Provider Handbook

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SECTIONS

Eligibility and Coverage

❖ Member Eligibility:

Subscribers and dependents of TakeCare must reside within the service area. TakeCare defines service area as the geographic area in which a health insurance plan's benefits are made available. Our service area is the island of Guam, the Commonwealth of the Marianas Islands, and the Republic of Belau (Palau).

Specialty referrals outside the service area must be prior authorized and approved even if the member's plan has an out-of-network benefit. This is to ensure coverage under the member's plan benefits.

❖ Verification of Member Eligibility:

As a Participating Provider, you can verify member eligibility through any of the following:

◆ Verification through TC-EVA portal. TakeCare provides all Participating Providers with access to the TakeCare Eligibility Verification Access (TC-EVA) portal. Verification can done by clicking on the following link: https://tcproviderportal.takecareasia.com/Account/

◆ Automated Eligibility Verification. This can be done by calling our Customer Service line at 671-647-3526. Our Customer Service representatives are available 24 hours – 7days a week to provide eligibility information.

◆ TakeCare Identification Cards. All eligible TakeCare members are provided a TakeCare ID that they can present at the time of visit. It is strongly recommended that member eligibility is verified at the time of visit. TC-EVA and TakeCare's Customer Service can provide the most updated information on member's eligibility.

A member's eligibility must be verified each time he/she visits the provider.

This is essential for the following reasons:

- Employer group may change benefit plans
- Benefits may change
- Supplemental benefits may be added
- Copayment must be determined based on selected plan
- Fraudulent use of health plan coverage may occur

Note: If you have questions about eligibility, call the TakeCare Customer Service Department at 671-647-3526

❖ Dual Coverage:

Depending on the plan that the member subscribed to, a TakeCare member may be eligible under two active plans. It is strongly recommended that providers verify if a member is covered under more than one insurance.

When a member has dual coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. TakeCare determines which coverage is primary according to the National association of Insurance Commissioners (NAIC) guidelines. As a primary payor, TakeCare will pay based on the member's benefits and coverage. If the TakeCare is secondary, TakeCare will determine its allowance and pay up to the allowable benefit. TakeCare will not pay more than the allowable benefit.

Co Payments/Co-insurance

Copayments should be collected when professional services are rendered which would generate a charge per office visit. As a point of clarification, professional services would include but are not limited to the following examples:

- Services rendered by a physician
- Services rendered by a physician's assistant
- Services rendered by a nurse practitioner

❖ Laboratory/Radiology and other Diagnostic Services

Laboratory, radiology and other diagnostic services require a copayment/coinsurance by the member depending on the member's plan. If the member's plan is a deductible plan, then member will have to pay for all eligible charges until their single deductible is met for each individual member (at least three (3) individual members under a family coverage must meet each of their individual deductible before the family deductible will be met). It is important to verify the member's copayment, coinsurance and deductible at the time of visit through TC Provider portal.

❖ Preventive Annual Physicals

TakeCare is in compliance with regulatory requirements to offer preventive services in accordance with the recommendations with the US Preventive Services Task Force (USPSTF). Under TakeCare's core benefits, annual physical exams are covered at a 100% as required by law under the Affordable Care Act (ACA). A detailed listing of services can be found on Page 21 of this manual.

**Adult Preventive Guidelines-see appendix page 33*

❖ Urgent Care Copayments

Urgent Care require a copay/coinsurance by the member depending on the member's plan. If the member's plan is a deductible plan, then member will have to pay for all eligible charges until their single deductible is met for each individual member (at least three (3) individual members under a family coverage must meet each of their individual deductible before the family deductible will be met). It is important to verify the member's copayment, coinsurance and deductible at the time of visit through TC provider portal. The emergency room copayment/coinsurance is applicable when the member is referred to the hospital emergency room for emergency services. Emergency services are not subject to deductible. Emergency room copayments are due to the hospital that renders care. However, if the member is admitted as an inpatient, the emergency room copayment is waived.

❖ Nonpayment of Copayment

When a member cannot pay the applicable copayment before the services are provided, the Provider has the following options:

- Reschedule the appointment (unless an emergency visit).
- Bill the member.
- Call the Customer Service Department if the member continues to refuse to make copayments.

❖ Annual Out-of-Pocket Maximum

akeCare provides an annual out-of-pocket maximum. This ensures that copayments/coinsurance are not a barrier to receiving health care. The annual out-of-pocket max sets a limit on the total cost in copayments/coinsurance a member would need to pay during any benefit year. Once a member has met the out-of-pocket maximum, no further payment is charged for services received during the remainder of the benefit year. Note, deductibles do not count towards the out-of-pocket maximum.

Utilization Management

TakeCare's Utilization Management Program is designed to ensure the delivery of high quality, cost efficient health care for the members. The program is under the administrative and clinical direction of the Manager of the Medical Management Department or Designee and Health Plan Medical Director. The Executive Management Team evaluates and approves the Utilization Management Program annually. Updates occur as required.

❖ Referral System

✦**Specialist Referrals** - The Primary Care Physician (PCP) may request a consultation from a participating specialist physician at any time. A referral is required from the PCP prior to consultation with any participating specialist

✦**Emergency Room Services** - No referrals are required for treatment of an emergency medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

◆Placing the health of the individual or, with respect to a pregnant woman, the health of the woman, or her unborn child, in serious jeopardy;

◆Serious impairment to bodily functions;

◆Serious dysfunction of any bodily organ or part.

Emergency Room services are also covered if referred by an authorized Plan representative, PCP or Plan specialist. Plan notification (referral) is not required for payment of Emergency Room services for an emergency medical condition. The member is instructed to contact his/her Primary Care Physician after receiving urgent care services in any setting. The intent of this procedure is to allow the Primary Care Physician to coordinate any needed follow up care. Referrals are not required for payment of urgent care services received in an urgent care facility.

Emergency room utilization is monitored quarterly and members with a pattern of overuse/abuse are referred to Case Management for investigation and follow-up.

✦**Out-of-Network Referrals** - These requests are reviewed individually and determinations are made based on the patient's medical needs and the availability of services within the Provider Network to meet these needs. Services that are available within the network are not approved outside the network except in cases where the patient's health care status could be negatively impacted by not approving the Out-of-Network services. In any event the member prefers to access services at an Out-of-Network provider/facility for the purpose of convenience, approval will be based on the Out-of- Network benefit. Member share or responsibility must be fully acknowledged by the member. Decisions of this nature are made by the Manager of the Medical Management Department or Designee and Health Plan Medical Director.

✦**Tertiary Care Services** - All referrals to Plan tertiary care centers are reviewed on an individual basis. The member's medical needs and the availability of the requested services within the non-tertiary care network are taken into consideration. Formal or informal consultation with a participating specialist, if available, is required prior to considering a referral for tertiary care services. The participating specialist's recommendations for referral to a tertiary care center are taken into consideration by the Manager of the Medical Management Department or Designee when he/she makes the determination. Both Plan and Primary Care Physician should agree with the referral.

✦**Predetermination of Benefits/Outpatient Certification** – Certain procedures, durable medical equipment and injectable medications are prior authorized. TakeCare uses MCG (Milliman Care Guidelines) criteria for Imaging, Procedures and Diagnostics. When MCG criteria do not exist within TakeCare's purchased products, criteria are developed internally by the Product Committee Working Group or Pharmacy and Therapeutics Working Group as appropriate.

✦**Diagnostic Imaging**-Pre-established medical necessity/appropriateness criteria are utilized in the certification of elective outpatient CT scans, CTA of the coronary arteries, MRIs MRAs and Nuclear Cardiology studies. Prior authorization is not required when the diagnostic imaging studies are done as part of an emergency room visit for an emergency medical condition or an authorized inpatient stay.

**Prior Authorization Request Form-see appendix page 30*

❖ Referral Prior Authorization Process

TakeCare monitors review medical necessity through the referral authorization process. A referral authorization form should be utilized to track and provide documentation of medical necessity. TakeCare complies with federal guidelines decision and notification timeframes for all utilization management determinations. TakeCare requires all pre-certifications follow a general standard of submission. All referral documentation must be disease specific and forwarded to the appropriate specialty care for management. All requests must include pertinent information related to the member's condition such as laboratory findings, imaging and other diagnostic reports. This facilitates timely review and adjudication of the request. Requests with incomplete documentation will be put on hold until all required reports and documentation are submitted. Failure to comply with this requirement can result to delays and even denials. The following determinations may be made upon review of the referral:

✦**Approved as requested** - No changes

✦**Approved at modified** - Referral approved, but the requested provider or treatment was modified

✦**Pended** - Need additional documentation or information

✦**Denied** – Not a covered benefit or not meeting criteria for the benefit

TakeCare's UM staff will work with the providers to efficiently render the appropriate decisions. Providers are expected to cooperate with the UM staff by fulfilling the requirements of the prior authorization process. Should the Provider disagree with the authorization determination, he/she may resubmit the referral reconsideration with any additional documentation or information that supports the request.

❖ Retroactive Review of Referral Authorization

If a provider renders services to a member without prior authorization, that provider may request a retrospective review. IPA Utilization Management Department may give consideration on a case-to-case basis for authorization, on circumstances that did not indicate conscious circumvention of the authorization process.

❖ Reconsideration of Adverse Decisions

In the event of an adverse UM decision, the denial notice to the practitioner contains information on how to activate the reconsideration process. Reconsiderations may be telephonic or in writing and are conducted between the provider or health care facility and the reviewer who made the adverse determination. Reconsideration determinations are made within two (2) business days after receipt of the request. If the reviewer cannot be available within two (2) business days, the reviewer may designate another reviewer. The determination may be expedited if the seriousness of the medical condition of the member requires an expedited decision. TakeCare reviews these special circumstances and can expedite decision if the 2 business day waiting period may result in any of the following situations:

- ✦Place the health of the individual or, with respect to a pregnant woman, the health of the woman, or her unborn child, in serious jeopardy;
- ✦Serious impairment to bodily functions;
- ✦Serious dysfunction of any bodily organ or part.

