



Newly Contracted CHW Orientation

Revised 9/2026



Newly Contracted CHW Orientation

AGENDA:

1. Introduction
2. Alliance Mission, Vision and Values
3. The Managed Care Model
4. How Members join the Alliance
5. Member Eligibility
6. CHW Benefit
7. Alliance Information

Welcome to the Alliance!

Who are we?

- Central California Alliance for Health (the Alliance)
- County Organized Health System
- Serving thousands of members in Santa Cruz, Monterey, San Benito, Mariposa and Merced Counties
- Operate using the Managed Care Model

What programs do we cover?

- Medi-Cal
- Alliance Care IHSS (Monterey)
- Alliance TotalCare (D-SNP HMO)

Alliance Mission, Vision and Values

Our Mission

Accessible, quality health care guided by local innovation.

Our Vision

Healthy people. Healthy communities. (English)



Our Values



EQUITY

Eliminating disparity through inclusion and justice.



INTEGRITY

Telling the truth and doing what we say we will do.



IMPROVEMENT

Continuous pursuit of quality through learning and growth.



COLLABORATION

Working together toward solutions and results.

Provider Portal

Provider Portal Representative: Pamila Vang

Phone Number: (831) 430-5518

Email: pvang@ccah-alliance.org

Some of the functions include:

- Member Eligibility
- Search and Submit RAF/TAR
- Claims information
- Reports
- Additional Resources
- Provider Directory
- Procedure Code Lookup Tool

The screenshot shows the Central California Alliance for Health Provider Portal. At the top, there is a header with the logo on the left, a photo of a healthcare provider in the center, and the text 'Central California Alliance for Health Provider Portal' on the right. Below the header, the page is divided into several sections. On the left is a 'Main' sidebar menu with links like 'Home', 'Claims Search', 'RA Search', 'Overpayment Letters Search', 'Eligibility Verification', 'Provider Directory', 'Prescription History', 'Data Submissions', 'Manage Users', 'Auths and Referrals', 'Reports', and 'Log Out'. The main content area includes 'Important Information for Providers' with system downtime notices, 'Attention! Don't create a HIPAA breach!' with a warning about notifying the Alliance, 'Portal News' with recent updates, 'Provider News' with recent articles, and 'Quick Links and Resources' with various support links. On the far right is a 'Quick Links' sidebar with sections for 'My Portal Account', 'Resources', 'Need Help?', and 'Provider Events Calendar'.

The Alliance Provider Portal Login Page: <https://thealliance.health/for-providers/provider-portal/>

Using the Provider Portal: <https://thealliance.health/for-providers/provider-portal/using-the-provider-portal/>

Provider Portal New Account Request Form: <https://thealliance.health/for-providers/provider-portal/provider-portal-account-request-form/>

Entering and Managing Requests in the Provider Portal: [Jiva FAQs: Entering and Managing Requests in the Provider Portal - Central California Alliance for Health](#)

Member Eligibility

Prior to patient visit:

Verify **eligibility** at every visit

Eligibility can change month to month and must be reverified

How to verify eligibility?

Provider Portal: Available
24 hours a day. 7 days a week

Member Services :
(800) 700 3874
English: ext. 5505
Spanish: ext. 5508

Alliance Automated System:
(800) 700 3874 ext. 5501

Reasons why a member may not be eligible:

- Share of cost (members would become FFS)
- Moved out of Alliance service area
- Lost eligibility

Reasons why a member may not be linked to a practice:

- State Medi-Cal
- Administrative member

Membership Cards

Alliance Cards



Alliance Member ID Card
Front



Alliance Care IHSS Member ID Card
Front



TotalCare Member ID Card Front

State Medi-Cal Card



Member Benefits

- Behavioral Health Services (Mild to Moderate)
- Primary care
- Specialty care
- Allied services (PT, OT, ST, Acupuncture, Chiro)
- Durable Medical Equipment
- Self-referred services (OB Sensitive Services)
- Physician Administered Drugs
- Emergency & Urgent visits
- Inpatient and outpatient hospital care
- Diagnostic services (lab, x-ray, imaging)
- Enhanced Care Management (ECM)
- Community Supports
- Doula Services
- Vision Care
 - Covered through Vision Services Plan (VSP)
 - Toll-free access line Monday through Friday from 6:00 am to 7:00 pm Phone: 800-877-7195



Link: [Benefit descriptions can be found in the Member Handbook on the Alliance website](#)

Language Assistant Services

Face-to-Face Interpreting

- Prior approval is needed
- American Sign Language (ASL) is available to deaf or hard-of-hearing members for all Alliance covered services
- For use when the following situations are present:
 - Members who are deaf or hearing-impaired
 - End-of-life issues
 - Abuse or sexual assault issues
 - Complex procedures or courses of therapy

Telephonic Interpreting

Language Line Solutions: Available 24/7 to support members at all points of contact

No prior approval needed

Over 200 foreign languages

CBDIO Interpreting: Specializes in Indigenous languages from Mexico and Central America

[Cultural and Linguistic Website](#)

NMT & NEMT

NMT - Non-Medical Transportation *No Special Medical Assistance Needed*



Ambulance,
wheelchair
accessible vehicle
or litter van.

