

- Be a claim for an Alliance member eligible at the time of service
- Be an original bill
- Contain correct national standard coding, including but not limited to CPT, HCPCS, Revenue, and ICD-9 codes
- Not be altered by handwritten additions to procedure codes and/or charges
- Be signed, if paper
- Be printed with ink that is dark enough to be electronically imaged, if paper
- Be received within the filing period

• Electronic Claims Submission

The Alliance offers providers the speed, convenience, and lower administrative costs of electronic claims filing, also known as Electronic Data Interchange (EDI). Providers interested in submitting claims electronically can contact our Claims department at **510-747-4530** for additional information. Claims that require attachments may not be sent electronically; they must be submitted on the appropriate claim forms with the attachments.

• Where to Send Your Claims

Paper claims for Alliance members should be submitted for payment as follows:

Claim Type	Member's Medical Group	Address
Professional Medical Service	Alameda Alliance for Health (Alliance)	Alameda Alliance for Health P.O. Box 2460 Alameda, CA 94501-0460
Professional Medical Service	Children First Medical Group (CFMG)	Children First Medical Group P.O. Box 981705 El Paso, TX 79998
Professional Medical Service	Community Health Center Network (CHCN)	Community Health Center Network 101 Callan Ave, 3rd Floor San Leandro, CA 94577
Institutional (Hospital, SNF, etc.)	Alliance and CHCN	Alameda Alliance for Health P.O. Box 2460 Alameda, CA 94501-0460
Institutional (Hospital, SNF, etc.)	Children First Medical Group (CFMG)	Children First Medical Group P.O. Box 981705 El Paso, TX 79998

• Timely Filing Timeframes

All claims must be submitted timely for consideration of payment. Claims submitted after the appropriate filing deadline will be denied, unless documentation substantiating the delay in billing is provided. Claims submitted prior to the actual date of service (or date of delivery for supplies and DME) will also be denied.

When the Alliance is the Primary Payer on the Claim: Participating (contracted) providers must submit claims 180 calendar days post-service. Post-service is defined as after the date of service for professional or outpatient institutional providers, or after the date of discharge for inpatient institutional providers.

When the Alliance is Not the Primary Payer under Coordination of Benefits (COB): Providers must submit a claim to the Alliance within 90 days from the date of payment or date of denial notice from the primary payer. Providers must also submit a copy of the Remittance Advice (RA) /Explanation of Benefits (EOB) from the primary payer, indicating the date of resolution by the primary payer, whether paid, contested, or denied.

When an Alliance Member Does Not Present Accurate Insurance Information, and Another Payer or the Member is Billed for the Service: Providers are required to submit a claim to the Alliance within 60 days of receiving the correct insurance information from the member or incorrect payer. Providers must also submit proof that the member or another payer had been billed.

Corrected Claim Previously Denied by the Alliance as an Incomplete Claim: The claim must be submitted correctly for reconsideration of payment within 90 days of the date of the original denial by the Alliance. A corrected claim may be mistaken as a duplicate claim submission unless it is clearly identified as such.

Proof of Timely Filing: If a claim has been denied for timely filling, the following are acceptable forms of documentation for payment reconsideration:

- RA/EOB from the primary insurance carrier
- Copy of enrollment card presented at time of service

• General Claims Processing Guidelines

Acknowledgement of Claim Receipt: The Alliance will identify and acknowledge the receipt of a claim within two (2) working days of receipt if the claim was received electronically or within 15 working days if a paper claim was received.

Claim Processing Time: The Alliance will process and pay all clean claims within 45 business days of receipt.

Clean Claim: A clean claim is defined as a claim which, when it is originally submitted, contains all necessary information, attachments, and supplemental information or documentation needed to determine payer liability, and make timely payment.

Interest On Claims: The Alliance will calculate and automatically pay interest, in accordance with AB1455 requirements, to all providers of service who have not been reimbursed for payment, within 45 business days after the receipt of their clean claim.

