Non-PAR/Non-Traditional Provider Supplemental Information

Cultural Sensitivity

Driscoll Health Plan (DHP) places great emphasis on the wellness of its Members. A large part of quality health care delivery is treating the whole patient and not just the medical condition. Sensitivity to differing cultural influences, beliefs and backgrounds, can improve a provider's relationship with patients and in the long run the health and wellness of the patients themselves. DHP encourages all providers to be sensitive to varying cultures in the community.

Value Added Services for CHIP/STAR/STAR Kids Members

CHIP - http://driscollhealthplan.com/programs/chip/value-added-services

STAR - http://driscollhealthplan.com/programs/star/value-added-services

STAR Kids - http://driscollhealthplan.com/programs/star-kids/value-added-services-star-kids

Prior Authorization and Referrals

Print and complete the Texas Standard Prior Authorization Request for Health Care Services Form

Contact the DHP Utilization Management Dept. at 1-877-455-1053 (FAX 1-866-741-5650)

or the Texas Standard Prior Authorization Request Form for Prescription Drug Benefits and call or fax it back to the number provided on the form.

Filing a Complaint

Member / Provider Complaint

A provider, Member, or someone acting on behalf of a Member ("Complainant"), may file a complaint by calling Customer Services at 1-877-220-6376 for Nueces SA or 1-855-425-3247 for Hidalgo SA. A Member advocate is available to help with filing the complaint.

A complaint may also be filed with the Health and Human Services Commission (HHSC) at 1-888-973-0022. A complaint may be filed orally, in person, or in writing.

To file a verbal complaint, the Complainant may call Customer Services at 1-877-220-6376 for Nueces SA or 1-855-425-3247 for Hidalgo SA, or the Provider may call Provider Services at 1-877-324-3627 for Nueces SA or 1-855-425-3247 for Hidalgo SA. The mailing address, e-mail and fax number where complaints may be directed is as follows:

Driscoll Health Plan
ATTN: Performance Excellence Team
4525 Ayers Street
Corpus Christi, TX 78415
Email - DHP_QM_Complaints@dchstx.org
Fax Number – 361-808-2725

You may also contact the State to file a Provider Complaint at HPM_Complaints@hhsc.state.tx.us and for STAR Health at STAR.Health@hhsc.state.tx.us

Mail:
Texas Health and Human Services Commission
Complaints and Incident Intake
Mail Code E249
P.O. Box 149030
Austin, TX 79711-3247

Resolving the complaint - An acknowledgement letter will be sent within five (5) days of receiving the complaint or completed complaint form, if applicable. DHP will resolve all complaints within thirty (30) calendar days from receipt of the complaint. The Complainant will be sent a complaint resolution letter summarizing the results of the issue presented, including information on the appeal processes and timeframes for appeals.

Complaint Appeal

If the Complainant is not satisfied with the complaint resolution, an appeal may be filed. An appeal must be filed within thirty (30) days of the date on the complaint resolution letter. Information regarding the appeal of the complaint decision is included with the decision response. The appeal must be in writing. Appeal decisions are made within thirty (30) days of receiving the appeal. Included in the appeal letter is the process used to make the determination. In addition to appealing the response to DHP, the Complainant has the right to contact HHSC by calling 1-800-252-8263.

CHIP Appeal Form - English

CHIP Appeal Form - Español

STAR/STAR Kids Appeal - English

STAR/STAR Kids Appeal Form - Español

Administrative Claim Appeal:

An administrative claim appeal is a request for review of claim reimbursement, or denial, for technical and nonmedical reasons. All administrative claim appeals must be submitted in writing, along with supporting documentation for the appeal.

Appeal submissions must be received by DHP within one hundred and twenty (120) days from the Explanation of Payment (EOP) date. DHP will process the appeal and respond in writing, and/or or adjust any appropriate claim(s), within thirty (30) days from the receipt of the appeal. All administrative claim appeals must be finalized within twenty-four (24) months from the date of service.