NMT is for Alliance members who can enter and disembark from a vehicle independently. Physician certification statement (PCS) form not valid for this service. Alliance assessment and approval is required.

Fax requests not accepted. Members must call the Alliance 5-7 days prior to make arrangements.

For assistance call: **800-700-3874, ext. 5577**

vs.

NEMT - Non-Emergency Medical Transportation *Special Medical Assistance Needed*



Public bus
system (bus
pass), ride share
or private
vehicle.



NEMT is for Alliance members who need special medical equipment while traveling to/from an approved appointment. Submission of a Physician certification statement (PCS) form is required for eligibility. Form available at: https://www.ccah-alliance.org/Form%20Library/PCS_NEMT_Form.pdf

For assistance call: **800-700-3874, ext. 5640**

Providers can use the link below to access the electronic version of the non-emergency medical transportation (NEMT) request form for Alliance members

https://thealliance.health/wpcontent/uploads/Transportation_Services_Request_Form.pdf

Nurse Advice Line (NAL)

Member NAL Flyer



Nurse Advice Line

Feeling sick and have questions?
Call 844-971-8907 (TTY: Dial 711)
to talk to a nurse.

If you are having a medical emergency, call 911 or go to the nearest emergency room.

What is the Nurse Advice Line?
The Nurse Advice Line is a service available to all Alliance members. You can call if you have questions about your health or your child's health. A registered nurse will help you with what to do next.

The service is available 24 hours a day, 7 days a week at no cost to you.

When do I call the Nurse Advice Line?
Call the Nurse Advice Line when:

- You or your child is sick, and you cannot reach or get an appointment with your doctor.
- Examples: Your child has a fever or rash, is vomiting, or your baby's crying is unusual.
- You are not sure if you should go to the emergency room.
- You have questions about your health or your child's health.
- You are under 18 years old and want to talk in private about your health concerns.

When you call:
If you have your Alliance Member ID card with you, have it ready to tell the nurse your ID number.

Call 844-971-8907 (TTY: Dial 711)

When you call the Alliance Nurse Advice Line about your health questions, you will be entered into a monthly raffle. You could win a \$50 Target gift card!

HEALTHY PEOPLE. HEALTHY COMMUNITIES.
www.ccah-alliance.org

Nurse Advice Line



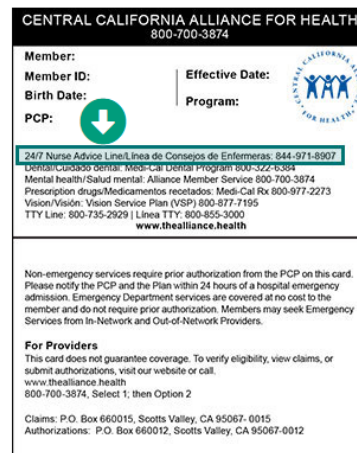
Dial 844-971-8907 (TTY: Dial 711)

24 hours a day, 7 days a week.

The Alliance's Nurse Advice Line provides members with answers to health care questions 24 hours a day, seven days a week.

Please ensure that our members know that they can use the Nurse Advice Line for non-emergency questions when your office is closed, or if they are unable to reach you.

The phone number for the Nurse Advice Line is printed on Alliance Member ID cards.



CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
800-700-3874

Member:
Member ID:
Birth Date:
PCP:

Effective Date:
Program:

24/7 Nurse Advice Line/Línea de Consejos de Enfermeras: 844-971-8907

24/7 Urgent Care/Línea de Urgencias: 800-700-3874
Mental Health/Salud mental: Alliance Member Service: 800-700-3874
Prescription drugs/Medicamentos recetados: Medi-Cal Rx: 800-977-2273
Vision/Visión: Vision Service Plan (VSP): 800-877-7195
TTY Line: 800-735-2929 | Linea TTY: 800-855-3000
www.thealliance.health

Non-emergency services require prior authorization from the PCP on this card. Please notify the PCP and the Plan within 24 hours of a hospital emergency admission. Emergency Department services are covered at no cost to the member and do not require prior authorization. Members may seek Emergency Services from In-Network and Out-of-Network Providers.

