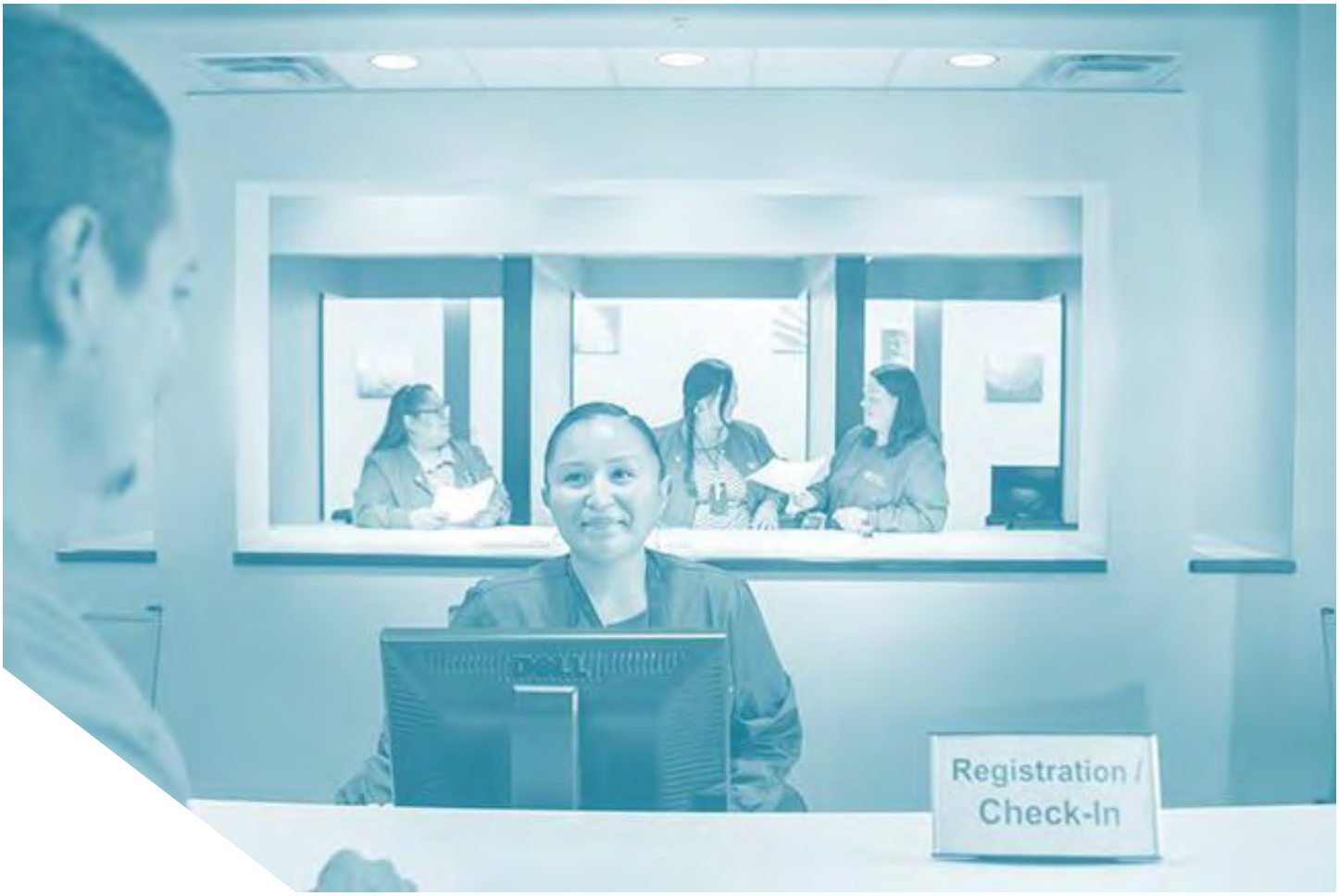


PMS
PRESBYTERIAN MEDICAL SERVICES

Our purpose is you.