For questions regarding administrative claim appeals, please contact Provider Services at 1-877-220-6376 for Nueces Service Area and 1-855-425-3247 for Hidalgo Service Area.

Administrative claim appeals may be submitted to DHP as follows:

DHP ADMINISTRATIVE CLAIM APPEAL SUBMISSION	
DHP Provider Portal:	www.driscollhealthplan.com
Email:	DHP.PortalAppeals@dchstx.org
Fax:	361-808-2776
Mail:	Attention: Claims Appeal Department P.O. Box 3668 Corpus Christi, TX 78463-3668

Adverse Medical Determination Appeals are processed by the Medical Appeals Department. For assistance with these types of appeals, please contact Appeals Department at 1-877-220-6376 for Nueces SA and 1-855-425-3247 for Hidalgo SA**.**

Driscoll Health Plan
ATTN: Member Appeals Department
4525 Ayers Street
Corpus Christi, TX 78415
Email - dhp.portalappeals@dchstx.org
Fax Number – 361-808-2186

Provider Appeal Process to HHSC

(Related to claim recoupment due to member disenrollment)

Provider may appeal claim recoupment by submitting the following information to HHSC:

• A letter indicating that the appeal is related to a managed care disenrollment/recoupment and that the provider is requesting an Exception Request.

• **The Explanation of Benefits (EOB) showing the original payment.** Note: This is also used when issuing the retro-authorization as HHSC will only authorize the Texas Medicaid and Healthcare Partnership (TMHP) to grant an authorization for the exact items that were approved by the plan.

• **The EOB showing the recoupment and/or the plan's "demand" letter for recoupment.** If sending the demand letter, it must identify the client name, identification number, DOS, and recoupment amount. The information should match the payment EOB.

• **Completed clean claim.** All paper claims must include both the valid NPI and TPI number. Note: In cases where issuance of a prior authorization (PA) is needed, the provider will be contacted with the authorization number and the provider will need to submit a corrected claim that contains the valid authorization number.

Mail appeal requests to:

Texas Health and Human Services Commission HHSC Claims Administrator
Contract Management Mail Code-91X
P.O. Box 204077
Austin, Texas 78720-4077

For more information or to answer any questions you may have on filing an appeal or the appeals process please use the contact information listed below.

DHP Provider Services: Nueces SA: 1-877-DCH-DOCS (324-3627); Hidalgo SA: 1-855-425-DCHP (425-3247)

Texas Standard Prior Authorization Request Form for Health Care Services

NOFR001 | 0415 Texas Department of Insurance

Please read all instructions below before completing this form.
Please send this request to the issuer from whom you are seeking authorization. ***Do not send this form*** *to the Texas Department of Insurance, the Texas Health and Human Services Commission, or the patient's or subscriber's employer.*

Beginning September 1, 2015, health benefit plan issuers must accept the Texas Standard Prior Authorization Request Form for Health Care Services if the plan requires prior authorization of a health care service.

In addition to commercial issuers, the following public issuers must accept the form: Medicaid, the Medicaid managed care program, the Children's Health Insurance Program (CHIP), and plans covering employees of the state of Texas, most school districts, and The University of Texas and Texas A&M Systems.

Intended Use: Use this form to request authorization **by fax or mail** when an issuer requires prior authorization of a health care service. An Issuer may also provide an **electronic version of this form** on its website that you can complete and submit electronically, through the issuer's portal, to request prior authorization of a health care service.

Do not use this form to: 1) request an appeal; 2) confirm eligibility; 3) verify coverage; 4) request a guarantee of payment; 5) ask whether a service requires prior authorization; 6) request prior authorization of a prescription drug; or 7) request a referral to an out of network physician, facility or other health care provider.

Additional Information and Instructions:

Section I – Submission:
An issuer may have already entered this information on the copy of this form posted on its website.