Verbal and written notification of the determination will be made within two (2) business days of making the decision. Information on how to appeal an adverse reconsideration decision on behalf of the member is included with the denial letter to the practitioner. (See Member Appeals Process)

❖ Inpatient Hospital Certification

To ensure that all hospital admissions are medically appropriate and that the health care services are being provided in the most appropriate setting, the Plan reviews all hospital, long term acute care facility (LTAC), skilled nursing facility and inpatient rehabilitation admissions. Elective admissions may be reviewed before the member enters the hospital. Urgent and emergency admissions are reviewed the first business day after the admission occurs. For on-island admissions, this review process is performed on–site by the by Concurrent Review Nurse. For off-island facility, this process is performed through telephone or by telefax with the Case Manager/Utilization Review Department at each hospital. Pre-established medical necessity/appropriateness criteria are utilized to assure consistency in the certification process. Upon determination that an admission meets criteria, the Concurrent Review Nurse assigns a length of stay in anticipation of the concurrent review process. The admission continues to be reviewed at appropriate intervals until discharge planning results in the patient's discharge. Authorization of the admission includes all physician and ancillary services rendered during the inpatient stay. Excluded are those services that are not a covered benefit, such as convenience items.

The following methods of review are utilized:

- ✦**Prospective Review** - Using MCG Level of Care Criteria, elective inpatient hospitalizations are reviewed to assure that the services are provided in the appropriate setting. Elective inpatient care may be reviewed prior to the admission to assure that the services are provided in the most appropriate setting.

✦**Concurrent Review** – MCG Level of Care Criteria are utilized to evaluate the quality and appropriateness of care and to assess the medical necessity of continued stay. Again, pre-established criteria are utilized. At this time, discharge planning may also be initiated to plan for continuing care after discharge. All proactive planning, coordinating, and facilitating transitions of care are documented in the FACETS system. Any Stay where the intensity of service indicated that the patient might be transferred to a lower level of care, should first be discussed with the admitting physician to clarify treatment and disposition plans. If there is a discrepancy between the attending physician and the Concurrent Review Nurse with regards to the level of care from the current level of care, the Senior Manager for Medical Management in consultation with the Chief Medical Officer should be contacted and informed of the patient's status and treatment plan. The physician-to-physician communication should result in a resolution of the situation.

✦**Retrospective Review** - Analysis of patient care data for medical necessity, quality of care and appropriateness of setting after the care has been delivered will identify patterns of health care services of institutions, physicians, and members.

✦**Discharge Planning** - Patients who require continuing care after release from the hospital are identified and appropriate services are arranged through participating home care, medical equipment providers and other providers.

✦**Continuity of Care**- TakeCare has established a policy to ensure all necessary information related to the member's care are forwarded to the appropriate members of the health care team for care continuity. All referral documentation must be disease specific and forwarded to the appropriate specialty care for management. All referrals must include pertinent information related to the member's condition such as laboratory findings, imaging and other diagnostic reports. All information must be compiled and saved in the Department shared drive. This is to ensure adequacy of information on the member's condition where future care will be provided. The Lead RN Case manager will be responsible for proactively planning, coordinating, and documenting all transitions of care (i.e. inpatient, outpatient, extended care) in FACETS.

Note: TakeCare members who are new to the plan and are being managed by non- network providers in non-network facilities will be allowed to keep their providers for continuity of care. TakeCare contracting department will attempt to secure in-network agreement throughout the duration of treatment.

❖ Other Outpatient Certification

Prior authorization is conducted for select outpatient procedures and durable medical equipment to ensure appropriateness of the service and availability of coverage. A list of services that require prior authorization can be found on TakeCare's Member handbook and coverage brochures as well as the member's schedule of benefits

Coverage for specific self-injectable drugs is provided under either the medical or prescription drug benefit to decrease disease progression and avoid future costly medical care. Prior authorization is conducted to assure that the pharmaceutical is the most appropriate, cost-effective intervention.

The Utilization/Case Management Department reviews all home health care services prospectively and concurrently to assure that the services provided are medically necessary and being provided in the most appropriate setting.

❖ Prescription Drug Utilization Management

TakeCare utilizes Elixir as its Pharmacy Benefit Manager (PBM). Quantity limits, dollar limits, step therapy and prior authorization (criteria established by the Pharmacy and Therapeutics Working Group) are placed on certain drugs.

The utilization management process is activated by the pharmacist, ordering physician or member when the member accesses these drugs. The UM staff collects all pertinent medical information and has the authority to approve coverage if criteria are met. All other determinations are made by the Manager of the Medical Management Department or Designee and Health Plan Medical Director. All UM processes, including verbal and written notification of the decision to the provider and member, are followed in making the determination.

❖ Utilization Management Decision/Notification Timeframes

Request Type	Decision Standard	Verbal/e- Notification	Written Notification
Non-urgent W Pre-Servicef	ithin 2 working days rom receipt of request	Within 3 working days ofW making the decision	ithin 3 working days of making the decision
Urgent Pre-ServiceW	ithin 24 hours making the decision	Same day as decision	Within 2 calendar days of
Concurrent ReviewW	ithin 24 hrs. of receipt W of request	ithin 24 hrs. of receipt of request	Within 24 hrs. of receipt of request
Retrospective Review	Within 25 calendar days of receipt of request	None requiredW	ithin 5 calendar days of making the decision
Envision Drug requests covered under medical o or pharmacy benefito	Within 24 hrs. of receipt f request	Within 24 hrs. of receipt of request	Within 24 pharmacy benefit hrs. of receipt f request (denials only)

❖ Case Management

The Case Management Program was established to more effectively manage specific high- risk segment of the population. Members are reviewed for potential case management when specific criteria are triggered. The Case Manager Associate will review the case to determine if a positive impact can be made in the quality and cost-efficiency of the care.

Cases are screened for the following:

- high cost diagnosis
- unusual patterns of treatment
- extensive service utilization (Extended stays and readmissions)
- specific disease processes which can be impacted
- ways of improving quality of care

Providers will be notified of identified cases to ensure the Primary Care Physicians are involved and fully aware of the member's condition progress. Providers are also encouraged to notify TakeCare of any potential high-risk case that may benefit from the Case Management Program.

Case Management Referral Form-see appendix page 37

❖ Behavioral Health Services

TakeCare conducts utilization and case management for mental health/chemical dependency services provided to all members.

For non-acute/outpatient cases, services are available through contracted Behavioral Health providers under TakeCare. However, in the event that there is a need for more specialized services, the Plan must make arrangements for services outside this network. When this occurs, the Plan is financially liable for the services and follows them closely to ensure that quality care is being provided in the most appropriate setting. In addition, the Plan is responsible for the provision of inpatient mental health/chemical dependency services as provided in the plan member's schedule of benefits.

For urgent and acute cases, members are directed to the Emergency Services and Crisis Intervention Center of the Guam Behavioral Health and Wellness Center (GBHWC).

Crisis Hotline: (671) 647-8833/ 647-8834.

Utilization and case management functions for behavioral health services follow the same processes as general medical. This includes out-of-network specialist (psychiatrist/psychologist) referrals, tertiary care and inpatient certification. Outpatient prior authorization is conducted for partial hospitalization and intensive outpatient treatment.

❖ Access to UM Staff

Utilization and Case Management staff is available Monday through Friday (excluding holidays) from 8:00 a.m. to 5:00 p.m. to answer questions regarding UM decisions, authorization of care and the UM program. The Department has both local and toll-free telephone and telefax numbers. Telephone lines are staffed with professionals who have access to most information/ resources needed to provide a timely response. Callers have the option of leaving a voice mail message either during or after business hours. TakeCare standards require returning all phone inquiries within the day or the next business day.

UM Contact Information:
Tel: 671-646-6956 ext. 7222, 7232, 7182, and 7203
Fax: 671-647-3541
Email: medicalmanagement@takecareasia.com

❖ Medical Necessity

According to Plan policy, medical necessity/appropriateness is defined as those services determined by the Health Plan or its designated representative to be:

- preventive, diagnostic, and/or therapeutic in nature,
- specifically relates to the condition which is being treated/evaluated,
- rendered in the least costly medically appropriate setting (e.g., inpatient, outpatient, office),
- based on the severity of illness and intensity of service required,
- not solely for the Member's convenience or that of his or her physician and
- is supported by evidence-based medicine

❖ Medical Necessity Criteria

The Utilization Management Program is conducted under the administrative and clinical direction of the Manager of the Medical Management Department or Designee and Health Plan Medical Director. Medical necessity and Appropriateness criteria are developed, reviewed and approved by the physician entities prior to implementation. Part of this review process may also include input from appropriate participating subspecialists. As part of the review of the Utilization Management Program, all criteria are reviewed and updated as needed, but no less than annually. Providers are advised annually that criteria are available upon request. Internally developed criteria and a general list of services that require prior authorization are listed in the member's handbook and schedule of benefits.

The individual needs of the member and the resources available within the local delivery system are considered when applying Utilization Management criteria.

continued on next page

✦**Inpatient Certification** - the Utilization Management Program uses the 25th edition of Milliman Care Guidelines (MCG) as the basis of the inpatient certification process. In addition, the MCG criteria are applied in reviewing the appropriateness of admissions for inpatient rehabilitation services, admissions to skilled nursing facilities, mental health and chemical dependency partial hospitalization, intensive outpatient and ambulatory services and for home health care services.