Misdirected Claims: When a claim is incorrectly sent to the Alliance that should have been sent to one of its delegated partners (i.e., CHCN, Beacon, etc.), the Alliance forwards the claim to the appropriate delegated partner within ten working days of receipt of the claim. The Alliance also sends a notice of denial to the provider with instructions to bill the delegated partner.

Billing Members: Providers are prohibited from billing Alliance members for covered services, Under the California Health and Safety Code, Section 1379, it is illegal to bill a member who is enrolled in a State program for services provided. Alliance members are never responsible to pay participating providers any amount for covered medical services, other than approved co-insurance, deductibles or copayment amounts as part of the member's benefit package. Providers may not seek reimbursement from the member for a balance due. Providers may not bill Alliance members for covered services, open bills, or balances in any circumstance, including when the Alliance has denied payment. Providers may only bill members for co-payments, non-benefits and for non-covered services.

Overpayments and Recoupments: Overpayments can happen for several reasons, including, but not limited to:

- Alliance claim processing error
- Another party paid for the service (i.e., COB)
- Duplicate payment made by the Alliance when service is payable, in part or full, to another provider
- Retroactive change to member eligibility.

The Alliance Claims department makes recoupment requests in writing within 365 days of the date the original claim was paid. A provider may either contest the request for recoupment or pay the requested monies within 30 working days of receipt of the notification of overpayment or adjustment by the Alliance. If the provider does not contest or repay the requested monies within 30 working days, the Alliance may offset the requested amount against future claim payments.

Procedure and Diagnosis Codes: Providers must use procedure and diagnosis codes that are covered by Medi-Cal and that adhere to national correct coding standards to bill for services for Alliance Medi-Cal, Group Care, and Healthy Families members.

Coordination of Benefits (COB): Coordination of Benefits is used to determine the order of payment responsibility when an Alliance member is covered by more than one health plan or insurer. The Alliance is always the payer of last resort for Medi-Cal members; all other coverages are primary. State and federal laws require practitioners to bill other health insurers prior to billing the Alliance.

All claims must be submitted to the Alliance within 90 days from the date of payment on the primary payer's Explanation of Benefits (EOB) form. A copy of the EOB must accompany the claim. If the primary plan denies services asking for additional information, that information must be submitted to that carrier prior to submitting claim to the Alliance. When the Alliance is the secondary payer under COB rules, the Alliance will generally pay the lesser of the following amounts for covered services:

- The actual charge made by the provider, less the amount paid by the other coverage.
- The amount the Alliance would have paid if the individual did not have other coverage.
- If the primary insurance payment exceeds the fully allowed contracted rate, neither the Alliance nor its member is financially responsible for any additional amount.

• Service-Specific Claims Processing Guidelines

Ambulance, Emergency, Urgently Needed, And Post-Stabilization Care Services:
The Alliance is financially responsible for ambulance, emergency, urgently needed, and post-stabilization care services, whether services are obtained in or out of network. The Alliance makes prompt determination and reasonable payment to or on behalf of the members for these services when the financial responsibility is that of the Alliance.

Family Planning Services and STD Services: PCPs and specialists providing family planning and STD services may be reimbursed fee-for-service except when the services are provided by PCPs to his/her capitated members. PCPs rendering these services to his/her assigned members may be reimbursed fee-for-service for those procedures not included in the capitation, though all services should be documented on the claim form.

HIV Testing and Counseling: The Alliance pays providers fee-for-service for HIV testing and counseling except when the services are provided by a PCP to his/her capitated members. PCPs rendering these services to his/her capitated members may reimbursed fee-for-service for those procedures not included in the capitation, though all services should be documented on the claim form.