Section II – General Information:
Urgent reviews: Request an urgent review for a patient with a life-threatening condition, **or** for a patient who is currently hospitalized, **or** to authorize treatment following stabilization of an emergency condition. You may also request an urgent review to authorize treatment of an acute injury or illness, if the provider determines that the condition is severe or painful enough to warrant an expedited or urgent review to prevent a serious deterioration of the patient's condition or health.

Section IV – Provider Information:
- If the Requesting Provider or Facility will also be the Service Provider or Facility, enter "Same."
- If the requesting provider's signature is required, you may not use a signature stamp.
- If the issuer's plan requires the patient to have a primary care provider (PCP), enter the PCP's name and phone number. If the requesting provider is the patient's PCP, enter "Same."

Section VI – Clinical Documentation:
- Give a brief narrative of medical necessity in this space, or in an attached statement.
- Attach supporting clinical documentation (medical records, progress notes, lab reports, etc.), if needed.

Note: *Some issuers may require more information or additional forms to process your request. If you think more information or an additional form may be needed, please check the issuer's website before faxing or mailing your request.*
Note: *If the requesting provider wants to be called directly about missing information needed to process this request, you may include the provider's direct phone number in the space given at the bottom of the request form. Such a phone call cannot be considered a peer-to-peer discussion required by 28 TAC §19.1710. A peer-to-peer discussion must include, at a minimum, the clinical basis for the URA's decision and a description of documentation or evidence, if any, that can be submitted by the provider of record that, on appeal, might lead to a different utilization review decision.*

TEXAS STANDARD PRIOR AUTHORIZATION REQUEST FORM FOR HEALTH CARE SERVICES

SECTION I — SUBMISSION

Issuer Name:	Phone:	Fax:	Date:

SECTION II — GENERAL INFORMATION

Review Type:	☐ Non-Urgent	☐ Urgent	Clinical Reason for Urgency:	

SECTION III — PATIENT INFORMATION

Name:	Phone:	DOB:	☐ Male ☐ Female ☐ Other ☐ Unknown
Subscriber Name (if different):	Member or Medicaid ID #:	Group #:	

SECTION IV — PROVIDER INFORMATION

Requesting Provider or Facility		Service Provider or Facility	
Name:		Name:	
NPI #:	Specialty:	NPI #:	Specialty:
Phone:	Fax:	Phone:	Fax:
Contact Name:	Phone:	Primary Care Provider Name (see instructions):	
Requesting Provider's Signature and Date (if required):		Phone:	Fax:

SECTION V — SERVICES REQUESTED (WITH CPT, CDT, OR HCPCS CODE) AND SUPPORTING DIAGNOSES (WITH ICD CODE)

Planned Service or Procedure	Code	Start Date	End Date	Diagnosis Description (ICD version____)	Code

☐ Inpatient ☐ Outpatient ☐ Provider Office ☐ Observation ☐ Home ☐ Day Surgery ☐ Other: _____

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Cardiac Rehab ☐ Mental Health/Substance Abuse

Number of Sessions:_____ Duration:_____ Frequency:_____ Other: _____

☐ Home Health (MD Signed Order Attached? ☐ Yes ☐ No) (Nursing Assessment Attached? ☐ Yes ☐ No)

Number of Visits:_____ Duration:_____ Frequency:_____ Other: _____

☐ DME (MD Signed Order Attached? ☐ Yes ☐ No) (Medicaid Only: Title 19 Certification Attached? ☐ Yes ☐ No)

Equipment/Supplies (include any HCPCS Codes):_____ Duration: _____

SECTION VI — CLINICAL DOCUMENTATION (SEE INSTRUCTIONS PAGE, SECTION VI)

An issuer needing more information may call the requesting provider directly at: _____

Texas Standard Prior Authorization Request Form for Prescription Drug Benefits

Please read all instructions below before completing this form.

Please send this request to the issuer from whom you are seeking authorization. ***Do not send this form*** to the Texas Department of Insurance, the Texas Health and Human Services Commission, or the patient's or subscriber's employer.