For Providers
This card does not guarantee coverage. To verify eligibility, view claims, or submit authorizations, visit our website or call.
www.thealliance.health
800-700-3874, Select 1; then Option 2

Claims: P.O. Box 660015, Scotts Valley, CA 95067-0015
Authorizations: P.O. Box 660012, Scotts Valley, CA 95067-0012

Alliance Medi-Cal Member ID Card



TotalCare
HMO D-SNP

Member Name:
Member ID:
Care Management Phone: 800-700-3874, ext. 5512

PCP Group:
PCP Phone:
MEMBER CANNOT BE CHARGED FOR MEDICAL SERVICES
Copays: PCP/Specialist: \$0 ER: \$0
CMS Contract #H5692 Plan Benefit Package #001

Medicare Rx
Rx BIN: 015574
Rx PCN: ASPROD1
Rx GRP: CCA05
Rx ID:

Notice to Members: In case of an Emergency, call 9-1-1 or go to the nearest Emergency Room (ER). This plan covers ER services in the U.S. and worldwide.
Member Services: 833-530-9015 (TTY: 800-735-2929 (Dial 711))
Behavioral Health: 800-3874, ext. 5512
Pharmacy Help: 800-347-5841
Medi-Cal Dental: 800-322-6384 or TTY 1-800-735-2922
Nurse Advice Line: 844-971-8907 (TTY: 711)
Website: www.thealliance.health/totalcare

Send Claims to: Central California Alliance for Health, Attn: Claims
1600 Green Hills Road, Suite 101
Scotts Valley, CA 95066
Claims Inquiry: 831-430-5503

Alliance TotalCare Member ID Card

Link: <https://thealliance.health/for-providers/manage-care/clinical-resources/nurse-advice-line/>

Benefits Not Covered by the Alliance

The services listed here are covered for members by the stated entities:

- Dental Services (Denti-Cal)
- Inpatient Mental Health Services (State Medi-Cal)
- Substance Use Disorder Treatment Services (Co. BH and State Medi-Cal)
- Local Education Authority Services (Regional Centers)
- Outpatient prescription drugs
- Serious Mental Illness Health Services (County BH Dept)
- Institutional long-term care (for stays longer than the month of entry)

Accessibility- Timely Access To Care

Urgent Care Appointments	Wait Times
For services that do not require prior authorization	48 hours
For services that do require prior authorization	96 hours
Non-Urgent Care Appointments	Wait Times
Primary care appointment (including first pre-natal visit and preventive visits)	10 business days
Mental health* care appointment (with a non-physician provider)	10 business days
Non-urgent follow up appointment with a Mental health care (non-physician provider) or substance use disorder provider ²¹	10 business days from the prior appointment
Specialist/Specialty Care appointment (including Psychiatrists)	15 business days
Ancillary service appointment for the diagnosis or treatment of injury, illness, or other health condition	15 business days
Skilled Nursing Facility Services and Intermediate Care Facility Services for Long Term Care (Santa Cruz County)	Placement within 7 business days
Skilled Nursing Facility Services and Intermediate Care Facility Services for Long Term Care (Monterey, Merced, Mariposa, and San Benito County)	Placement within 14 calendar days

For more information regarding Timely Access To Care, please review [Policy 300-1509- Timely Access To Care](#)