IHS CONTRACT HEALTH SERVICE PROVIDER MANUAL

IHS CONTRACT HEALTH SERVICE PROVIDER MANUAL

1. INTRODUCTION

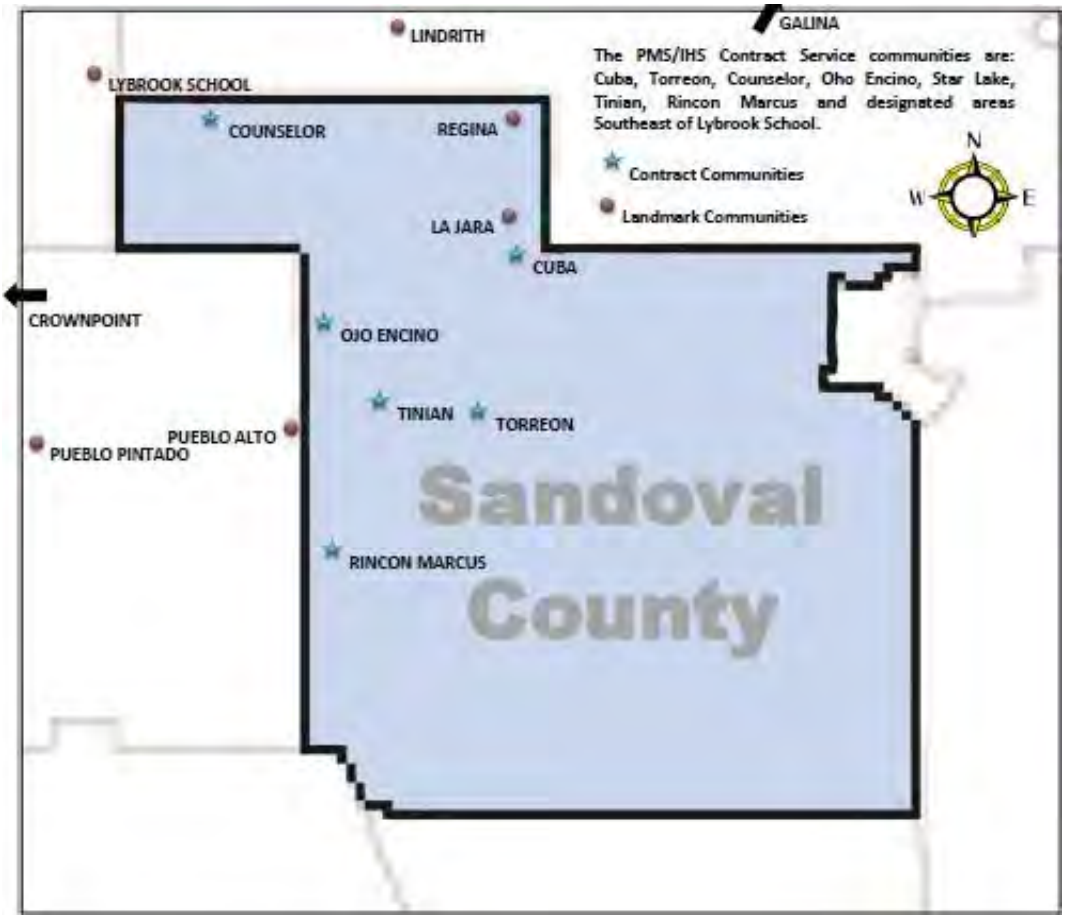
Effective July 1, 2000, the United States Public Health Services/Navajo Area Indian Health Service (IHS) and Presbyterian Medical Services (PMS) of Santa Fe entered into a contract pursuant to which PMS administers health care claims for a specific population of Native Americans residing in a designated service area around Cuba, New Mexico. This program is managed in part by the PMS Checkerboard Area Health System (CAHS) located in Cuba, New Mexico.

This manual details procedures that are required of health care providers ("Participating Providers") who seek to be reimbursed by PMS and/or IHS for provision of health care services to certain IHS beneficiaries.

2. COVERED POPULATION

The Native American population covered by this contract is part of the population served by the Crownpoint IHS Service Unit and is identified as IHS beneficiaries residing within defined chapter boundaries and portions of communities which may include: (1) Counselor, Ojo Encino and Torreon Chapters; (2) Star Lake, Cuba, Rincon Marcus and Tinian Communities; and (3) designated area southeast of Lybrook School. Such IHS beneficiaries are referred to herein as the "Covered Members."