Beginning September 1, 2015, health benefit plan issuers must accept the Texas Standardized Prior Authorization Request Form for Prescription Drug Benefits if the plan requires prior authorization of a prescription drug or device.

In addition to commercial issuers, the following public issuers must accept the form: Medicaid, the Medicaid managed care program, the Children's Health Insurance Program (CHIP), and plans covering employees of the state of Texas, most school districts, and The University of Texas and Texas A&M Systems.

Intended Use: Use this form to request authorization **by fax or mail** when an issuer requires prior authorization of a prescription drug, a prescription device, formulary exceptions, quantity limit overrides, or step-therapy requirement exceptions. An Issuer may also provide an **electronic version of this form** on its website that you can complete and submit electronically, through the issuer's portal, to request prior authorization of a prescription drug benefit.

Do not use this form to: 1) request an appeal; 2) confirm eligibility; 3) verify coverage; 4) request a guarantee of payment; 5) ask whether a prescription drug or device requires prior authorization; or 6) request prior authorization of a health care service.

Additional Information and Instructions:

Section I – Submission:

Enter the name and contact information for the issuer or the issuer's agent that manages or administers the issuer's prescription drug benefits, as applicable. An issuer or agent may have already prepopulated its contact information on the copy of this form posted on its website.

Section VI – Prescription Compound Drug Information:

List the quantities of ingredients in units of measure (mg, ml, etc.).

Section VIII – Patient Clinical Information:

Enter ICD Version 9 or 10, as applicable.

Section IX — Justification:

In the space provided or on a separate page:

- Provide pertinent clinical information to justify requests for initial or ongoing therapy, or increases in current dosage, strength, or frequency.
- Explain any comorbid conditions and contraindications for formulary drugs.
- Provide details regarding titration regimen or oncology staging, if applicable.
- Provide pertinent information about any step-therapy exception, if applicable.

Attach supporting clinical documentation (medical records, progress notes, lab reports, etc.), if needed.

Note: Some issuers may require more information or additional forms to process your request. If you think more information or an additional form may be needed, please check the issuer's website before faxing or mailing your request.

TEXAS STANDARDIZED PRIOR AUTHORIZATION REQUEST FORM FOR PRESCRIPTION DRUG BENEFITS

SECTION I — SUBMISSION

Submitted to: **Navitus Health Solutions**	Phone: 877-908-6023	Fax: 855-668-8553	Date:

SECTION II — REVIEW

☐ Expedited/Urgent Review Requested: By checking this box and signing below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Signature of Prescriber or Prescriber's Designee:_____

SECTION III — PATIENT INFORMATION

Name:	Phone:	DOB:	☐ Male ☐ Female Other Unknown	
Address:	City:		State:	ZIP Code:
Issuer Name (if different from Section I):	Member or Medicaid ID #:	Group #:		
BIN # (if available):	PCN (if available):	Rx ID # (if available):		

SECTION IV — PRESCRIBER INFORMATION

Name:		NPI #:	Specialty:	
Address:		City:	State:	ZIP Code:
Phone:	Fax:	Office Contact Name:	Contact Phone:	

SECTION V — PRESCRIPTION DRUG INFORMATION

(If this is a compound drug, identify all ingredients in Section VI, below.)

Requested Drug Name:				
Strength:	Route of Administration:	Quantity:	Days' Supply:	Expected Therapy Duration:

To the best of your knowledge this medication is:

☐ New therapy ☐ Continuation of therapy (approximate date therapy initiated):

For Provider Administered Drugs Only:

HCPCS Code: NDC #: Dose Per Administration:

SECTION VI — PRESCRIPTION COMPOUND DRUG INFORMATION

Compound Drug Name:

Ingredient	NDC #	Quantity	Ingredient	NDC #	Quantity

SECTION VII — PRESCRIPTION DEVICE INFORMATION

Requested Device Name:	Expected Duration of Use:	HCPCS Code (If applicable):