✦**Outpatient/Other Certification** - Where it exists, the 2016 20th edition of Milliman Care Guidelines (MCG) criteria are used to determine medical necessity for outpatient services. When absent from the MCG criteria sets, internal criteria for certification are based on current evidence-based medical literature and are developed by the Product Committee or the Pharmacy and Therapeutics Working Groups. At least annually, the criteria are reviewed by the Working Groups and applicable participating subspecialists. The criteria are used by the Utilization and Case Management Coordinators during the prior authorization process.

✦**Diagnostic Imaging** - The 25th edition of Milliman Care Guidelines (MCG) Criteria is used as the basis for authorization of the following but not limited to elective, outpatient Imaging studies:

- CT Scans
- MRIs
- MRAs
- Nuclear Cardiology
- Cardiac CTA

✦**Durable Medical Equipment** - Medicare guidelines are used in the prior authorization of select durable medical equipment for the Commercial and Medicare product lines. A list of durable medical equipment that requires prior authorization are listed on the member's handbook and benefit brochure.

✦**Transplants** - depending on the member's coverage, it is TakeCare's policy that all requests for organ transplants be reviewed by the Manager of the Medical Management Department or Designee, Health Plan Medical Director and Health Plan Administrator. Members are directed to the most appropriate Center of Excellence transplant facility for evaluation based on benefits.The Case Manager works with the facility transplant coordinator to send all transplant recommendation to TakeCare's contracted transplant network.

✦**New Technology Assessment** - The Plan investigates all requests for new technology or a new application of existing technology utilizing current evidenced-based literature as a guideline to determine whether the new technology is investigational in nature. If further information is needed, the Plan utilizes additional sources, including Medicare and Medicaid policy, Food and Drug Administration (FDA) releases and current medical literature. This includes medical and behavioral health procedures and devices. Pharmaceuticals are investigated by the Pharmacy and Therapeutics Committee. If the new technology/pharmaceutical or new application of an existing technology or pharmaceutical is addressed in the above documents, the information is taken into consideration by the Product Committee in consultation with the Medical Director at the time of benefit determination. If the new technology/pharmaceutical or new application of an established technology/pharmaceutical is not addressed in the above documents, the Chief Medical Officer may confer with an appropriate specialist consultant for additional information. This information will be presented to the Product Committee or Pharmacy and Therapeutics Committee to provide a recommendation to the Plan Administration regarding coverage. The decision will be based on safety, efficacy, cost and availability of information in published literature regarding controlled clinical trials. If a decision cannot be made, a committee of specialists may be convened to review the new medical technology/pharmaceutical and make a recommendation to the Plan Administration.

❖ Medical Necessity Determinations

Medical necessity determinations are made based on information gathered from many sources. Each case is different. However, these sources may include some or all of the following:

- Primary Care Physician
- Specialist physician
- Hospital Utilization Review Department
- Patient chart
- Home health care agency
- Skilled nursing facility
- Physical, occupational or speech therapist
- Behavioral health/chemical dependency provider
- Patient or responsible family member

The information needed will often include the following:

- Patient name, ID#, age, gender
- Brief medical history
- Diagnosis, co morbidities, complications
- Signs and symptoms
- Progress of current treatment, including results of pertinent testing
- Providers involved with care
- Proposed services
- Referring physician's expectations
- Psychosocial factors, home environment

The Concurrent Review Nurse, Medical Review Specialist and the Lead RN Case Manager will use this information, along with good nursing judgment, departmental policies and procedures, needs of the individual member and characteristics of the local delivery system, including the availability of the proposed services within the network service area, to make a decision. The Concurrent Review Nurse, Medical Review Specialist and the Lead RN Case Manager has the authority to approve services based on medical necessity. If the decision is outside the scope of the Concurrent Review Nurse, Medical Review Specialist and the Lead RN Case Manager's authority, the case is referred to the Chief Medical Officer and the Medical Management Manager or Designee and Medical Director for a determination. The Medical Management Manager or Designee and Medical Director, as appropriate, are the only Plan representatives with the authority to deny payment for services based on medical necessity/appropriateness. Alternatives for denied care/services are given to the requesting provider and member and are based on the criteria set used or individual case circumstances. In making determinations based on contract benefit exclusions/limitations, the Member Handbook, Schedule of Benefits, and the Employer Group Services Agreement are used as references.

❖ Clinical Practice Guidelines

Adopting Clinical Practice Guidelines assists practitioners and members in making decisions about appropriate care for specific clinical circumstances and to improve patient outcomes.

TakeCare utilizes its practitioners to develop/adopt/implement Clinical Practice Guidelines for non-preventive acute or chronic medical conditions and preventive and non-preventive based on reasonable medical evidence and sound scientific basis, in consideration of needs of our member demographics and population, and the recommendations of regionally or nationally recognized organizations, to assist practitioners/members in decisions about appropriate care for specific circumstances. Clinical Practice Guidelines may be referred to as treatment protocols, practice parameters or clinical pathways. Medical Clinical Practice Guidelines will be distributed to all contracted practitioners who are likely to use them as appropriate to their area of practice including new practitioners as they are added, new guidelines when adopted and when updated or revised.Clinical Practice Guidelines will be utilized as a clinical basis in TakeCare's Disease Management Program. The Provider Organization will identify and implement opportunities/interventions for improvement and measure the effectiveness of those interventions.

TakeCare considers clinical practice guidelines to be an important component of our medical care delivery system. TakeCare performs an assessment of the disease prevalence of our membership every two years. Our disease prevalence based, health management programs have adopted nationally published clinical practice guidelines that are developed by relevant specialty physician organizations, and designed to monitor and improve the treatment outcomes for high-volume/high-risk diseases. Similarly, TakeCare requires its contracted Providers to adopt the TakeCare Clinical Practice Guidelines.

❖ The Role of the Medical Director

The Medical Director is responsible for the Utilization Management Program and, therefore, should take an active role in the implementation, development, and promotion of managed care systems. This should include development of Utilization Management Policies and Procedures, and criteria used for authorization and review, and the implementation of a process to educate Providers on the Utilization Management Program. The Medical Director is expected to provide leadership, direction, and education for both the UM and QI Programs and to act as physician liaison in the resolution of UM and QI issues with the primary care and specialist physicians. The Medical Director also serves as an important resource and key contact for the Utilization Management and Quality Improvement nurse(s) when evaluating specific cases. The Medical Director is responsible for interfacing with TakeCare's UM Staff and the network providers regarding benefits or administrative issues.

❖ Role of the Primary Care Physician

An important component of a successful UM Program is the role of the primary care physician (PCP) as manager of all health services provided to the member. (This is sometimes referred to as the "Gatekeeper" concept). Quality and continuity of care are maintained when the PCP provides a greater range of primary care services. This means that the PCP serves as the single point of contact, reference, resource, and consultation for all health services provided to the member.The PCP is expected to support UM Committee recommendations and discuss them, when needed, with their patients. Nothing contained in this Provider Manual is intended to interfere with the physician-patient relationship or shall be interpreted to discourage or prohibit participating providers from discussing treatment options or-providing other medical advice or treatment deemed appropriate. The member looks to the PCP to provide expertise and direction of their health care needs, and perceives the PCP to be a representative of TakeCare. The PCP's role in successfully recognizing and appropriately addressing the needs of the member will be of primary importance in the achievement of the health and satisfaction of members.

❖ Urgent and Emergency Care Services

Emergent Care Procedure- The definition of Emergent Care is the sudden and unexpected onset or occurrence of a symptom, illness, medical condition or injury which requires immediate diagnosis and/or treatment in order to alleviate or attempt to prevent severe pain, permanent disability, serious medical complications or loss of life.

The definition of Urgent Care is medical services which are required without delay in order to prevent the serious deterioration of a member's health as a result of an unforeseen illness or injury.

In an emergency, the member should dial 911 for ambulance and/or paramedic services. It is recommended for the TakeCare's Participating Providers to provide the emergency room phone numbers, contracted hospital, and office hours of the provider to their patients. This is a personal and direct way of ensuring this information is received by the member.

It is also advisable for the network provider to develop a relationship with its contracted hospital's emergency room department and implement a system where the ER notifies the PCP when a member has arrived in the ER. While this process may not prevent ER visits, input from the PCP can significantly reduce the scope, and therefore the cost, of the ER work-up.

There are also urgent, but not necessarily life-threatening emergencies for which emergency room services may appropriately be authorized. In these cases the member should be directed to the PCP's office (if during office hours) or an Urgent Care Facility whenever appropriate. TakeCare members have full access to FHP Urgent Care. The use of Urgent Care Facilities and/or extended office hours can significantly reduce emergency room visits and cost.

❖ Emergency Room After Hours Call

TakeCare Participating Providers must have 24 hours a day, seven (7) days a week physician contact system in place. The provider may utilize an answering service for after-hours calls, who will then contact the physician on call. The on-call physician should be a qualified contracted physician who is familiar with the member's health plan procedures, and the affiliated contracted facilities and providers.

TakeCare also requires the provider to have the following:

- ✦ Written criteria and standards for Emergent and Urgent Services. The criteria must be in a format that can be made available to state regulatory agencies or members upon request.
- ✦ Provider must adhere to policies and procedures in place to resolve disputes between primary care physicians and attending emergency physicians regarding patient's condition, hospital transfers and hospital discharge.
- ✦ Provider must have means to provide or arrange emergency care on a 24 hour basis

❖ Emergency Services within the Service Area

In the event of an emergency or accident, a member should seek immediate medical attention and make sure someone else notifies TakeCare within forty-eight (48) hours or as soon as reasonably possible after initial receipt of services to inform the Plan of the location, duration and nature of the services provided. **TakeCare Customer Service can be reached at (671) 647-3526 or toll-free at (877) 484-2411; Medical Referral Services Hotline can be reached (671) 300-5995 or toll free at 1 (800) 671-8075.**

If the member presents to the Emergency Room, the member must be provided with a medical evaluation to determine whether an emergency medical condition exists and stabilize the condition. For Urgent Care services, the member's PCP should assess and decide whether

❖ Emergency Services outside the Service Area

Members requiring Out-of-Area emergency hospitalization will be managed and coordinated by the TakeCare's Medical Management Department. This includes all medical services, including Urgently Needed Services, provided outside the service area except for those Out-of-Area Services which are elective.