3. SUMMARY OF BENEFITS



Reimbursement to participating partners covers the provision of medically necessary health care services to Covered Members, including inpatient services with support services, emergency medical services, outpatient specialty services & diagnostic services, in accordance to IHS Priority 1.

4. IHS PAYOR OF LAST RESORT

The IHS is the "payor of last resort" for Covered Members, notwithstanding any State or Local law or regulation to the contrary.

A. IHS is a residual resource and not an entitlement program. As a result, neither PMS nor IHS will pay for services provided to a Covered Member if the Covered Member is (1) eligible for alternate payment resource (e.g., Medicare, Medicaid, private health insurance, worker's compensation, etc.); or (2) would be eligible for an alternate payment resource under State or local law or regulation if he/she were not an IHS beneficiary.

B. When a Covered Member is potentially eligible for an alternative payment resource, Participating Providers are responsible for assisting the Covered Member in completing application forms necessary to obtain such payment resources. In addition, it is the Participating Provider's responsibility to bill all applicable alternate payment resources.

5. CARE COORDINATION

A. Purpose

The purpose of the IHS Contract Health Care Coordination Program is to provide a framework to monitor and manage the use of patient care resources. The Care Coordination Program actively promotes the most efficient delivery of patient care services while maintaining a level of quality in keeping with professionally recognized standards. On behalf of IHS, PMS/CAHS conducts Care Coordination for patients who have IHS as their Primary Payor.

The primary objective of the Care Coordination Program is to facilitate the most appropriate use of resources for each patient based on clinical needs. Care Coordination provides an on-going evaluation of service appropriateness throughout the treatment process. This process begins prior to treatment and continues through the course of treatment.

1. All non-emergent services require prior authorization from PMS. This process is necessary to assure payment for services rendered.
2. Prior to Treatment, care coordination involves referral of treatment modalities to available resources and level of care which may be appropriate to meet patient's immediate needs and to provide continuing care.
3. During and After Treatment, care coordination entails reviewing each patient's clinical treatment information; promoting timely and efficient patient care services and ongoing continued care; discharge planning and aftercare follow-up with the patient, his/her family or guardians; and the involved inpatient/outpatient treatment for Native Americans residing within the defined Chapter boundaries and portions of the communities.
4. Discharge Planning - Discharge Planning assistance can be coordinated through the IHS care coordination team, who will work with all appropriate CAHS staff to assist in care coordination and planning.

B. Prior Authorization

1. Requesting Prior Authorization (PA) - All non-emergent services require prior authorization.

a. Requests for PA are to be directed to PMS/CAHS Claims Coordinator. Emergency medical services do not initially require PA but notification requirements apply. Notification to PMS/CAHS must be made within 72 hours for all non-emergent services. After notification, if the Covered Member receiving emergency services requires emergent inpatient care, the provider facility will notify PMS/CAHS Claims Coordinator. The Claims Coordinator can be reached at (575) 289-3291. Only services that have been prior authorized, using PMS/CAHS Diagnostic, Specialty and Coordinated Care form, will be considered for payment.

   The PMS/CAHS Claims Coordinator is available Monday-Friday from 8am to 5pm. If the PMS/CAHS Claims Coordinator is not available, or if you send the request after hours, please fax Prior Authorization requests to 575-289-2320.

PMS/CAHS DIAGNOSTIC, SPECIALTY AND COODINATED CARE FORM

The PMS/CAHS Diagnostic, Specialty and Coordinated Care form is used to request Prior Authorization for all non-emergent services requested for Covered Members. The following fields are required in order for this claim to be considered for approval:

BOX 1 APPOINTMENT DATE AND TIME

BOX 2 FACILITY TO WHICH PATIENT IS BEING REFERRED

BOX 3 FACILITY PHONE #

BOX 4 FACILITY ADDRESS – INCLUDING ZIP CODE

BOX 5 PATIENT NAME

BOX 6 PATIENT GENDER

BOX 7 DATE OF BIRTH

BOX 8 MEDICAL RECORD NUMBER – REFERRING FACILITY #

BOX 9 MAILING ADDRESS

BOX 10 PATIENT PHONE # - IF APPLICABLE

BOX 11 TRIBAL AFFILIATION AND CIB # (IF AVAILABLE)