SECTION VIII — PATIENT CLINICAL INFORMATION

Patient's diagnosis related to this request:	ICD Version:	ICD Code:

(Provide the following information to the best of your knowledge)
Drugs patient has taken for this diagnosis:

Drug Name	Strength	Frequency	Dates Started and Stopped or Approximate Duration	Describe Response, Reason for Failure, or Allergy

Drug Allergies:	Height (if applicable):	Weight (if applicable):

Relevant laboratory values and dates (attach or list below):

Date	Test	Value

SECTION IX — JUSTIFICATION (SEE INSTRUCTION PAGE SECTION IX)

DRISCOLL HEALTH PLAN -- REQUEST FOR AN APPEAL - CHIP

Date: _____

Thank you for providing us with your appeal request. It will help us to work on your appeal if you fill out this form and return to us. You do not have to ask for this appeal in writing for us to complete this process.

Name of the Person Requesting the Appeal (Print)

(Last Name)_____(First Name)_____(M.I.) _____

Relationship to the Patient: (Place an 'X' before one)
( ) Self ( ) Person acting on behalf of the Patient ( ) Provider

Patient Information:

Name_____ Member ID _____
Date of Birth____/___/_____ Phone: (___) ___-_____
Address_____ City _____
State_____ Zip Code_____

Provider Information: *Please provide information about the doctor or other health care provider that has primary responsibility for the care, treatment, and services rendered to the patient.*

Name_____Phone:(___) ___-_____ Fax: (___) ___-_____
Address _____ City_____ State_____Zip Code_____

Information Regarding the Appeal:

Original Date of Service:_____
Date of Denial _____

_____

Reason for Appeal

_____
_____
_____
_____

Please submit any additional documentation that you would like considered with this appeal

Signature _____

***Please return this form to*:** Driscoll Health Plan
Attn: Clinical Appeals Department
615 N Upper Broadway, Suite 200-C
Corpus Christi, Texas 78401-0764
Fax Number: 361-808-2186

If you have any questions concerning the appeal process, please feel free to call us at 1-877-451-5598.
A member advocate will help you with the process.

DRISCOLL HEALTH PLAN -- SOLICITUD DE APELACIÓN - CHIP

Fecha: _____

Gracias por su solicitud de apelación. Puede completar su apelación oralmente o por escrito. No tiene que devolver este formulario para procesar su apelación. Si completa este formulario nos ayudará a trabajar en su solicitud.

Nombre de la persona que solicita la apelación: (con letra de imprenta)

(Apellido)_____(Nombre)_____(M.I.)_____

Número de teléfono: _____ _____
(código de área) (número)

Relación con el Miembro: (Marque una)

( ) Representante legalmente autorizado ( ) El miembro de la familia ( ) Amigo ( ) Proveedor ( ) Abogado ( ) Proveedor de Registro ( ) Miembro

Información del Miembro:

Nombre:_____ Número de identificación del miembro:_____

Fecha de nacimiento:_____/___/_____ Número de teléfono: (___)_____-_____

Dirección:_____ Ciudad:_____

Estado: _____ C.P: _____

Información del proveedor: (*Proporcione la información del médico u otro profesional de la salud que sea el principal responsable de la atención, el tratamiento y los servicios brindados al paciente):*

Nombre:_____Número de teléfono: (___)_____-_____Número de fax: (___)_____-_____

Dirección:_____Ciudad:_____Estado: _____ C.P:_____

Información relativa a la Apelación:

Fecha original de servicio:____/____/____Fecha de denegación:____/____/____

Número de referencia:_____

Motivo de la apelación: _____

_____

Por favor, envíe cualquier documentación adicional que le gustaría considerar con esta apelación

Entregue este formulario a: Driscoll Health Plan
Quality Management Department
Atención: Member Appeals Team
4525 Ayers Street
Corpus Christi, Texas 78415
Número de fax: 361-808-2186

Si tiene alguna pregunta relacionada con el proceso de apelación, llámenos sin costo al 1-877-324-7543.
Un defensor para miembros le ayudará con el proceso.