❖ Confidentiality

TakeCare has written policies and procedures to protect a member's personal health information (PHI). The Medical Management Department collects only the information necessary to conduct case management services or certify the admission, procedure or treatment, length of stay, frequency and duration of health care services. TakeCare is required by law to protect the privacy of the member's health information. Before any PHI is disclosed, TakeCare must have a member's written authorization on file. Within the realm of utilization review and case management, access to a member's health information is restricted to those employees that need to know that information to provide these functions. A full description of TakeCare's Notice of Privacy Practices may be found on the Member Handbook. As a standard, TakeCare requires all Participating Providers adhere to the guidelines of Health Insurance Portability and Accountability Act of 1996 (HIPAA) by establishing guidelines, structures, and policies to protect PHI.

❖ Member Appeal Process

There may be instances where either a member, a member's Legal Representative or an Authorized Person is not satisfied with a coverage decision made by the Plan. TakeCare has established policies and procedures for registering and responding to member grievances and appeals. All UM denials contain a product-line specific appeals process that explains to the member and provider how to appeal the denial determination. The product specific appeals Processes meet all Federal and Territorial regulatory requirements. Member Appeals Process can be found on the Member Handbook. TakeCare wants to provide the maximum opportunity for members to communicate their concerns regarding their plans and to receive an immediate response. TakeCare encourages members to contact TakeCare Member Services Department with any questions, comments or concerns. The objective of the Member Appeals department is to act as the consumer advocate throughout the appeals process.

If a member does not agree with TakeCare's decision and wishes to appeal, the member can contact:

TakeCare Customer Services Department
(671) 647-3526 or Toll free at 1-877-484-2411

❖ Member Rights And Responsibilities

TakeCare ensures that all members are aware of their rights and responsibilities as TakeCare members. As standard, TakeCare requires all Participating providers comply with the policy. The Member Rights and Responsibilities provide guidance to the members about their rights and responsibilities regarding their health care needs and services they receive from the provider. Member Rights and Responsibilities can be found on the member handbook available in the TakeCare at www.takecareasia.com

Quality Management

❖ Access Standards for Medical Services

TakeCare established the following standards of access to medical care:

- **Annual Physical Examination:** Within forty-two (42) calendar days for a patient requesting a complete physical examination (including history).
- **Non-Urgent/Routine visits**: These conditions require a visit in a timely fashion, but are not considered urgent. The standard is no more than seven (7) days for this access category.
- **Urgent Care:** These non-life threatening, but serious conditions require medical intervention within twenty-four (24) hours of member contact with the physician's office.
- **Specialty Referrals:** For non-urgent cases, the standard is no more than fourteen (14) days from the date of the referral.

❖ Appointment Waiting Times

The TakeCare standard for physician office wait time is thirty (30) minutes from the scheduled appointment time until the patient is seen by the physician. TakeCare Participating Providers should establish a method of evaluating wait time in a waiting room. These times could be checked periodically, on a random basis, to establish average waiting time.

❖ Missed Appointment/No Show

TakeCare recommends the development of a policy and procedure for tracking and managing "no-show" and missed appointments. The following elements are necessary:

All missed appointments are documented "No Show", or similar wording, in the member's chart.

- All missed appointment charts are held for physician review.
- If upon physician review the member is in need of follow-up, the physician will instruct the office staff to contact the member either by phone or letter, de pending on the urgency of the situation.
- The office staff will document the physician review of the chart as well as the follow-up, i.e. patient canceled; appointment made for next day. Verify physician's signature in the chart.

TakeCare's Participating Provider is required to develop a no show/missed appointment policy and monitor its effectiveness and to identify members who exhibit a chronic tendency towards missed appointments. Missed Appointments/No Show tracking will be monitored during periodic audits for recredentialing purposes.

❖ Confidentiality Standards

TakeCare Participating Providers will develop policies and procedures to ensure the confidentiality of all member, peer review, and Quality Management information in accordance with the Health Insurance Portability and Accountability Act (HIPAA). The confidentiality policies and procedures must at a minimum, address:

A confidentiality agreement signed by all employees.

- Identify staff that has access to the medical records.
- Identify mechanisms to safeguard the medical records from access by anyone other than staff authorized to access medical records.
- Release of medical information to any source.
- Periodic and regular training of staff and employees on HIPAA

Because the relationship and communication between physician and patient is privileged, the medical record containing information about the relationship is confidential. The physicians' code of ethics, as well as state law, protect against disclosure of the contents of medical records to persons or agencies who are not properly authorized to receive such information.

❖ Medical Record Documentation

As a standard, TakeCare requires Participating Providers to develop written policies and procedures regarding medical record standards. These standards will, at a minimum include the following:

- Record format and layout
- Documentation standards
- Confidentiality
- Posting of Reports
- Turn around time for dictation
- Turn around time for hospital records

Medical record documentation should be:

- Organized
- Divided into sections
- Ordered chronologically by section
- Securely affixed, page by page
- Individual for each patient

A medical record should include the following:

- Patient name and/or identification number are on each page
- Personal biographical data including address, employer, home and work phone number, marital status, and emergency contact name and phone number
- Entries that are legible:
  - The entries should be legible to someone other than the writer
  - All entries should be dated, signed, and identify author and title, i.e., RN, LVN, MA or MD
- Allergies or adverse reactions are noted on the front of the chart and/or on each progress note. No known allergies (NKA) or adverse reactions should also be noted.
- Problem lists should indicate significant illness and medical conditions
- Current medications must be listed or documented on the progress note at each encounter
- Past medical history should be easily identified including serious accidents, surgical procedures, illness, history of risk factors, family planning, and adult immunizations
- Identification of habits such as smoking, alcohol use, and substance abuse
- Documentation for each encounter is to include
  - Date of Service
  - Vital signs as appropriate
  - Chief complaint that brought member to the provider
  - Physical examination relating to chief complaint
  - Appropriate diagnostic studies ordered
  - Working diagnosis with complete findings
  - Treatment plan relating to working diagnosis
  - Notation indicating follow up care, call, or visit
  - Specific time for return to be noted in days, weeks, months, or as needed
  - Problems from previous visit should be addressed
  - Authentication and verification of medical record contents by network providers.
- Documentation of medically appropriate referral to patient education must be present in the medical record, e.g., Diabetes Mellitus, Hypertension, Chronic Asthma, Emphysema, Smoking Cessation, Weight Reduction,etc.
- Documentation of preventive care and health maintenance such as:
  - Adult Screens: Immunizations, colonoscopies, mammograms, pap smears
  - Annual physicals
  - EKG's and chest x-rays when appropriate
- Documentation of No show/failed appointments noted, reviewed by physician and follow-up documented
- Abnormal labs and follow-up evidence of primary care physician review of lab results, imaging study, and consult summaries

- Reports from consultants/referral physicians in chart
- Documented evidence of continuity and coordination of care
- Records of Hospitalizations
- Advance Directive as appropriate

❖ Complaints and Grievance

The member's perception of quality care is an important aspect in member satisfaction. The provider must develop policies and procedures to address member complaints or grievances. The policy should include the following:

- Appropriate interaction with member
- Documentation of member concerns
- Steps to follow toward resolution
- Quality Management, and Peer Review will review pertinent findings
- Responses to the member regarding findings

TakeCare recommends regular tracking of member complaints and grievance. Results and findings must be reported to TakeCare's Quality Improvement Committee for review and monitoring. Physician related issues are compiled and reviewed for recredentialing purposes.

❖ Provider Responsibility

All member complaints and grievances are tracked by Member Services. In the event of an oral or written complaint, the Participating Provider shall cooperate in the investigation and resolution of the complaint.

TakeCare Participating Providers will comply with all final determinations made by TakeCare through the Member Appeals and Grievance Procedures.

❖ Physician Office Standards

At a minimum, TakeCare requires the following standards for physician office:

- Access/triage
- Handicapped accommodations
- Documentation of the most current fire inspection
- Clinical staffing and credentials
- Provide clear identification and directions to office
- Provide housekeeping for waiting/exam/restrooms
- Smoke detector, fire alarm, sprinkler system, or fire extinguisher
- Policy and procedure that ensures security of drugs, prescription pads, needles and syringes
- Policy on storage, dispensing, labeling of medications, and monitoring of expiration dates.

❖ Safety and Regulation Standards

TakeCare Participating Providers must develop a written safety emergency plan covering the following:

- Medical Emergency Procedures-calling 911, obtaining emergency equipment
- Disaster Emergency Procedures- Evacuation plans for fire, flood and earthquakes
- The evacuation plan must be posted and visible TakeCare requires that an emergency drill be conducted at least annually. The safety standards that TakeCare requires of a provider are the same guidelines required by the State. These requirements include the installation of such items as fire extinguishers, exit signs and escape route signs. TakeCare requires the provider to adopt guidelines and policies on the following:
- Material Safety Data Sheets (MSDS)-These guidelines are required when handling any substance that may be considered toxic that is stored within the work site and to which employees are exposed. The guidelines contain information regarding the treatment of exposure to the chemical agents.
- Infection Control/Universal Precautions-Due to the nature of health care, infection control must be a consideration when dealing with the patient. It is expected that the provider group has established policies on Infection control to include periodic training on Universal precautions and procedures addressing equipment and supply sterilization. All OSHA standards must be met in each provider's office.
- All health care employers ensure that their employees follow universal precautions and have access to protective equipment and clothing.