CHW Definition & Covered Services

CHW Definition

Preventive health services to prevent disease and disability

To prolong life

To promote physical and mental health

Covered Services

Health Education

Health Navigation

Screening & Assessments

Individual Support or Advocacy

Violence Prevention Services

Asthma Preventative Services

CHW Supervising Provider

The organization employing or overseeing the CHW

CCAH contracts with the supervising provider

Medi-Cal enrollment is required

Can delegate management & day to day supervision of CHWs

Does not need to be physically present where CHW services are provided

Does not need to be the same entity as the recommending provider

CHW Supervising Provider Responsibilities

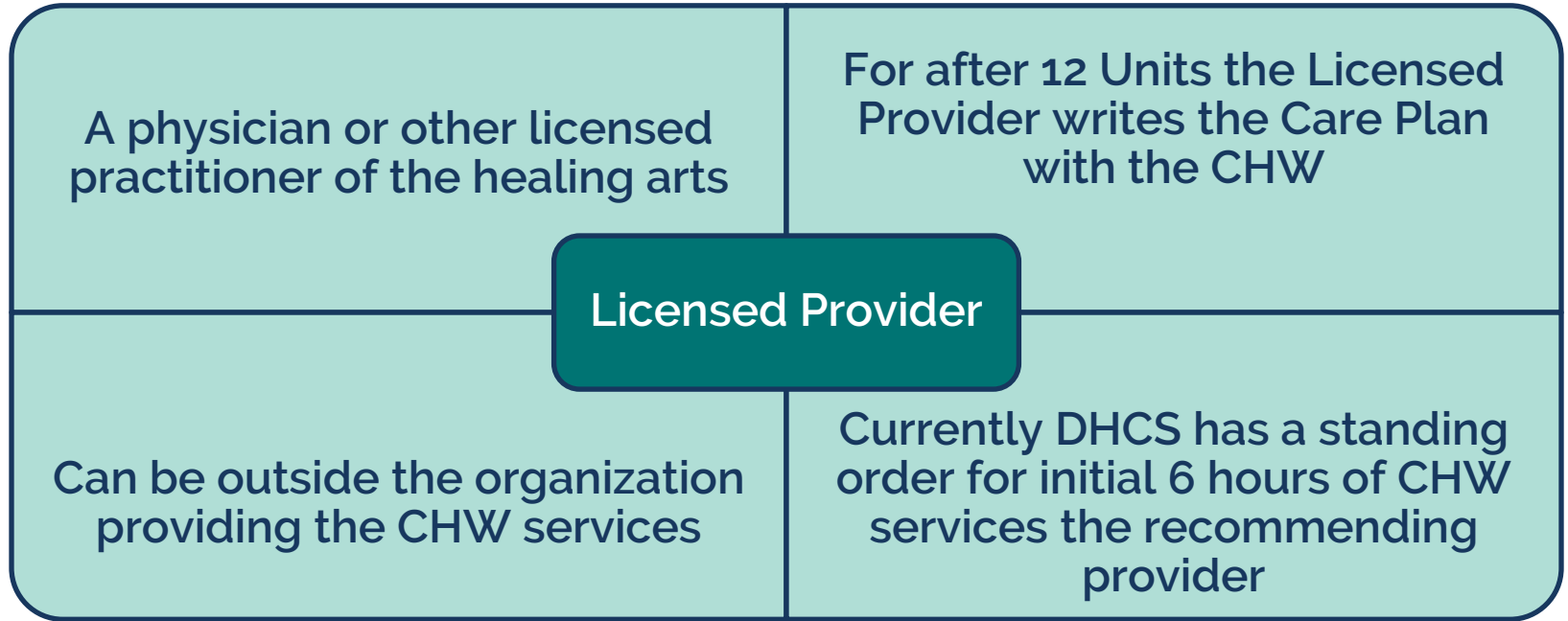
Ensures that CHWs meet the qualifications listed in the APL

Oversees the services delivered to members

Submits claims for services

Ensures CHW services complies with requirements

CHW Licensed Provider Oversight Required for CHW services over 12 Units (6 hours)



CHW Utilization Requirements

First 12 Units (6hrs)

- There is a statewide [standing recommendation](#) for CHW services from DHCS for the first 12 units (6 hours).

Second 12 Units (6hrs)

- Authorization is required
 - Submit via Alliance Provider Portal or fax using TAR form.
- Plan of Care is required to be submitted with the authorization via Alliance Provider Portal or fax
 - Licensed provider (include NPI on box 19) and CHW writes Plan of Care
 - Plan of Care must not exceed 1 year

Plan of Care

- Reviewed every 6 months

Alliance CHW Policies

- [Policy 300-4035 Community Health Worker Requirements](#)
- [Policy 404-1738 Community Health Worker](#)

CHW Plan of Care Specifications



Specifies the condition



Lists other health care professionals involved



Contains written objectives



Specifies services required for meeting objectives



Frequency and duration of services

CHW Visit Documentation



Date & Time of Services



Duration of Services



Nature of Services Provided

A large, light-colored graphic on the left side of the image. It consists of a heart shape with a stethoscope wrapped around it. The stethoscope's tubing forms a large 'C' shape that encircles the heart.

Claims Billing Information

CHW Billing

Maximum frequency for a CHW visit is four units (two hours) per day

Members receiving ECM services **may not** also receive CHW services

First 12 units no auth required. Second set of 12 units requires prior auth.

CHW Billing Codes

CPT BILLING CODE	DESCRIPTION	NUMBER OF PATIENTS
98960	Self management education and training, face to face, 30 mins	1
98961	Self management education and training, face to face, 30 mins	2 - 4
98962	Self management education and training, face to face, 30 mins	5 - 8

See Policies #404-1738 and #300-4035 for more information on CHW services

CHW Required Modifiers

MODIFIER	DESCRIPTION
U2	Used to denote services rendered by Community Health workers
U3	Used to denote services rendered by Asthma Preventive Service providers
GQ	Used to denote Telehealth, used in the secondary modifier position