DRISCOLL HEALTH PLAN -- REQUEST FOR AN APPEAL - STAR/STAR Kids

Date: _____

Name of the Person Requesting the Appeal (Print)

(Last Name)_____(First Name)_____(M.I.)_____

Phone number: _____
(area code) (number)

Member Consent Form to allow an Authorized Representative to Appeal on behalf of member:

Relationship to the Member: (Please check one)

( ) Legally Authorized Representative ( ) Family Member ( ) Friend ( ) Provider ( ) Attorney
( ) Provider of Record

I give consent for my representative,_____(*Insert representative name*), to appeal, on my behalf, the denial made by DHP.

_____ _____
Member Signature (Parent or Legally Authorized Representative if applicable) Date

Member Information:

Name:_____ Member ID: _____
Date of Birth:_____/___/_____ Phone: (__) _____-_____
Address:_____ City:_____
State: _____ Zip Code: _____

Provider Information (*Please provide information about the doctor or other health care provider that has primary responsibility for the care, treatment, and services rendered to the member):*

Name:_____Phone: (___)_____-_____ Fax: (___)_____-_____
Address: _____ City: _____ State:_____Zip Code: _____

Information regarding the Appeal:

Original Date of Service:____/____/____Date of Denial:____/____/____
Referral Number: _____

Reason for appeal:

_____

_____

Please submit any additional documentation that you would like considered with this appeal

***Please return this form to*:** Driscoll Health Plan - Quality Management Department
Attn: Clinical Appeals Team
4525 Ayers Street
Corpus Christi, Texas 78415
Fax Number: 361-808-2186

If you have any questions concerning the appeal process, please feel free to call us at 1-877-324-7543.
A member advocate will help you with the process.

DRISCOLL HEALTH PLAN -- SOLICITUD DE APELACIÓN STAR/STAR Kids

Fecha: _____

Nombre de la persona que solicita la apelación (con letra de imprenta)

(Apellido)_____(Nombre)_____(M.I.)_____

Número de teléfono: _____
(código de área) (número)

Formulario de Consentimiento del Miembro para permitir que un Representante Autorizado en nombre del miembro:

Relación con el Miembro: (Marque una)

( ) Representante legalmente autorizado ( ) El miembro de la familia ( ) Amigo ( ) Proveedor ( ) Abogado ( ) Proveedor de Registro

Doy mi consentimiento para que mi representante,_____(Insertar nombre representativo), apele, en mi nombre, la denegación hecha por DHP.

_____ _____
Firma de miembro (Padre o Representante Legalmente Autorizado si corresponde) Fecha

Información del Miembro:

Nombre:_____ Número de identificación del miembro: _____
Fecha de nacimiento:_____/___/_____ Número de teléfono: (___) - _____
Dirección:_____ Ciudad:_____
Estado: _____ C.P: _____

Información del proveedor (*Proporcione la información del médico u otro profesional de la salud que sea el principal responsable de la atención, el tratamiento y los servicios brindados al paciente):*

Nombre:_____Número de teléfono: (___)_____-_____Fax: (___)_____-_____
Dirección:_____Ciudad:_____Estado:_____C.P: _____

Información relativa a la Apelación:

Fecha original de servicio:____/____/____Fecha de denegación:____/____/____
Número de referencia: _____

Motivo de la apelación:

_____

_____

Por favor, envíe cualquier documentación adicional que le gustaría considerar con esta apelación

Entregue este formulario a: Driscoll Health Plan
Quality Management Department
Attn: Member Appeals Team
4525 Ayers Street
Corpus Christi, Texas 78415
Fax Number: 361-808-2186

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Un defensor para miembros le ayudará con el proceso.