The regulation requires employers to develop a written exposure control plan, for individuals with occupational exposure to blood and body fluids, the plan must include:

- Job classification
- Job tasks and responsibilities
- Procedures that specify the methods to protect the employees from infection

❖ Triage Protocols

The Participating Providers must develop triage protocols which clearly outline the following components:

- List of specific medical symptoms for which the receptionist must contact the physician.
- Triage will be documented in the member's medical chart.

❖ Health Education

TakeCare believes that, given appropriate information and support for using it, health plan members can be full partners in managing their health. Thus, TakeCare recommends Participating Providers to develop written policies and procedures for health education of the members. TakeCare requires health education learning opportunities in the following areas be made available:

- Diabetes
- Heart Disease
- Hypertension
- Maternal/Child Health
- Smoking Cessation
- Weight Management

TakeCare realizes that much education takes place, on an informal basis, between the physician and patient, but also encourages the utilization of TakeCare Wellness and Disease Management Programs.

Available Wellness Programs:

- Cardiac Risk Management Program
- Children Health Improvement Program
- Diabetes Management Program
- Group Fitness Classes
- Nicotine Cessation Program
- Teen Talk Workshop
- WellMommy-WellBaby Program
- Wellness and Nutrition Consultation

**Wellness Referral forms-See appendix page 36*

❖ Abnormal Laboratory Results

The Participating Providers must have a written policy regarding reporting of abnormal laboratory results. The policy must include:

- How the physician is notified
- How is member notified
- How result is documented within the Medical Record
- Tracking process
- Member non-compliance with medical advice

❖ Periodic Health Evaluations/Screenings

TakeCare is in compliance with regulatory requirements to offer preventive services in accordance with the recommendations with the US Preventive Services Task Force (USPSTF). The following services covered under this mandate include:

- Items or services an "A" or "B" rating in the current recommendations of the USPSTF.
- Immunizations for routine use as recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention.
- Preventive care and screenings for infants, children, and adolescents provided for in the guidelines supported by Health Resources and Services Administration (HRSA).
- Preventive care and screening for women provided for I the guidelines supported by HRSA.

❖ Specialty Referrals

TakeCare requires Participating Providers to have written policies and procedures which describe the following components of specialty referrals:

- Referral process
- Referral tracking
- Member notification
- Tracking services rendered
- Appeals process for denied referrals

Provider Dispute Resolution

TakeCare has established a Provider Dispute Resolution Procedure, as amended from time to time, to provide a mechanism by which contracting providers may submit disputes arising out of the performance of the provider agreement or relating to decisions made by TakeCare pursuant to the provider agreement for review and resolution on an informal and timely basis. The Provider Dispute Resolution Procedure does not provide a mechanism by which to attempt to renegotiate the terms of the provider agreement, which shall be subject to renegotiation according to the applicable provisions of the provider agreement.

❖ Submission and Resolution of Disputes Without Arbitration

✦All provider disputes arising out of the performance of the provider agreement or relating to decisions made by TakeCare pursuant to the provider agreement should be submitted by the provider in writing and sent to the following department within TakeCare at the following address:

Plan Contracting/Provider Relations Department
P.O. Box 6578, Tamuning, Guam 96931

✦To obtain information or assistance in submitting a dispute to TakeCare for review and resolution under this Provider Dispute Resolution Procedure, a provider may call TakeCare's Provider Relations Department at (671) 647-3526.

✦If the Provider Relations Department is unable to resolve a provider's dispute, it will be referred to the appropriate person or department within TakeCare. The person or department will review the relevant information, documents and/or records and any information submitted by the provider.

✦If there are specific procedures followed by TakeCare which relate to the provider's dispute, such procedures shall be followed by TakeCare and the provider. For example, disputes relating to utilization management issues will be resolved in accordance with TakeCare's Utilization Management Program and disputes relating to quality management will be resolved in accordance with TakeCare's Quality Management Program.

✦If there are no specific procedures followed by TakeCare which relate to the provider's dispute, the responsible person or department shall use reasonable efforts to resolve the dispute, in consultation with the provider, in a timely manner.

❖ Arbitration

Any provider dispute which is not resolved to the provider's satisfaction after following the above Provider Dispute Resolution Procedure may be submitted by the provider to arbitration in accordance with the provisions of the agreement

❖ Provider/Member Grievances and Appeals

A provider may join with or assist a TakeCare member to submit a member grievance or complaint for resolution under the TakeCare Member Grievance and Appeals Procedure. All member grievances and complaints shall be addressed and resolved under the TakeCare Member Grievance and Appeals Procedure and not under the Provider Dispute Resolution Procedure specified above.

Claims Processing and Adjudication

❖ Claims Processing

The following outlines how claims are processed

✦Claims are received by the TakeCare Claims department through:

- ◆Providers manually delivering their claims
- ◆Mail
- ◆Electronic Claims Submission

✦Once the claims are received, the claims are batched by provider and scanned into Docushare allowing the TakeCare Claims department to have access to the claims. Claims received by TakeCare are processed through a claims system, Facets.

✦Facets maintains information on members' eligibility, members' benefit and the contract terms of the providers.

✦**Clean Claims**- A clean claim is defined as having all appropriate information for payment.

✦**Claims Adjudication;**

The TakeCare Claims examiners use the "first in first out" method in determining the order of the claims batch to be processed. When a clean claim is entered into Facets, Facets will determine if the member is eligible at the time of service and apply the copay/coinsurance/deductible of the members' benefits and determine the amount to pay the provider.

✦**Claims Turn Around Time**

TakeCare processes clean claims for payment within the time frames outlined in the contract or 45 days after the receipt of clean claims if the contract is silent.

TakeCare makes payments based on contracts agreed upon between TakeCare and the participating provider. TakeCare addresses any dispute or complaint regarding claims payment through the Provider Dispute Resolution process outlined in Section E of this manual.

✦**Coordination of Benefits** - General Information Coordination of Benefits (COB) also referred to as non-duplication of benefits, is the practice of two or more plans coordinating their provision of health benefits to members who have multiple coverage.

COB regulations were developed by the National Association of Insurance Commissioners (NAIC), and adopted by various state HMO regulators and Departments of Insurance, and are designed to accomplish the following:

- ◆Members benefit by having maximum benefits and minimal out-of-pocket expenses between coordinating plans.
- ◆No member, plan or provider will benefit from excess payments (over 100%) toward the costs associated with necessary health services.
- ◆Claim expenses for services that have been provided by a plan may be shared by another plan.

Currently, all of the health benefits provided by TakeCare under the Provider and Hospital Group Agreement are subject to the COB provision.

❖ Coordination of Benefits -Medicare

Under some circumstances, TakeCare's benefits will be secondary to those medical benefits to which a member is entitled as a Medicare beneficiary. Should the cost of medical or hospital services exceed Medicare's coverage, TakeCare benefits shall be provided as secondary up to TakeCare's liability.

❖ Coordination of Benefits -Workers' Compensation

Workers' Compensation has primary responsibility for payment in all compensable work related injuries or illnesses. TakeCare shall not furnish benefits to any member which duplicates the benefits to which a member is entitled under Workers' Compensation law.

In the event of a dispute, arising between the member and his/her Workers' Compensation coverage, regarding the ability to collect under Workers' Compensation laws, TakeCare will provide the benefits described in the Medical and Hospital Group Subscriber Agreement until the dispute is resolved.

In the event TakeCare (for reasons such as a pending Workers' Compensation Appeals Board case) provides benefits which duplicate those under Workers' Compensation, the member is required to reimburse TakeCare, or its nominee, for the cost of all related services and benefits provided, upon obtaining a monetary recovery whether due to settlement or judgment under Third Party Reimbursement Process.

❖ Service Denials

When a member requests a specific service, treatment plan or physician referral, the treating physician is required to review the medical necessity of the request. If there is no medical indication for the requested treatment, service or referral, the physician should offer an alternative treatment plan to the member. If TakeCare determines a referral is inappropriate or services can be provided, the primary care physician you should discuss and offer the member an alternative treatment plan. If the member is not satisfied with the suggested alternative treatment plan, TakeCare generates a denial letter that provides the member with his/her appeal rights.

TakeCare recommends that such instances be brought before the Medical Management Department for formal review.

❖ Claim Denials

Every claim submission is reviewed with consideration of the following:

- Review the claim against emergent/urgent care criteria if applicable.
- Review the appropriateness of the service(s)
- Review if the services were authorized
- Determine if the service(s) would have been authorized if the member had gone through the proper channels (referral process/coordination).
- Identify whether the provider of service is contracted

A denial may be appropriate after a thorough review of the components listed above and if the claim is for services:

- That are not a covered benefit, or
- That are determined non-emergent/non-urgent and not authorized
- That were not authorized.

If a Provider disagrees with TakeCare's decision, a formal written appeal should be submitted to:

TakeCare's Customer Service Department
P.O. Box 6578 Tamuning, Guam 96931

Credentialing and Recredentialing Program

The purpose of TakeCare's Credentialing and Recredentialing Program is to provide a process to obtain, verify, review and evaluate a physician's and other practitioner's professional credentials, qualifications and other criteria to determine whether the practitioner should be approved to provide or to continue to provide health care services to TakeCare members.

❖ Objectives:

The objectives of the Credentialing Program are to:

- Maintain a system of current and accurate credentialing/recredentialing information.
- In conjunction with the Quality Management Program, maintain an ongoing coordinated and comprehensive monitoring system to detect practitioner issues that may arise.
- Conduct focused review and establish, implement and monitor corrective action plans when deficiencies have been identified.
- Identify opportunities for improvement in the credentialing/recredentialing process.
- Comply with TakeCare's internal policies and procedures, state and federal regulatory requirements other accreditation organizations related to credentialing and recredentialing activities.