Place of Service Codes

POS CODE	DESCRIPTION	POS CODE	DESCRIPTION
02	Telehealth		
03	School	22	On Campus – Outpatient Hospital
04	Homeless Shelter	23	Emergency Room – Hospital
05	Indian Health Service Free - standing Facility	31	Skilled Nursing Facility
06	Indian Health Service Provider - based Facility	32	Nursing Facility
07	Tribal 638 Free - standing Facility	33	Custodial Care Facility
08	Tribal 638 Provider - based Facility	34	Hospice
11	Office	49	Independent Clinic
12	Home	50	Federally Qualified Health Center
13	Assisted Living Facility	52	Psychiatric Facility - Partial Hospitalization
14	Group Home	53	Community Mental Health Center
15	Mobile Unit for preventative and diagnostic services	54	Intermediate Care Facility/Individuals with intellectual Disabilities
16	Temporary Lodging	60	Mass Immunization Center
17	Walk-in Retail Health Clinic	62	Comprehensive Inpatient Rehabilitation Facility
18	Place of Employment - Worksite	65	End Stage Renal Disease Treatment Facility
19	Off Campus – Outpatient Hospital	71	Public Health Clinic
20	Urgent Care Facility	72	Rural Health Clinic
21	Inpatient Hospital	99	Other Place of Service

CMS 1500 Claim Form

CMS-1500 Completion

Page updated: August 2020

The Health Insurance Claim Form (CMS-1500) is used by Allied Health professionals, physicians, laboratories and pharmacies to bill supplies and services to the Medi-Cal program. Providers are required to purchase CMS-1500 claim forms from a vendor. Claim forms ordered through vendors must include red "drop-out" ink.

Most claims for these services and supplies may also be submitted through Computer Media Claims (CMC). For CMC ordering and enrollment information, refer to the CMC section in the Part 1 manual.

For additional billing information, refer to the CMS-1500 Special Billing Instructions, CMS-1500 Submission and Timeliness Instructions and the CMS-1500 Tips for Billing sections in this manual.

HEALTH INSURANCE CLAIM FORM											
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12											
☐ PICA ☐ PICA											
1. MEDICARE ☐ MEDICAID ☒ TRICARE ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ FECA ☐ OTHER ☐ (Medicare) (Medicaid) (Other) (Member) (Other) 1a. INSURED'S I.D. NUMBER (For Program in Item 1)											
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) PATIENT'S LAST NAME, FIRST NAME 3. PATIENT'S BIRTH DATE SEX											
4. INSURED'S NAME (Last Name, First Name, Middle Initial) MEDI-CAL ID NUMBER											
5. PATIENT'S ADDRESS (No. Street) PATIENT'S COMPLETE ADDRESS 6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐											
7. INSURED'S ADDRESS (No. Street) CITY STATE ST ZIP CODE TELEPHONE (Include Area Code) 8. RESERVED FOR NUCC USE											
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER b. RESERVED FOR NUCC USE c. RESERVED FOR NUCC USE d. INSURANCE PLAN NAME OR PROGRAM NAME 10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐ b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State) c. OTHER ACCIDENT? YES ☐ NO ☐ d. CLAIM CODES (Designated by NUCC)											
11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐ b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ If yes, complete items 9, 10, and 11d. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party to which assignment below. SIGNED DATE											
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED 14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM/DD/YY) 15. OTHER DATE QUAL. MM DD YY											
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM/DD/YY TO MM/DD/YY 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. NAME 17b. NPI											
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM/DD/YY TO MM/DD/YY 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)											
20. OUTSIDE LAB? YES ☐ NO ☐ \$ CHARGES 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) A. (DIAGNOSIS CODE 1) B. (DIAGNOSIS CODE 2) C. (DIAGNOSIS CODE 3) D. (DIAGNOSIS CODE 4) E. (DIAGNOSIS CODE 5) F. (DIAGNOSIS CODE 6) G. (DIAGNOSIS CODE 7) H. (DIAGNOSIS CODE 8) I. (DIAGNOSIS CODE 9) J. (DIAGNOSIS CODE 10) K. (DIAGNOSIS CODE 11) L. (DIAGNOSIS CODE 12)											
22. PRIOR AUTHORIZATION NUMBER F. CHARGES G. D. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z. 23. PRIOR AUTHORIZATION NUMBER F. CHARGES G. D. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.											
24. A. DATES OF SERVICE FROM MM/DD/YY TO MM/DD/YY B. PLACE OF SERVICE C. PROCEDURE, SERVICE, OR SUPPLY (Describe Universal Coder's Modifier) 25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. PATIENT ACCOUNT NUMBER 27. ACCEPT ASSIGNMENT? YES ☐ NO ☐											
28. TOTAL CHARGE \$ TOTAL CHARGES 29. BILLING PROVIDER INFO & PH # (PHONE NUMBER) 30. BILLER ADDRESS											
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on this invoice apply to this bill and are made a part thereof.) SIGNED DATE 32. SERVICE FACILITY LOCATION INFORMATION NAME AND ADDRESS OF SERVICE FACILITY a. FACILITY NPI b. NON-NPI NUMBER											
33. BILLING PROVIDER INFO & PH # (PHONE NUMBER) 34. BILLER NPI c. NON-NPI NUMBER											

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE CRO61653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