BOX 12 COMMUNITY/CHAPTER WHERE PATIENT RESIDES

BOX 13 EMERGENCY CONTACT & PHONE #

BOX 14 TYPE OF SPECIALTY

BOX 15 REASON FOR REFERRAL

BOX 16 PRIORITY OF REQUEST (PRC PRIORITY IS IN HOUSE FOR CAHS)

BOX 17 DIAGNOSIS

BOX 18 REFERRING PROVIDER – NAME AND CREDENTIALS

BOX 19 SPECIALTY PROVIDER NAME – NAME AND CREDETIALS

BOX 20 CAHS STAFF MEMBER WHO AUTHORIZED REFERRAL

BOX 21 AUTHORIZATION # GIVEN BY CAHS STAFF MEMBER

BOX 22 ALL AVAILABLE INSURANCE INFORMATION – CAHS USE

BOX 23 FOLLOW UP AUTHORIZATION #S GIVEN BY CAHS STAFF MEMBERS

BOX 24 # OF FOLLOW UP VISITS APPROVED

b. A service may be authorized as a result of the prior authorization process. If it is approved, an authorization letter will be mailed to the Participating Provider at that time. However, if an authorization cannot be issued as a result of failure to meet criteria, the Participating Provider will be asked for additional information, if appropriate. If denial occurs, a letter will be issued stating the reason for denial.

(See Attachments A)

C. 72-Hour Notification Requirement

1. In non-emergency cases, a sick or disabled Covered Member, or any individual or agency acting on behalf of the Covered Member, or the Participating Provider shall, PRIOR TO THE PROVISION OF ANY MEDICAL CARE AND SERVICES, notify PMS/CAHS IHS Claims Management office of the need for services and the individual's eligibility by faxing the notification for to the IHS Claims Coordination fax number – (575)289-2320.

The PMS/CAHS Contractor 72 hour Emergency Notification and Prior Authorization Request Form is all emergency room visits and for services requested as a result of emergency room visits, and for all hospitalizations for Covered Members. The following fields are required in order for this claim to be considered for approval:

BOX 1 PATIENT NAME

BOX 2 PATIENT SOCIAL SECURITY NUMBER

BOX 3 PATIENT ADDRESS

BOX 4 PATIENT DATE OF BIRTH

BOX 5 PATIENT COMMUNITY OF RESIDENCE

BOX 6 PATIENT DATE OF EMERGENCY ROOM VISIT OR ADMISSION

BOX 7 PATIENT DISCHARGE DATE

BOX 8 PATIENT INSURANCE PAYOR TYPE – IHS ONLY

BOX 9 PATIENT INSURANCE PAYOR TYPE – MEDICARE, SPECIFICALLY

BOX 10 PATIENT INSURANCE PAYOR TYPE – 3RD PARTY INSURER

BOX 11 PATIENT INSURANCE PAYOR TYPE – MEDICAID, SPECIFICALLY

BOX 12 DATE OF AUTHORIZATION REQUEST

BOX 13 DATE PAYOR TYPE VERIFIED

BOX 14 FACILITY CONTACT PERSON, FOR QUESTIONS

BOX 15 FACILITY CONTACT PHONE #

BOX 16 FACILITY CONTACT E-MAIL ADDRESS

BOX 17 EMERGENCY ROOM HOSPITAL NAME

BOX 18 EMERGENCY ROOM HOSPITAL ADDRESS

BOX 19 EMERGENCY ROOM HOSPITAL TELEPHONE

BOX 20 EMERGENCY ROOM HOSPITAL CONTACT FAX #

BOX 21 PATIENT DIAGNOSIS

BOX 22 DIAGNOSIS ICD-9 CODE FOR VISIT

BOX 23 MODE OF EMERGENCY TRANSPORT – AMBULANCE

BOX 24 MODE OF EMERGENCY TRANSPORT – HELICOPTER

BOX 25 MODE OF EMERGENCY TRANSPORT – FIXED WING

BOX 26 MODE OF EMERGENCY TRANSPORT - UNKNOWN

BOX 27 PMS DATE OF RECIEPT OF NOTIFICATION

BOX 28 PMS VERIFICATION OF PATIENT COVERAGE – YES HAS INSURANCE COVERAGE

BOX 29 PMS VERIFICATION OF PATIENT COVERAGE – NO INSURANCE COVERAGE

BOX 30 PMS APPROVAL AUTHORIZATION NUMBER

BOX 31 HOSPITALIZATION REQUEST FROM WHICH HOSPITAL

BOX 32 HOSPITAL ADDRESS

BOX 33 HOSPITAL PHONE NUMBER

BOX 34 HOSPITAL FAX NUMBER

BOX 35 PATIENT DIAGNOSIS OF ADMISSION

BOX 36 DIAGNOSIS ICD-9 CODE

BOX 37 ADMISSION APPROVED

BOX 38 ADMISSION DENIED

BOX 39 REASON FOR DENIAL

BOX 40 DENIED BY

BOX 41 APPROVAL AUTHORIZATION NUMBER

(See Attachment B)

D. Referral Process

Prior Authorization must be obtained by the Participating Provider for referral of Covered Members to other health care providers. (The Covered Member is to be returned to the Participating Provider as soon as medically appropriate for monitoring of progress.) **This requirement includes referral to radiology programs.**

1. The referring Participating Provider is to complete, date and sign (signature stamp is acceptable) the Presbyterian Medical Services/CAHS Referral Form to Checkerboard Area Health System Claims Coordinator. If obtaining prior authorization by telephone, the Participating Provider is to write the Claims Coordinator's name or authorization number and date in the space provided on the form.

PMS/CAHS
Attention: IHS Claims Coordinator
Fax: (575) 289-2320 This is a confidential fax line.
Phone: (575) 289-3291 ext. 236

E. Utilization Review

Utilization Review (UR) is performed through Presbyterian Medical Service's utilization Review Team

1. **Utilization Review Team**
   The Utilization Review Team follows Covered Members through regular telephone review with Participating Provider staff. Length of stay may be extended or decreased according to Covered Members' progress. Transfer of Covered Members to IHS hospitals may be coordinated by PMS/CAHS UR Team if long term hospitalization is required and patient condition will allow the transfer.

2. **Length of Stay Reconsideration**
   PMS has established mechanisms for hospitals to request further days of stay. This request may be verbal or written. Additional documentation or information may be requested by the PMS/CAHS Utilization Review Team or Administrator in order to increase length of stay.

3. **Retrospective Claims Review**
   Retrospective review is conducted by the PMS/CAHS Utilization Review Team and/or Administrator. All claims submitted by providers are reviewed to make sure the services being billed are covered and are medically necessary. Claims meeting the criteria are processed for payment. Denial letters are sent to provider for claims not meeting contract criteria.

BILLING FOR SERVICES

A. ACCEPTABLE CLAIM FORMS

PMS/CAHS requires all providers to use one of two forms when submitting claims for payment:

1. A current HCFA 1500 billing form is used when submitting claims for all professional services, including ancillary services and professional services rendered in a hospital setting. The current HCFA 1500 is the one dated (02/12).
2. A **UB04 CMS1450** billing form is used when submitting hospital facility charges for inpatient and outpatient services.

   PMS will not process claims received on any other type of claim form.

B. COMPLETING A HCFA 1500

When filing a claim on HCFA 1500, there are certain fields on the form that are required to be completed. Listed in this section are the required field numbers, along with explanations. The number of the field corresponds with the field number on the HCFA 1500 claim form.

HCFA 1500 FORM (02/12 VERSION)

The HCFA 1500 form is used to bill professional services provided to Covered Members. The following fields are <u>required</u> in order for this claim to be considered a clean claim:

BOX 1 PROGRAM

BOX 1a INSURED'S ID NUMBER

BOX 2	PATIENT NAME
BOX 3	BIRTHDATE
BOX 4	INSURED'S NAME
BOX 5	PATIENT ADDRESS
BOX 6	PATIENT RELATIONSHIPS TO INSURED
BOX 7	INSURED'S ADDRESS
BOX 9	OTHER INSURED'S NAME
BOX 9a	OTHER INSURED'S GROUP/POLICY NUMBER
BOX 9b	OTHER INSURED'S DOB AND GENDER
BOX 9c	OTHER INSURED'S EMPLOYER OR SCHOOL
BOX 10	WAS THE CONDITION RELATED TO
BOX 11	INSURED'S GROUP/POLICY NUMBER
BOX 11a	INSURED'S DOB AND GENDER
BOX 11b	INSURED'S EMPLOYER OR SCHOOL
BOX 11c	INSURED'S PLAN OR PROGRAM NAME
BOX 11d	IS THERE ANOTHER HEALTH BENEFIT PLAN
BOX 12	PATIENT'S SIGNATURE
BOX 13	INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
BOX 14	DATE OF CURRENT
BOX 17	NAME OF REFERRING PHYSICIANS OR OTHER SOURCE
BOX 20	OUTSIDE LAB
BOX 21 A-L	DIAGNOSIS OR NATURE OF ILLNESS
BOX 23	PRIOR AUTHORIZATIONS NUMBER OR NAME
BOX 24a	DATE OF SERVICE(S)
BOX 24b	PLACE OF SERVICE
BOX 24c	EMG
BOX 24d	PROCEDURE, SERVICES OR SUPPLIES (CPT/HCPCs and modifiers)
BOX 24e	DIAGNOSIS POINTER
BOX 24f	CHARGES
BOX 24g	DAYS OR UNITS
BOX 24i	ID QUAL
BOX 24j	RENDERING PROVIDERS NPI #
BOX 25	FEDERAL TAX ID NUMBER

BOX 26 PATIENT ACCOUNT NUMBER

BOX 27 ACCEPTS ASSIGNMENT

BOX 28 TOTAL CHARGE

BOX 29 AMOUNTS PAID

BOX 30 BALANCE DUE (IF DIFFERENT THAN **ITEM** 28)

BOX 31 SIGNATURE OF PROVIDER

BOX 32 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (CANNOT BE A P.O. BOX)

BOX 32A FACILITY NPI

BOX 33 BILLING ADDRESS

BOX 33A BILLING NPI

C. COMPLETING THE UB04 CMS1450

The **UB04 CMS 1450** will be used to bill facility services provided. The following fields are required in order for this claim to be considered a clean claim:

BOX 1 PROVIDER NAME, ADDRESS AND TELEPHONE NUMBER

BOX 3A PATIENT CONTROL NUMBER

BOX 3B MEDICAL RECORDS #

BOX 4 TYPE OF BILL

BOX 5 FEDERAL TAX ID NUMBER

BOX 6 STATEMENT COVERS PERIOD

BOX 8A PATIENT NAME

BOX 9A-E PATIENT ADDRESS

BOX 10 PATIENT BIRTHDATE

BOX 11 PATIENT GENDER

BOX 12 ADMISSION/START OF CARE DATE

BOX 13 ADMISSIONS HOUR

BOX 14 TYPE OF ADMISSION

BOX 15 SOURCE OF ADMISSION

BOX 16 DISCHARGE HOUR

BOX 17 PATIENT STATUS

BOX 18-28 CONDITION CODES

BOX 38 RESPONSIBLE PARTY NAME AND ADDRESS

BOX 42 REVENUE CODE

BOX 43 REVENUE DESCRIPTIONS

BOX 44 HCPCS/RATES

BOX 45 SERVICE DATE

BOX 46 UNITS OF SERVICE

BOX 47 TOTAL CHARGES (BY REVENUE CODE CATEGORY)

BOX 50 PAYOR NAME

BOX 51 HEALTH PLAN ID

BOX 52 RELEASE OF INFORMATION CERTIFICATION INDICATOR

BOX 53 ASSIGNMENT OF BENEFITS CERTIFICATION INDICATOR

BOX 54 PRIOR PAYMENTS-PAYORS AND PATIENT

BOX 55 ESTIMATED AMOUNTS DUE

BOX 58 INSURED'S NAME

BOX 59 PATIENTS RELATIONSHIP TO INSURED

BOX 61 INSURED'S UNIQUE ID

BOX 63 TREATMENT AUTHORIZATION CODE

BOX 65 EMPLOYER NAME

BOX 66A-Q DIAGNOSIS CODES

BOX 67 PRIMARY DIAGNOSIS CODE

BOX 69 ADMITTING DIAGNOSIS

BOX 74 PRINCIPAL PROCEDURE CODE AND DATE, if inpatient stay

BOX 74BAE OTHER PROCEDURE CODES AND DATES, if applicable

BOX 76 ATTENDING PHYSICIAN'S NPI, QUAL, NAME

BOX 77 OPERATING PHYSICIAN ID

BOX 80 REMARKS, if Applicable (USED FOR PATIENT MAILING ADDRESS)

D. CLAIM SUBMISSIONS REQUIREMENTS

PMS requires that Participating Providers initially submit claims for payment within ninety (90) days from date of service. A "clean claim" is defined as one that can be processed (adjudicated) without obtaining additional information from the provider of service or from a third party.