Minor Consent Services: Minor Consent Services, described below, may be billed fee-for-service except when rendered by a PCP to his/her capitated members. Minor Consent Services include:

- Sexual assault
- Confirmation or rule out pregnancy
- Family planning, including medically emergent abortions
- Sexually transmitted diseases
- HIV testing

Sterilization Services (Medi-Cal Only): California law (Title 22, Sections 51305.1 and 51305.4) requires that Medi-Cal beneficiaries who request sterilization surgery complete a form (PM-330) attesting that they are giving informed consent for the procedure. PM-330 forms must be completed and signed 30 days prior to the surgery and filed in the medical record. Medi-Cal members may not waive the 30-day waiting period. California law requires that a copy of the signed consent form be submitted to payers before payment can be released. Consequently, the Alliance will not reimburse professional or facility fees associated with tubal sterilizations, vasectomies, or hysterectomies, until an appropriately completed PM-330 consent form is submitted by the primary surgeon.

Vaccines: Administration of routine pediatric immunizations is paid fee-for-service to the PCP. The appropriate administration codes must be submitted on the CMS 1500. For Medi-Cal members, PCPs have access to free vaccines through the Vaccines for Children (VFC) Program. To enroll, visit the VFC Program's website at http://www.cdc.gov/vaccines/programs/vfc/providers/default.htm Vaccines not covered by the VFC Program should be sent to the Alliance for reimbursement.

Laboratory - Clinical, Cytopathology, And Pathology: Quest Diagnostics is the Alliance's contracted partner for most outpatient clinical laboratory services. Except for emergency and urgent care services, and those lab services identified as covered under PCP capitation or specifically identified as reimbursed fee-for-service, laboratory services must be provided by Quest. Pathology services, identified as CPT-4 procedure code range 88300-88399, are payable by the Alliance only when performed in conjunction with emergency or urgent care services, or surgical services performed in an inpatient hospital, out-patient hospital, or free-standing surgical facility setting.

Office-Based Injectables: Except for injectables administered in an inpatient setting, claims for injectables administered in the office must include the National Drug Code (NDC) for each drug. Claims that do not include NDCs will be denied. Effective September 1, 2009, office based injectables are reimbursed in the following manner:

- Medi-Cal rates for Alliance Medi-Cal and Group Care members
- Average Wholesale Price minus fifteen percent (AWP – 15%) if a Medi-Cal rate does not exist for a particular drug

Medical Supplies: Claims for medical supplies, including disposable gloves, incontinence, ostomy, tracheostomy, wound care and urological supplies, must be submitted in the following manner:

- Level II HCPC codes are required.
- The Universal Product Number (UPN) for each item is required.
- Electronic medical supply transactions must be submitted in the 837 4010A1 professional format.

Medical supplies are reimbursed in the following manner:

- At a provider's contracted rates, or

If a contracted rate does not exist for a particular item, it will be reimbursed at the Average Wholesale Price minus fifteen percent (AWP – 15%).

Complaints

• Claim Dispute Process for Contracted Providers

The Alliance Claims Department has an established process for receipt and review of claims disputes from contracted providers. Providers can contact the Claims Department at 510- 747-4530 for additional information and to check the status of their disputes.

Definition of a Claim Dispute: A claim dispute is a provider's written notice to the Alliance challenging, appealing or requesting reconsideration of a claim (or a group of substantially similar claims that are individually numbered) that has been denied, adjusted or contested.

Claim disputes also include situations where a provider is seeking resolution of a billing determination or other contract dispute or is disputing a request for reimbursement of an overpayment of a claim.

Required Information: At a minimum, each claim dispute must include the provider's name, provider's contact information, a clear identification of the disputed item, the date of service, and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect.

Where to Send Your Claim Dispute: Claim disputes are processed by the Alliance Claims Department and can be sent to:

Alameda Alliance for Health
Claims Department – Notice of Provider Dispute Unit
P.O. Box 2460
Alameda, CA 94501-4506
Phone **510-747-4530**

Time Period for Submission of Claim Disputes: Claim disputes must be received by the Alliance within 365 days after the last date of action that led to the dispute. Claim disputes that do not include all required information as described above may be returned for completion. An amended dispute that includes the missing information must be submitted to the Claims Department within thirty (30) working days of a returned dispute.