❖ Scope

The TakeCare Credentialing and Recredentialing Program applies to physicians (M.D.s), osteopathic physicians (D.O.s), dentists (D.D.S.s), podiatrists (D.P.M.s) chiropractors (D.C.s) and other licensed independent practitioners who are approved to provide services to TakeCare members outside the inpatient setting and who are listed in TakeCare's Provider Directory furnished to members.

❖ Confidentiality

TakeCare maintains the confidentiality of all information obtained about physicians and other practitioners in the credentialing/recredentialing process as required by law.

❖ Initial Credentialing

The provider applicant must provide a completed, signed and dated credentialing application to TakeCare and any additional information requested by TakeCare in order to properly verify and evaluate the practitioner's qualifications. All questions listed on the application must be answered, and explanations given for all "yes" answers. The credentialing applications request the following information from the practitioner:

- A valid state professional license number
- Clinical privileges in good standing at a TakeCare contracted hospital(s) designated by the practitioner as the primary admitting facility, as applicable;
- A valid Federal Drug Enforcement Agency (DEA) number or certificate, as applicable, or Controlled Substance Registration (CSR) certificate (if required by the state), and whether such certificate (s) have ever been suspended, revoked or limited;
- Graduation from professional school and completion of a formal residency or fellowship training program, as applicable;
- Board certification, if the practitioner states that he or she is board certified on the application (American Board of Medical Specialties or American Osteopathic Association for physicians);
- Work history for at least the past five (5) years.
- Professional liability claims history for, at a minimum, the past five (5) years, with details of any claims/lawsuits that resulted in settlements or judgments paid by or on behalf of the practitioner, as well as the outcome (if the suit or claim has been resolved);

- A statement by the practitioner regarding absence of a physical or mental health condition that would substantially impair the practitioner's ability to competently and safely carry out the scope of his or her duties on behalf of TakeCare, and a statement by the practitioner regarding absence of impairment due to chemical dependency/substance abuse;

- A statement by the practitioner regarding history of loss of limitation of professional license and/or felony convictions;

- A statement by the practitioner regarding history of loss or limitation of privileges or disciplinary activity.

Other documents may be required for certain types of practitioners to meet specific license-type requirements.

The applicant must submit a signed and dated attestation certifying the correctness and completeness of the information provided on and with the application.

A signed and dated consent and release form completed by the applicant authorizing TakeCare to obtain confidential information for credentialing purposes

(See Authorization and Release Information Form- appendix page 31).

❖ Credentialing Review

TakeCare follows state and regulatory requirements for all review and processing of credentialing application. This includes but not limited to:

✦National Practitioner Data Bank to obtain information regarding any disciplinary actions taken by hospitals and/or managed care organizations that limited, suspended or revoked the practitioner's privileges, and any malpractice claims/lawsuits filed against the practitioner.

✦TakeCare will query state medical boards/agencies or other applicable state licensing board/agency and/or the Federation of State Medical Boards to obtain information regarding any adverse actions, previous and/or current state sanctions, restrictions or limitations on licensure or any disciplinary actions taken against the practitioner's licensure and/or limitations on scope of practice.

✦TakeCare will verify the practitioner's Medicare/Medicaid practitioner status and review for previous sanction activity by Medicare/Medicaid through query of one of the following:

- Office of Inspector General (OIG)- US Department of Health and Human Services – Exclusions

- System for Award management (SAM)- excluded party listing

- FEHBP-Debarment records

Additional references may be requested when there are questionable quality or competency issues, disciplinary issues, or issues related to substance abuse or mental or physical health.

A pre-contractual on-site visit to the offices of each primary care physician (PCP) and obstetrician/gynecologist (OB-GYN) will be conducted, including documentation of a structured review of the quality of the facility within which care is provided, including the physical accessibility of the space and the adequacy of the examination and

waiting areas at each office site, and an evaluation of the medical record keeping practices at each site to ensure conformity with TakeCare's standards.

When all requested information has been received and all verifications have been completed, the Credentialing department will forward the completed application and all information in the Credentials File to the Credentialing Committee for review and decision. The Credentialing Committee will review and evaluate all credentials documentation and determine if the applicant meets the credentialing criteria and qualifications for providing services for TakeCare.

The Credentialing Committee's determination to approve a practitioner for participation in the TakeCare network will include designation of the practitioner as a primary care physician or specialist and the scope of the practitioner's practice for TakeCare.

❖ Approval and Notification

If the applicant is determined to meet TakeCare's criteria and is approved, the applicant will be notified in writing of his/her acceptance into the network. The practitioner is then eligible to treat TakeCare members and will be included in TakeCare's Provider Directory.

If the applicant does not meet TakeCare's criteria and is not approved, he/she will be notified in writing of the reason for the denial of the application and given a copy of the criteria.

The Credentialing department monitors monthly state licensing board reports and Medicare Sanction lists and will notify TakeCare's Credentialing Committee of any issues discovered during the monitoring period.

❖ Recredentialing Process

Every three (3) years, a Recredentialing application will be sent to the practitioner update the following:

- Professional License(s)
- DEA Certificate (If applicable)
- CSR Certificate (If applicable)
- Board Certification certificate(s) (If applicable)
- Malpractice Insurance certificate (If not available, a Malpractice Insurance Waiver). The Recredentialing application will request that the practitioner update.

The Credentialing Specialist will query the National Practitioner Data Bank, state medical boards or other applicable state licensing agency/board, the Medicare and Medicaid sanction reports, and malpractice liability claims history in the same manner as was required for the initial credentialing process.

The Network Management department staff will coordinate and conduct an appraisal of the professional performance, judgment and clinical competence over the previous two (2) years of each participating practitioner. The appraisal will include review of performance monitoring data from the following sources:

- quality assurance review reports (practice-specific);
- utilization management reports (profile of utilization);
- member complaints (regarding the practitioner);
- member satisfaction surveys (practice-specific);
- medical record review reports (for practice-specific issues); and
- the office site visits conducted as part of the recredentialing process.

The information is reviewed by TakeCare's Credentialing Officer and a recommendation is made to the Credentialing Committee regarding approval or denial of recredentialing. If any adverse issues are discovered through the recredentialing process, additional information will be requested and presented to the Credentialing Committee for review.

The Credentialing Committee reviews and evaluates all information provided on the recredentialing application, including updated health status information, all reverification of credentialing information from primary sources, the performance monitoring data resulting from the practitioner's performance appraisal, and the results of the on-site visit office visit and structured review and medical record keeping evaluation, and takes appropriate action in the same manner as specified for the initial credentialing process.

If a practitioner's recredentialing application is denied (the practitioner's participation in TakeCare's network is terminated) based upon deficiencies in the practitioner's quality of care, professional competence or conduct, the practitioner will be notified in writing of the reason for the termination and the right to request a fair hearing on the matter in accordance with TakeCare's Fair Hearing Procedure. (Refer to TakeCare's Fair Hearing Procedure). If TakeCare terminates a practitioner for reasons related to quality of care, professional competence or conduct, TakeCare will submit the required report to the National Practitioner Data Bank and state medical board or other licensing board as required by law.

❖ Changes in Capacity

TakeCare participating Providers must provide at least ninety (90) calendar days prior written notice to TakeCare of any significant changes in the practice which include but are not limited to:

- Inability of provider group to properly serve additional members due to the lack of Primary Care Physicians.
- Primary Care Physician or any participating practitioner closing/opening his practice to any additional new members.
- Closure of any office or facility used by Provider Group Primary Care Physicians or other Participating Practitioners.

Participating Provider Groups and its Primary Care Physicians and/or other Participating Practitioners shall continue to accept such members until the expiration of the notice period.

❖ Physician Restriction

Physicians who are participating within the TakeCare network as a practitioner may not be assigned as the Primary Care Physician for their family or themselves. The issues of confidentiality and objective medical observations are key in diagnosis and treatment of TakeCare members. Therefore, no TakeCare member or their dependents shall serve as their own Primary Care Physician.

❖ Peer Review

The purpose of the Peer Review is to ensure patient safety and quality care. All Peer Reviews are conducted using evidence-based guidelines, when available, or practice parameters developed by nationally recognized medical specialty societies. Peer Review can also examine broader trends in the performance of systems and/or processes of delivery of care. If incident based, the peer review should ensure that the principles of fairness and due process are afforded any practitioner involved. Since the demarcation between quality improvement and corrective action can be problematic, a strong effort is focused to achieve the goal of quality improvement while being objective, fair, transparent, and credible.

The Peer Review Process is a function under the Risk Management Committee applicable to all practitioners credentialed by TakeCare including but not limited to MD's, DO's, Oral surgeons, Dentists, DPM's, DC's, optometrists, psychologists, physician assistants, nurse practitioners, and nurse midwives.

The Peer Review process consists of tracking, monitoring of key aspects of care which includes but not limited to the following:

- Member complaints
- Quality of care issues and Adverse events
- Utilization management information/data
- Member Satisfaction Survey results
- Actions resulting from a malpractice claim

A summary of all Peer Review activities shall be quarterly to the Quality Improvement Committee, to include documentation of trends and level of severity, and status reports regarding corrective action plans, as part of the Peer Review Process.

❖ Medical Chart Review

TakeCare established Medical Chart review of selected patient charts from Provider's practice. The process utilizes specific criteria and thresholds to monitor practice patterns. Medical chart review is performed annually. An outline of TakeCare's standards of documentation can be found on Section D under Quality Management, page 18 of this provider manual.