Failure to adhere to this requirement will result in the denial of your claims. In order to assure proof of timely filing please: Fax claims to 575-289-2320 with a coversheet listing claims; or mail claims certified return receipt to address below – include a cover sheet listing claims or scan claims and e-mail them to rena.castillo@pmsnm.org with a copy to teresa.woodfill@pmsnm.org

These methods will be the only accepted proof of timely filing.

You are required to submit claims for all services rendered.

Please mail new claims to:

PMS Central Billing Office
Attention: IHS Claims
6000 Uptown Blvd. Ste 400
Albuquerque, NM 87110
(877) 222-4521

E. RESUBMITTING A CLAIM

If you feel your claim has not been properly processed, PMS/CAHS has set up a procedure to help you resolve those issues and resubmit your claim.

Although you may have met the initial ninety (90) day claim submission requirement, you have ninety (90) additional days from the date of adjudication to resubmit your claim for adjustment.

If you want to resubmit a claim, you must do the following:

1. Make a copy of your claim
2. Make a copy of the remittance advice.
3. Make a notation on the claim the remittance advice explaining why you are resubmitting the claim and clearly indicate any corrections you have made. Please sign and date your notation and provide Presbyterian Medical Services with a telephone number should we need to contact you.

Mail the claim and all attachments to:

PMS Central Billing Office
Attention: IHS Claims
6000 Uptown Blvd. Ste 400
Albuquerque, NM 87110
(877) 222-4521

The original 90 day submission requirements must be met in order to re-submit a corrected claim.

F. APPEAL OF A DENIED OF CLAIM

If you want to appeal the denial of a claim, you can do so within 30 days of the date of the denial letter. To have a denied claim reconsidered for payment, please do the following:

1. Make a copy of the claim and the letter of denial.
2. Make a copy of proof of timely filing, proof of patient residence, or any other supporting data that will assist in the reconsideration.
3. Send a memo or note justifying why you are appealing the denial. Please sign and date your request and include a telephone number should we need to contact you.
4. **Mail the claim and all attachments to:**

   PMS/CAHS
   Attention: Administrator
   P.O. Box 638
   Cuba, NM 87013
5. You will receive notification of the appeals decision within ten (10) working days.

If your appeal is denied by the Administrator, you may request further reconsideration by sending the above information the CAHS Region Director at:

PMS/CAHS
Attention: Region Director
P.O. Box 638
Cuba, NM 87013

G. THIRD PARY RESOURCES- SECONDARY PAYOR

By law, IHS is always the payor of last resort for Native Americans. Therefore, you must bill all third party resources and obtain an explanation of benefits from any other third party resource prior to billing PMS and/or IHS.

Once you receive the EOB from the alternate payor, you can then complete the appropriate claim form, and attach the EOB to that claim form and submit it to:

PMS Central Billing Office
Attention: IHS Claims
6000 Uptown Blvd. Ste 400
Albuquerque, NM 87110
(877) 222-4521

You have 90 days from the date of primary payment to submit your claim and the EOB. Claims for services submitted without EOB will be denied.

6. GRIEVANCE AND COMPLAINT PROCESS

A complaint or grievance may be filed by a Participating Provider if there is dissatisfaction with any aspect of the PMS/CAHS claims administration. This includes, but is not limited to: service, utilization management and claims processing. Disagreements that exist between you and PMS/CAHS such as denial letters and authorizations of services are handled through the process described in Section 5.F.

To file a complaint or grievance, the Participating Provider may follow these steps:

A. Contact the PMS/CAHS Claims Processing Coordinator at (575)289-3291 or you may submit a written complaint to:

PMS/CAHS Administrator
P.O. Box 638
Cuba, NM 87013

B. If your complaint is not resolved to your satisfaction, you may request a formal view. This review will be conducted by the CAHS Administrator, Region Director and/or PMS, Director of Operational Support. Please send this request, listing your complaint, in writing and mail this and any other additional information to PMS/CAHS Administrator, at the above address. You will receive notification within ten (10) working days acknowledging the receipt of your request and a decision regarding your request within thirty (30) days.