Acknowledgment of Claim Disputes: The Alliance Claims Department acknowledges receipt of all claim disputes from contracted providers in the following manner:

- Electronic disputes are acknowledged within two (2) working days of the date of receipt.
- Paper disputes are acknowledged within fifteen (15) working days of the date of receipt.

Instructions for Filing Substantially Similar Claim Disputes: Substantially similar multiple claims, billing or contractual disputes, may be filed in batches as a single dispute, provided that such disputes are submitted in the following format:

- Please sort disputes by similar issue
- Provide a cover sheet for each batch
- Number each cover sheet
- Please include a cover letter for the entire submission describing each dispute with references to the numbered cover sheets

Time Period for Resolution and Written Determination of a Claim Dispute: Within 45 working days from the date of receipt of the dispute or the amended dispute, the Alliance Claims Department will issue a written determination which will state the reasons for the Alliance's decision. If the dispute is determined in whole or in part in favor of the provider, the Alliance pays any outstanding monies determined to be due, and all interest and penalties required by law or regulation, within 5 working days of the issuance of the written determination.

• Appeals of Utilization Management Decisions

The Alliance has an established process for receipt and review of appeals of Utilization Management Unit (UM) decisions. Providers may appeal decisions to deny, modify, terminate, and defer requests on behalf of members. Appeals of these decisions are processed by the Alliance's Grievances and Appeals Unit (G&A), which can be reached at **510-747-4531** (phone) and **1-855-897-7174** (fax).

Time Period for Submission of Appeals of UM Decisions: Appeals must be received by the Alliance G&A Unit within 365 days of the UM Unit's decision to deny, modify, terminate, or defer a request.

Required Information: At a minimum, each appeal must contain the provider's name, provider's contact information, the member's name and identification number, and a clear explanation of the basis upon which the provider believes that the decision should be reconsidered. Medical records supporting the appeal should also be included.

Appeals that do not include all required information as described above may be returned for completion. An amended appeal that includes the missing information must be submitted to the G&A Unit within 30 working days of a returned appeal.

Acknowledgment of Appeals: The Alliance G&A Unit acknowledges receipt of all appeals from contracted providers within 15 working days of the date of receipt.

Time Period for Resolution and Written Determination of an Appeal: Within 45 working days from the date of receipt of the appeal or the amended appeal, the Alliance G&A unit will issue a written determination which will state the reasons for the Alliance's decision.

• Provider Discharge of Member Process

The Alliance allows PCPs and specialists to request discharge of members when medical services can no longer be successfully provided for reasons other than medical conditions. The Alliance works with each discharged member to choose another PCP or specialist who can best meet his or her needs. The process for discharging a member is described below:

1. PCPs/specialists must send member discharge requests to the Provider Services department in writing. Please include complete documentation regarding the nature of the problem and reason for the requested discharge. The Provider Services department will review the request and notify the PCP/specialist of the decision.
2. PCPs/specialists may only request the discharge of a member if medical care can no longer be successfully provided for reasons other than the member's medical conditions. Requests to discharge a member due to medical conditions, frequent visits, or high cost of care will be denied.
3. If the discharge request is granted, the Member Services department will notify the member regarding the change in status, and will work with the member to find a new PCP/specialist.