Member Demographics

HEALTH INSURANCE CLAIM FORM				PICA	
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 00/12					
1. MEDICARE ☐ (Medicare) ☒ (Medicaid) ☐ (Other) ☐ (Other)		2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE	
PATIENT'S LAST NAME, FIRST NAME		MM / DD / YY		SEX ☐ M ☐ F	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED		7. INSURED'S ADDRESS (No., Street)	
PATIENT'S COMPLETE ADDRESS		Self ☐ Spouse ☐ Child ☐ Other ☐		CITY	
CITY		STATE		STATE	
PATIENT'S CITY		ST		CITY	
ZIP CODE		TELEPHONE (Include Area Code)		ZIP CODE	
PATIENT'S 9-DIGIT ZIP		(PATIENT'S PHONE		()	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous)		a. INSURED'S DATE OF BIRTH	
b. RESERVED FOR NUCC USE		☐ YES ☐ NO		MM / DD / YY	
c. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? ☐ YES ☐ NO		SEX ☐ M ☐ F	
d. INSURANCE PLAN NAME OR PROGRAM NAME		c. OTHER ACCIDENT? ☐ YES ☐ NO		b. OTHER CLAIM ID (Designated by NUCC)	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE		10M. CLAIM CODES (Designated by NUCC)		c. INSURANCE PLAN NAME OR PROGRAM NAME	
I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.		d. IS THERE ANOTHER HEALTH BENEFIT PLAN?		d. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	
SIGNED		DATE		I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
SIGNED		DATE		SIGNED	

- 1 Medicaid Box
- 1a Member ID
- 2 Member Name
- 3 Member DOB & Gender
- 5 Member Address
- 6 Relationship Box

Referral to Services

Documentation Requirements

CHW services require a written recommendation by a physician or other licensed practitioner of the healing arts within their scope of practice under state law. Other licensed practitioners who can recommend CHW services within their scope of practice include physician assistants, nurse practitioners, clinical nurse specialists, podiatrists, nurse midwives, licensed midwives, registered nurses, public health nurses, psychologists, licensed marriage and family therapists, licensed clinical social workers, licensed professional clinical counselors, dentists, licensed educational psychologists, licensed vocational nurses, and pharmacists.

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

Providers are instructed to document the name or NPI # of the licensed practitioner who has written the recommendation to services in BOX 19 of the CMS Claim form to satisfy the documentation requirements outlined above.

HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 08/12

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP-TERM LIFE PLAN FECA (EMPLOYER) OTHER (Specify)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE SEX

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No. Street)

6. PATIENT'S COMPLETE ADDRESS

7. INSURED'S ADDRESS (No. Street)

8. PATIENT'S CITY STATE

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits other than myself or to the party who accepts assignment of benefits.)

13. INSURED'S DATE OF BIRTH MM DD YY SEX

14. DATE OF CURRENT ILLNESS, INJURY, OR PRESENTING COMPLAINT MM DD YY

15. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

16. PATIENT'S 9-DIGIT ZIP (PATIENT'S PHONE)

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE (NPI)

18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

19. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Specify A.L. to service line below) (Check)

20. PRIOR AUTHORIZATION NUMBER

21. DATE OF SERVICE FROM MM DD YY TO MM DD YY

22. PROCEDURE, SERVICE, OR SUPPLY (Specify Unusual Circumstances)

23. SERVICE CHARGES

24. A. DATE OF SERVICE FROM MM DD YY TO MM DD YY

25. FEDERAL TAX I.D. NUMBER

26. PATIENT'S ACCOUNT NO. (NUCC INSTRUCTION MANUAL AVAILABLE AT: WWW.NUCC.ORG)

27. ACCEPT ASSIGNMENT? YES NO

28. TOTAL CHARGE \$ TOTAL CHARGES

29. AMOUNT PAID \$

30. BILLING PROVIDER INFO & PHONE #

31. BILLER ADDRESS

32. BILLER NPI

33. NON-NPI NUMBER

34. FACILITY NPI

35. NON-NPI NUMBER

36. SIGNATURE OF PROVIDER OR PERSON AUTHORIZED

37. DATE

38. NAME AND ADDRESS OF SERVICE FACILITY

39. BILLER NPI

40. NON-NPI NUMBER

41. BILLER NPI

42. NON-NPI NUMBER

43. BILLER NPI

44. NON-NPI NUMBER

45. BILLER NPI

46. NON-NPI NUMBER

47. BILLER NPI

48. NON-NPI NUMBER

49. BILLER NPI

50. NON-NPI NUMBER

51. BILLER NPI

52. NON-NPI NUMBER

53. BILLER NPI

54. NON-NPI NUMBER

55. BILLER NPI

56. NON-NPI NUMBER

57. BILLER NPI

58. NON-NPI NUMBER

59. BILLER NPI

60. NON-NPI NUMBER

61. BILLER NPI

62. NON-NPI NUMBER

63. BILLER NPI

64. NON-NPI NUMBER

65. BILLER NPI

66. NON-NPI NUMBER

67. BILLER NPI

68. NON-NPI NUMBER

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Provider Demographics

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)		NUMBER ☐ YES ☐ NO		33. BILLING PROVIDER INFO & PH # (PHONE NUMBER)	
SIGNATURE OF PROVIDER OR PERSON AUTHORIZED		NAME AND ADDRESS OF SERVICE FACILITY		BILLER ADDRESS	
SIGNED ☐ DATE ☐				BILLER NPI ☐ NON-NPI NUMBER ☐	
NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)					