7. COMMITTEES

A. **Utilization Review Team**

The IHS Claims Coordinator and Administrator meet on a weekly basis, more frequently if needed, to discuss in-patient/discharge needs of PMS/CAHS patients. CAHS Region Director and/or PMS/Director of Operational Support may be included in person, by telephone or by e-mail. The PMS Vice President of Clinical Affairs participates in the Utilization Review Team when there are questions regarding clinical decisions or Priority 1 determination.

8. CREDENTIALING

PMS/CAHS deems credentialing status to a practitioner that can provide evidence that they have been credentialed by a JCAHO or NCQA accredited organization, when requested. If unable to provide this evidence, you will be subject to additional documentation.

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PMS/CHECKERBOARD AREA HEALTH CENTER (CAHS)

Diagnostic, Specialty and Coordinated Care Form

CAHS PATIENT REFERRAL	APPOINTMENT DATE:	TIME:	
FACILITY REFERRED TO:	FACILITY PHONE NUMBER:		
FACILITY ADDRESS:			
PATIENT NAME:	SEX:	DOB:	CHART #:
MAILING ADDRESS:	PHONE #:		TRIBAL AFFILIATION:
COMMUNITY/CHAPTER:	EMERGENCY CONTACT & PHONE #:		
SPECIALTY REFERRED TO:	SCHEDULING PRIORITY: ❑ 24 Hrs ❑ 1-3 Weeks ❑ > 1 Month PRC PRIORTIY: ❑ 1 ❑ 2 ❑ 3		

REASON FOR REFERRAL:

Diagnosis:

Referring Provider:

Specialty Provider Name:

Authorized by:_____ **Authorization #:**_____

PMS/CAHS USE ONLY

❑ PRIVATE INSURANCE: ID#:
❑ MEDICARE ❑ A ❑ B ID#:
❑ MEDICAID FFS ID#:
MGD CARE MEDICAID ❑ PHP ❑ MOLINA ❑ BCBS ❑ UHC
❑ OTHER: ID#:
❑ PMS/CAHS PRIMARY PAYOR
❑ PMS/CAHS SECONDARY PAYOR

PMS/CAHS Claims Submission

Attention: Rena Castillo, IHS Claims Coordinator
rena.castillo@pmsnm.org PO Box 638 Cuba, NM 87013 (575) 289-3291 (575) 289-2320 (fax)

Additional Follow-Up Authorizations

Authorization #		# of Visits Approved

PMS
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PMS/CAHS CONTRACTOR
72hour EMERGENCY NOTIFICATION AND PRIOR AUTHORIZATION REQUEST FORM

Patient: _____ Soc. Sec. #: _____

Address: _____ Date of Birth: _____

Community of Residence: _____ Admit Date _____ Discharge date_____

Payor Type: IHS only _____ Medicare _____ 3rd Party_____ Medicaid _____

Date of Authorization Request: _____ Payor Type Verification Date: _____

Facility Contact Person: Name _____ Phone # _____ E-mail _____

SECTION 1. EMERGENCY HOSPITALIZATION (Requires 72hour notification by fax to 575-289-2320)

What Hospital: _____

Hospital Address: _____

Hospital Phone #: _____ Fax #: _____

Diagnosis: _____ Diagnosis (ICD-9) Code: _____

Mode of Emergency transport : Ambulance _____ Helicopter _____Fixed Wing _____ Unknown _____

Confirm Receipt of Notification date _____ Verified Patient covered by PMS/IHS Contract _____Y _____N

Approval Authorization # _____

SECTION 2. HOSPITALIZATION PRIOR AUTHORIZATION (Required for all non-emergent hospitalizations)

Hospitalization – What Hospital: _____

Hospital Address: _____

Hospital Phone #: _____ Fax #: _____

Diagnosis: _____ Diagnosis (ICD-9) Code: _____

Approved _____ Denied _____ Reason for denial _____ Denied by _____

Approval Authorization # _____

Authorization approval is always pending receipt of Medicaid Approval or Denial

Follow up Information: Please provide PMS/CAHS with clinical summary for patient's PCP.