   The original assigned PCP/specialist must maintain responsibility for the member's care until reassignment is completed but for no more than 30 days. This responsibility includes giving the patient 30 days written notice of the discharge. The member discharge notice must state the following:

   - That the PCP/specialist will be available for emergencies and prescriptions for the 30 days or until a new PCP/specialist assignment is effective;
   - That the member should contact the Alliance Member Services department for assistance with selecting a new PCP/Specialist; and
   - That the PCP/specialist will make the member's medical records available to the member's new PCP/specialist upon request.
4. A copy of the member discharge letter that the PCP/specialist plans to send to the member once the discharge is granted must be sent to the Provider Services department along with the initial discharge request.
5. If the PCP/specialist or the member is dissatisfied with the Alliance's decision, the PCP/specialist or member may file a grievance.

• Member Grievance Process

A provider aware of a member with a problem or complaint about the Alliance, its policies, or its providers, should do the following:

1. Inform the member that she/he can call the Alliance Member Services department at **510-747-4567**,
2. Give the member a Complaint Form and a copy of the "Member Guide to the Complaint/Grievance Process." Copies of the Complaint Form and the "Member Guide to the Complaint/Grievance Process" are included the Attachments section. Grievance forms in four languages (English, Spanish, Chinese, and Vietnamese) can also be found in the Provider Services section of the Alliance website, under 'Health Ed and other Member Resources'.

The Alliance will acknowledge receipt of the member's complaint within five (5) days and offer a resolution or status within thirty (30) days. A member who files a complaint or grievance may not be discriminated against, and cannot be disenrolled from the Alliance solely on the basis of filing a complaint or grievance. Alliance members also have these other options if they have a complaint:

State Fair Hearing (Medi-Cal only) State Fair Hearings are administered by the California Department of Social Services, State Hearings Division. The telephone number is 1-800-952-5253 (Voice) or 1-800-952-8349 (TTY for those who are deaf or have limited hearing). Medi-Cal beneficiaries may also request a State Fair Hearing through the Alameda County Social Services Agency. As long as the request for a hearing is made within 90 days of the action in question, members may exercise this option before, during or after the Alliance's

Medi-Cal Managed Care Division Office of the Ombudsman can assist with enrollment and other problems. The office is open Monday - Friday, 8 a.m. – 5 p.m.; excluding holidays. The toll-free telephone number is **1-888-452-8609**.

Department of Managed Health Care (DMHC) This state agency regulates health plans like the Alliance. This option should be used after the plan's grievance process, except where there is an emergency, an unsatisfactory resolution by the plan, or the plan has not resolved a member's complaint within 30 days. Members may also contact DMHC in emergency situations without going through the plan's process.

DMHC HMO Help Center Members can contact **1-888-HMO-2219** (**1-888-466-2219**) or TTY: **1-877-688-9891**. It is open 24 hours a day, 7 days a week. The HMO Help Center can provide help in many languages. The department's website (http://www.hmohelp.ca.gov) has complaint forms and instructions online.

The HMO Help Center can also assist with a request for an Independent Medical Review (IMR). This is an administrative procedure that allows a member to present evidence for independent medical review. The reviewers are certified by DMHC. Alliance Medi-Cal members may request independent medical review if a State Fair Hearing has not been initiated and the member has completed the plan's grievance process.

Attachments

The following documents are included as attachments to this guide. Several can be found on the Alliance's websites at www.alamedaalliance.org.

1. Sample Member Identification Cards
2. Provider Portal Sign-Up Instructions
3. Frequently Asked Questions About Claims
4. Important Contact Numbers
5. Alliance Authorization Request Form
6. Medication Request Form for Alliance Medi-Cal, Group Care
7. Alliance Specialty Pharmacy Program Drug List
8. Notice of Provider Dispute Form
9. Member Grievance Forms (English, Spanish, Chinese, Vietnamese)
10. Member Rights & Responsibilities
11. Timely Access Regulations
12. Health Education Forms and Documents
13. ICD-10 Communication
14. PCP Change Request Form and Memo
15. Nurse Line for Group Care Members
16. Non-Emergent Ground Transport

Thank you for joining the Alameda Alliance for Health's provider network! Please contact Provider Relations if you have any questions or concerns.

We're here to help!
510-747-4510