- 31 Signature Line
- 33 Billing Provider
Address and Phone
- 33a Billing NPI

Electronic Claims Submissions

A clearinghouse platform for ***electronic claim submissions*** chosen by the provider

1. Providers select a clearing house
2. Provider submits EDI *enrollment form to the Alliance
3. 1 hard copy paper claim is required
4. Providers submit claims to the Alliance via the clearing house
5. Claims are processed in about 12 - 30 days
6. Remittance is sent to the provider from echo

[EDI Claims Enrollment Form - Central California Alliance for Health](#)

Timely Filing

Claims must be received within 6 months from the date of service to be considered timely and payable at 100% of the allowed amount

- Claims received 7-9 months after the date of service will be reimbursed at 75% of the allowed amount
- Claims received 10-12 months after the date of service will be reimbursed at 50% of the allowed amount
- Claims received more than a year after the date of service will be denied

Portal Resources

Echo

Owned and maintained by the vendor Change - Echo

The site to view and pull RA's and check information

Requires a log in given by Echo

Providerpayments.com

Customer Support 888-983-5574

Provider Portal

- Owned and maintained by CCAH
- The site to check member eligibility, auth status and claim status
- Requires a log in given by CCAH
- thealliance.health

Reading your Remittance Advice

Service Date	Proc/Rev Code (Modifiers)	Units	Explanation Code(s)	Total Charge	Allowed Amount	Provider Discount	Other Plan Payment	Other Adjustments	Patient Obligation				Net Payment Amount
									Co-ins	CoPay	Deduct	Non-Cov	
Claim Number: 00473:		1		Group ID:		Reference Number: CHC0003							
Provider:				Patient Name:		2		Subscriber Name:		3			
Network: CHC000				Patient Acct #:				Subscriber ID:					
08/02/24	G9012 (U8) (GQ)	1	COB15	4 \$44.00	\$0.00	\$44.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Claim Total:				\$44.00	\$0.00	\$44.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

Statement Summary	Total Charge	Allowed Amount	Provider Discount	Other Plan Payment	Other Adjustments	Patient Obligation	Net Payment Amount
	\$1,231,692.00	\$36,740.00	\$1,197,680.00	\$0.00	\$0.00	\$0.00	\$34,012.00

- 1) Claim Number
- 2) Patient Name
- 3) Subscriber name and ID
- 4) Date of Service, Billing Code, Units Billed, Explain Code
- 5) Net Payment Amount
- 6) Total Check Amount

Document Total	
Net Payment Amount:	\$34,012.00
Payment Adjustments:	\$0.00
Total Payment:	\$34,012.00

6

Resolving Denials

Contact the Claims Department

The Claims Customer service team is available from 8:30 – 4:30 to answer your questions and help you resolve claims issues 831-430-5503. Closed 11:30 – 12:30 for lunch

Review your RA

Details on next slide

Claim Number

Member ID and Date of Service

Submit Corrected Claims

Use Box 19 on the CMS 1500 and Box 80 on the UB-04 for documentation see policy 600-1009



Thank you!

For Questions, please reach out to your Provider Relations Representative at: 831-430-5504

Gender Affirming Care Senate Bill 923

Compliance with [Senate Bill 923-Gender-Affirming Care](#)

APL [APL 24-018](#)

This APL formally adopts the [Transgender, Gender Divers, or Intersex \(TGI\) Working Group recommendations](#) regarding the topics in the training curriculum for health care service plan staff.

This APL requires a plan to ensure all health care service staff complete evidence-based cultural competence training when providing trans-inclusive health care for individuals who identify as TGI. For more information refer to pages 7-10 of the APL

The Alliance is required to include which in-network providers offer gender-affirming services in provider directories and call centers no later than Feb 14, 2025.

[Please fill out this form](#) to let us know if you offer gender-affirming services.

For more information, please refer to DMHC APL 24-018.