TakeCare℠

Prior Authorization Form

Medical Management Department
Phone: (671) 646-6956 Fax: (671) 647-3541
Email: MedicalManagement@takecareasia.com

MEMBER INFORMATION: _____ Date: _____

Member Name: _____ DOB: _____

Contact numbers: _____

TakeCare ID #: _____ Other Insurance: _____

PLACE OF SERVICE :

Office: ☐ LBJ Tropical Hospital: ☐

Inpatient Service: ☐ On-island: ☐ Off-island: ☐ Preferred facility/POS: _____

PHYSICIAN INFORMATION : _____

Service Provider Requested: _____

Requesting Provider: _____

Primary Care Physician: _____

CLINICAL INFORMATION: (Please provide ICD/CPT codes)

Diagnosis (ICD-10)	**Procedure (CPT):**
1. _____	**1.** _____
2. _____	**2.** _____
3. _____	**3.** _____

Clinical History/Findings:

Brief History and Physical:

For TakeCare Medical Management Department Use Only:

Approved: _____

Modified: _____

Denied: _____

Reviewed By: _____ Date: _____

Other/Notes: _____

Elective Surgery should be scheduled after approval of the prior authorization request. This Authorization is valid only if member eligible. Request is good for 60 days from the above date, and valid for the services requested only. This request does not guarantee payment. Information on eligibility, benefits and exclusions can be found in the TakeCare member handbook. REFERRALS FOR OFF ISLAND CARE, SURGERY, MRI OR CT SCAN MAY BE FAXED OR EMAILED TO MEDICAL MANAGEMENT FOR APPROVAL.

PA Form Rev. 102015

TakeCare℠
A TanHoldings Company

Authorization And Release of Information Form

Modified Releases Will Not Be Accepted

By submitting this application I understand and agree as follows:

1. I understand and acknowledge that, as an applicant for medical staff membership and/or participation status with ***TakeCare Insurance Company, Inc.*** with whom I have, or wish to establish, a contractual relationship as a network provider, staff physician, or other provider of professional medical services (initial credentialing/ re-credentialing), I have the burden of producing adequate information for proper evaluation of my competence, character, ethics, mental and physical health status, and other qualifications. In this application I have provided information on my qualifications, professional training and experience, prior and current licensure, Drug Enforcement Agency registration and history, and certification of CPR training. I have provided peer references familiar with my professional competence and ethical character if requested. I have disclosed and explained any past or pending professional corrective action, licensure limitations or related matters, if any. I have reported my malpractice claims history, if any, and have attached or will provide a copy of current certificate professional liability coverage.

2. I further understand and acknowledge that ***TakeCare Insurance Company, Inc.*** will investigate the information in this application. By submitting this application, I agree to such investigation and to the disciplinary reporting and information exchange activities of ***TakeCare Insurance Company, Inc.*** as a part of the verification and credentialing process.

3. I authorized all individuals, institutions and entities of other hospitals or institutions with which I have been associated and all professional liability insurers with which I have had or currently have professional liability insurance, who may have information bearing on my professional qualifications, ethical standing, competence, and mental and physical health status, to consult with ***TakeCare Insurance Company, Inc.***

4. I consent to the inspection of records and documents that may be material to an evaluation of qualifications and my ability to carry out the clinical privileges/services I request. I authorize each and every individual and organization in custody of such records and documents to permit such inspection and copying. I am willing to make myself available for interviews if required or requested.

5. I release from any liability, to the fullest extent permitted by law, all persons for their acts performed in a reasonable manner in conjunction with investigating and evaluating my application and qualifications, and I waive all legal claims against any representative of ***TakeCare Insurance Company, Inc.*** who acts in good faith and without malice in connection with the investigation of this application.

6. I understand and agree that the authorizations and releases given by me herein shall be valid so long as I am an applicant for or have medical staff membership and/or clinical privileges/participation status at ***TakeCare Insurance Company, Inc.*** , unless revoked by me in writing.

7. For hospital or medical staff membership/clinical privileges, I acknowledge that I have been informed of, and hereby agree to abide by, the medical staff bylaws, rules, regulations and policies.

8. I agree to exhaust all available procedures and remedies as outlined in the bylaws, rules, regulations, and policies, and/or contractual agreements of ***TakeCare Insurance Company, Inc.*** where I have membership and/or clinical privileges/participation status before initiating judicial action.

9. I further acknowledge that I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization and Release shall be as effective as the original and authorization constitutes my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application.

PRINT NAME _____ SIGNATURE _____ DATE _____

TakeCare℠
A TanHoldings Company

Incentive Program
VALIDATION FORM

Congratulations on taking an important step in experiencing a balance lifestyle with TakeCare. It is important to "Know Your Numbers" in managing your overall health. Cholesterol, blood pressure, glucose and body mass index ("BMI") are key indicators of your health status. Constant monitoring, tracking and management of these indicators help prevent the occurrence of chronic diseases. Your participation on these screenings is strictly confidential. Please review the following instructions to ensure that all information you will provide and submit to TakeCare is complete and accurate. Note there are cases that your provider may charge a fee for these screenings.

Instructions

Step One: Obtaining your biometric health screening results. There are two options where you will be able to know and find out about this information:

Screening with your health care provider:

- Through your Annual Physical Exam ("APE") or TakeCare health screening. If you have completed your APE within the benefit year as part of your benefit coverage or participated in TakeCare's health screenings, you can ask your health care provider or TakeCare Wellness team to complete and validate this incentive form and provide those results to TakeCare; or

- If you have not had an APE or any health screening within your current benefit coverage period, you can visit your health care provider to conduct a screening. Please ensure that you bring and have this incentive form completed and validated during your appointment. Your health care provider will conduct the health screening for your cholesterol, blood pressure, glucose and BMI. Please refer to your Schedule of Benefits ("SOBs") to ensure coverage for any examinations and screenings that your provider will recommend.

Biometric Screening during the TakeCare Wellness Health Fair

- Attend a TakeCare Wellness Health Fair and obtain a biometric screening. Have your TakeCare Wellness complete the biometric and initial health screening portion of the form.

  Note that screening for HbA1C, LDL Cholesterol and Triglycerides can only be done at your health care provider and not at the TakeCare Wellness Fair.

Step Two: Completing and submitting the biometric and initial outcome based result screening form using this incentive program validation form.

- Once your results are available, your provider or TakeCare Wellness representative should complete the biometric and initial health screening portion of the form and validate it. Submit the completed incentive form through TC.Incentives@takecareasia.com.

  Any incomplete or non-validated form will not be allowed and your incentives will not be processed by TakeCare.

Step Three: Completing and submitting the outcome based result screening portion.

- Initial screening must be completed during the first quarter prior to submitting the second screening results of the outcome based portion. Obtain a second screening with your health care provider at the last quarter of your benefit period.

  Have your health care provider complete and validate the second portion of the outcome based screening results. Any incomplete or non-validated form will not be allowed and your incentives will not be processed by TakeCare.

  Submit the completed incentive form through TC.Incentives@takecareasia.com.

If you have questions or would like to get more information on TakeCare's incentive program, please contact our 24/7 Customer Service Number at (671) 647-3526 or Toll Free at 1-877-484-2411. You can also send an email to customerservice@takecareasia.com

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TakeCare℠
A TanHoldings Company

Incentive Program
VALIDATION FORM

WELLNESS INCENTIVE PROGRAM

(To be completed by physician, TakeCare Wellness Team or TakeCare Fitness partner)

Biometric Screening Incentive ☐ Outcome Based Result Screening Incentive ☐

Last Name, First Name, Middle Initial:

Employer Group Name _____ TakeCare Member Number _____

Date of Birth (MM/DD/YYYY) _____ Subscriber ☐ Dependent ☐

BODY MEASUREMENTS AND BIOMETRIC SCREENING (To be completed by physician)

SCREENING DATE (MM/DD/YYYY)_____ FASTING STATUS: Yes ☐ No ☐

WEIGHT _____ lbs.
HEIGHT _____ ft./in
BODY MASS INDEX (BMI) _____

BLOOD PRESSURE
SYSTOLIC _____ mm/HG
DIASTOLIC _____ mm/HG

GLUCOSE _____ mg/dl
HbA1C _____ mg/dl
TOTAL CHOLESTEROL _____ mg/dl
HDL CHOLESTEROL _____ mg/dl
LDL CHOLESTEROL _____ mg/dl
TRIGLYCERIDES _____ mg/dl

Screened By: _____ Provider Name: _____

Clinic/Facility: _____ Provider Signature:: _____

OUTCOME BASED REESULT SCREENING (To be completed by physician)

SCREENING DATE (MM/DD/YYYY)_____ FASTING STATUS: Yes ☐ No ☐

WEIGHT _____ lbs.
HEIGHT _____ ft./in
BODY MASS INDEX (BMI) _____

BLOOD PRESSURE
SYSTOLIC _____ mm/HG
DIASTOLIC _____ mm/HG

GLUCOSE _____ mg/dl
HbA1C _____ mg/dl
TOTAL CHOLESTEROL _____ mg/dl
HDL CHOLESTEROL _____ mg/dl
LDL CHOLESTEROL _____ mg/dl
TRIGLYCERIDES _____ mg/dl

Screened By: _____ Provider Name: _____

Clinic/Facility: _____ Provider Signature: _____

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Exercise Readiness Questionnaire (ERQ)

Child's Name_____ Date _____

DOB_____ Age_____ Home Phone_____ Work Phone_____

Regular exercise is associated with many health benefits. Increasing physical activity is safe for most people. However, some individuals should check with a physician before they become more physically active. Completion of this questionnaire is a first step when planning to increase the amount of physical activity in your life. Please read each question carefully and answer every question honestly:

☐ YES	☐ NO	**1)** Has a physician ever diagnosed your child with a heart condition and indicated for her/him to restrict physical activity?
☐ YES	☐ NO	**2)** When your child performs physical activity, does s/he feel pain in her/his chest?
☐ YES	☐ NO	**3)** When your child is not engaging in physical activity, has s/he experienced chest pain in the past month?
☐ YES	☐ NO	**4)** Does your child ever faint or get dizzy and lose her/his balance?
☐ YES	☐ NO	**5)** Does your child have an injury or orthopedic condition (such as a back, hip, or knee problem) that may worsen due to a change in physical activity?
☐ YES	☐ NO	**6)** Does your child have high blood pressure or a heart condition in which a physician is currently prescribing a medication?
☐ YES	☐ NO	**7)** Is your child currently pregnant?
☐ YES	☐ NO	**8)** Does your child have insulin dependent diabetes?
☐ YES	☐ NO	**9)** Does your child have current or history of asthma?
☐ YES	☐ NO	**10)** Do you know of any other reason why your child should not exercise or increase her/his physical activity?
☐ YES	☐ NO	**11)** Does your child have any food allergies: List foods below:

If you answered yes to any of the above questions, talk with your doctor before your child becomes more physically active. Tell your doctor your plan for him/her to exercise and to which questions you answer yes.

If you honestly answered no to all questions you can be reasonably certain you can safely increase your child's level of physical activity gradually.

If your child's health changes so you then answer yes to any of the above questions, seek guidance from a physician.

Parent/Guardian signature_____ Date _____

TakeCare℠
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Medical Clearance Form

Dear Doctor:

Your patient _____ wishes to take part in an exercise program and/or fitness assessment. The exercise program may include progressive resistance training, flexibility exercises, and a cardiovascular program; increasing in duration and intensity over time. The fitness assessment may include a sub-maximal cardiovascular fitness test and measurements of body composition, flexibility, and muscular strength and endurance.

After completing a readiness questionnaire and discussing their medical condition(s) we agreed to seek your advice in setting limitations to their program. By completing this form, you are not assuming any responsibility for our exercise and assessment program. Please identify any recommendations or restrictions for your patient's fitness program below (Physician's Recommendations).

Patient's Consent and Authorization

I consent to and authorize_____to release to_____ , health information concerning my daughter's/sons' ability to participate in an exercise program and/or fitness assessment. I understand this consent is revocable except to the extent action has already been taken. Authorization is not valid beyond one year from date of signature. Further disclosure or release of her/his health information is prohibited without specific written consent of person to whom it pertains.

Parent/Guardian signature_____Date _____

Trainer's signature_____Date _____

Physician's Recommendations

- ☐ I am not aware of any contraindications toward participation in a fitness program.
- ☐ I believe the applicant can participate, but urge caution because:
- ☐ The applicant should not engage in the following activities:
- ☐ I recommend the applicant not participate in the above fitness program.

Physician's name (print) _____ Date _____

Physician's signature _____ Phone _____ Fax _____

Address_____City _____ State _____ Zip_____

Wellness Department
P.O. Box 6578 | Tamuning, GU 96931
T (671)646.6956 F (671)647-3541

TakeCare℠
Wellness Program
A TanHoldings Company

Wellness Program Referral Form

Member Complete Information

Member Name: _____ DOB: _____ Member ID Number: _____ Date: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____ E-mail: _____

☐ Provider Referral (please include most recent lab work and consult notes)

Referring Provider: _____ Clinic/Facility: _____ Contact Number: _____

Primary Care Provider (if different from above): _____ Clinic/Facility: _____ Contact Number: _____

☐ Self Referral

Authorization
I authorize TakeCare Wellness to retrieve necessary information including but not limited to laboratory data, medication list and Provider's consult notes.

Member Signature: _____

Please provide ICD/CPT Codes: _____

Clinical History/Findings: _____

Health Education Classes	Description
☐ Cardiac Risk Management Class	Group session to manage blood pressure and cholesterol
☐ Children's Health Improvement Program (CHIP) (Ages 7 to 12)	A family oriented nutrition and fitness program (child must be accompanied by an adult)
☐ Diabetes Prevention Program	A year-long, group, lifestyle change program to prevent diabetes
☐ Diabetes Management - Basics	Group session for newly diagnosed diabetes patients
☐ Diabetes Self-Management Training	Individual case management for high-risk diabetes patients
☐ Quit Now: Nicotine Cessation Program	Nicotine cessation program that follows the American Cancer Society's Freshstart Program
☐ Nutrition/Wellness Coaching	Individual, in-person consultation
☐ Nurse Case Management	Individual case-management
☐ Other (please specify)	

Screening and Lab Results

Biometrics Screening Date	**Height:**	**Weight:**	**Body Mass Index**	**Body Fat %:**	**Waist Circumference:**
Lab Test Date Performed	**Blood Pressure:**	**T-Chol:**	**LDL:**	**HDL:**	**Triglycerides:**
Lab Test Date Performed	**Fasting Blood Glucose:**	**HgbA1c:**	**eGFR:**	**Creatinine**	**Urine Microalbumin:**
Other Tests Date Performed					
Diabetes Type: Year Diagnosed:	☐ Type 1	☐ Type 2 (NIDDM)	☐ Type 2 (IDDM)t	☐ Prediabetes	☐ Gestational DM

For TakeCare Official Use Only: ☐ Approved ☐ Modified ☐ Denied Reviewed By: _____ Date: _____
Comments:

Health Plan Accredited by
AAAHC
ACCREDITATION ASSOCIATION for AMBULATORY HEALTH CARE, INC.

Please attach pertinent laboratory results, medication list and latest provider consult notes.
Fax referral to (671) 647-3541 or email to wellness@takecareasia.com.
For more information, please contact our Customer Service team at 647-3526.

CONFIDENTIAL
REV 07102019

TakeCare℠
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Case Management Referral Form/ Assessment Form

Demographics: (Providers must complete Demographics Section only)

Member Name:		Member Number:	
Address:		Phone Contact:	
Date of Birth Age	☐ Male ☐ Female	Medicare? ☐ Yes #	☐ No
Primary Care Provider		Phone, Fax, Beeper, Cell	
Caregiver/Significant Other:		Contact Information	

Referral Reason:
- ☐ Frequent Re-admissions
- ☐ No family support
- ☐ Medication over/under dosing
- ☐ Non-compliant
- ☐ No PCP follow-up/specialist only
- ☐ Other
- ☐ No PCP Assigned

FOR TAKECARE'S USE ONLY

Living Arrangements:
- ☐ House
- ☐ GHURA
- ☐ Appt (___floor)
- ☐ Stairs
- ☐ other

Lives with:
- ☐ Alone
- ☐ Spouse
- ☐ Children(#__, ages___)
- ☐ Friends/Other relatives
- ☐ Other caregiver

Power of Attorney ☐ Yes ☐ No
Name: _____
Contact # _____
Advance Directive ☐ Yes ☐ No
Copy in home ☐ Yes ☐ No

Oriented to:
- ☐ Date
- ☐ Person
- ☐ Always
- ☐ Intermittently
- ☐ Time
- ☐ Place

Memory Status:
- ☐ Intact
- ☐ Intermittent Loss
- ☐ Total Loss/Confused

Behavior Status:
- ☐ Pleasant
- ☐ Combative
- ☐ Depressed
- ☐ Angry
- ☐ Anxious
- ☐ Cooperative
- ☐ Belligerent
- ☐ Other

Medications:	Problems Identified:

Plan:

Provider's Name: _____ Date: _____
(Please Print)

Signature: _____

PRIOR AUTHORIZATION FORM

TakeCare℠

Medical Management Department
Phone: (671) 646-6956 Fax: (671) 647-3541
Email: MedicalManagement@takecareasia.com

MEMBER INFORMATION: _____ Date: _____

Member Name: _____ DOB: _____

Contact numbers: _____

TakeCare ID #: _____ Other Insurance: _____

PLACE OF SERVICE :

Office: ☐ LBJ Tropical Hospital: ☐

Inpatient Service: ☐ On-island: ☐ Off-island: ☐ Preferred facility/POS: _____

PHYSICIAN INFORMATION : _____

Service Provider Requested: _____

Requesting Provider: _____

Primary Care Physician: _____

CLINICAL INFORMATION: (Please provide ICD/CPT codes)

Diagnosis (ICD-10)	**Procedure (CPT):**
1. _____	**1.** _____
2. _____	**2.** _____
3. _____	**3.** _____

Clinical History/Findings:

Brief History and Physical:

For TakeCare Medical Management Department Use Only:

Approved: _____

Modified: _____

Denied: _____

Reviewed By: _____ Date: _____

Other/Notes: _____

Elective Surgery should be scheduled after approval of the prior authorization request. This Authorization is valid only if member eligible. Request is good for 60 days from the above date, and valid for the services requested only. This request does not guarantee payment. Information on eligibility, benefits and exclusions can be found in the TakeCare member handbook. REFERRALS FOR OFF ISLAND CARE, SURGERY, MRI OR CT SCAN MAY BE FAXED OR EMAILED TO MEDICAL MANAGEMENT FOR APPROVAL.

PA Form Rev. FF03252021

TakeCare Insurance Contact Information:

Mailing Address:
P.O. Box 6578 Tamuning, Guam 96931

Physical Address:
415 Chalan San Antonio Street
Baltej Pavilion, Suite 108
Tamuning, Guam 96913

Administration
President/CEO: George Chiu
Telephone (671) 646-6956
Fax (671) 647-3551

Customer Service
Telephone: (671) 647-3526
Toll free number: (1-877-484-2411)
Fax: (671) 647-3542
Email: customerservice@takecareasia.com

Provider Contracting
Telephone: (671) 646-6956 ext. 7129
Fax: (671) 647-3549
Email: jennifer.artero@takecareasia.com

Business Hours:
Monday-Friday 8am-5pm
Saturday, Sunday and Holidays Closed

TakeCare℠
A TanHoldings Company