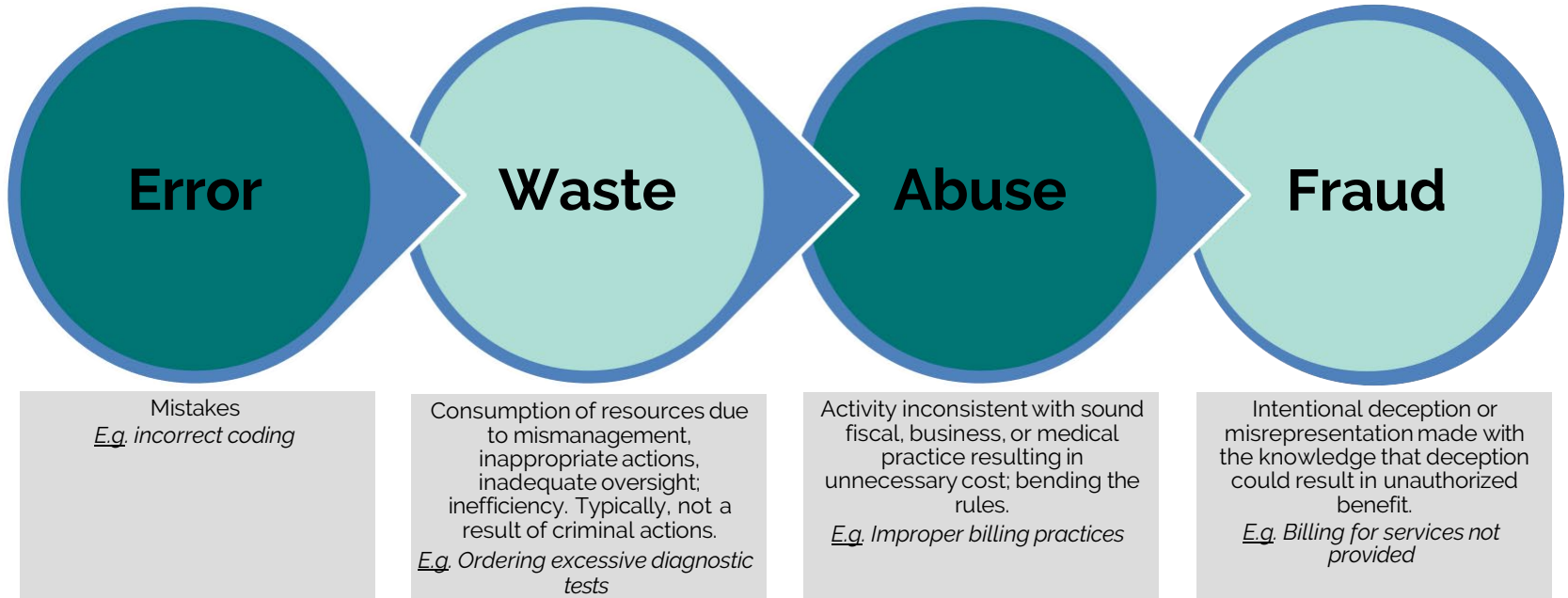
Confirm Review

After reviewing the information in this file, please click the link below to acknowledge that you have completed all necessary Network Provider Trainings.

Please note these trainings are required as part of the initial credentialing and re-credentialing process. Applications will not be considered complete or finalized until all required trainings have been completed

[Network Provider Training Attestation Form](#)

Fraud, Waste and Abuse (FWA)



Laws Relating to Fraud Waste and Abuse (FWA)

Laws to prevent engaging in fraudulent behavior and encouraging the reporting of FWA

Law / Requirement	Summary
Federal & California False Claims Act	- Prohibits the submission of fraudulent claims - Allows whistleblowers to be rewarded with a percentage of the money the government recovers
Anti-Kickback Statute	Prohibits asking for / receiving anything of value in exchange for referrals of federal health care business
Physician Self-Referral Law	Prohibits a physician from making referrals for certain designated health services to entities that they have a financial interest in
Medi-Cal Contract Requirements	Requires health plans to report suspected FWA to the Department of Health Care Services

[Training materials available via Office of Inspector General Health Care Fraud Prevention & Enforcement Action Team](#)



HIPAA Compliance

Providers are responsible for maintaining the confidentiality of Alliance member protected health information (PHI).

Law	Summary
Privacy Rule	- Ensures individuals' PHI is protected from unauthorized use/disclosure while allowing information flow needed to promote high quality care. - Includes: permitted / required disclosures, authorization to disclose information, patient right of access to records, etc.
Security Rule	- Establishes security standards for electronic PHI. - Includes: risk analysis, encryption, administrative / physical / technical safeguards to protect PHI
Breach Notification	Requires Covered Entities to notify patients if their PHI has been breached; includes standards for determining if a breach occurred



Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21 (EPSDT)

- On a biannual basis, all Network Providers must complete the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Training.
- Network Providers can access the training on the Alliance Provider Training webpage by clicking [Medi-Cal for Kids & Teens](#) under Resources.



Gender Affirming Care Senate Bill 923

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APL [APL 24-018](#)

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