Magellan Behavioral Health of Florida
Training Session
Child Welfare Prepaid Mental Health Program
Agenda

- Introductions
- Overview of CBC Partnership
- Overview of Magellan of Florida
- Overview of Prepaid Mental Health Program
- Transition of Care Plan
- Utilization Management
- How to Submit Clean Insurance Claims
- Website Overview
- Q&A
Community Based Care Partnership

- Partnership among the CBCs and Magellan of Florida
- General partners are the CBC of Seminole County and Magellan of Florida
- Other CBCs are limited partners
Overview of Magellan of Florida
Child Welfare Prepaid Mental Health Plan
January 2007
Magellan of Florida

- Established in 2004 and is a wholly owned subsidiary of Magellan Behavioral Health, Inc.
- Magellan Behavioral Health of Florida is registered to conduct business in Florida and with the Agency for Health Care Administration to provide Medicaid Services.
- Magellan Behavioral Health of Florida, Inc. is an entity that is solely dedicated to providing services to the Florida Medicaid programs.
- Magellan Behavioral Health of Florida will become URAC (Utilization Review Accreditation Commission) Accredited.
Magellan of Florida

- Physical Address: 7400 NW 19th St., Suite C, Miami, FL 33126
- Staffed 24/7 on site
- Murphy Leopold is the General Manager
- Staff will work in the Magellan of Florida office
- Staff is multilingual, interpreter services are available
- Toll-Free phone number is 800-327-5542
- Claims address for CW PMHP:
  Magellan Health Services, Inc.
  P.O. Box 1498
  Maryland Heights, MO 63043
Magellan of Florida

- Phone number for all services is 800-327-5542
- Providers should call this number for
  - Enrollee eligibility information
  - Preauthorization (where required)
  - Concurrent authorization (where required)
  - Claims inquiries
Overview of Child Welfare Prepaid Mental Health Program
Overview of Prepaid Mental Health Program

- The program starts February 1, 2007
- Goals are to:
  - Achieve better outcomes for children
  - Achieve better access to care
  - Improve mental health care that supports the permanency planning for children
Details of the Prepaid Mental Health Program – Who is Eligible?

- Children ages 0 to 18 who have an open case in the HomeSafeNet database and are Medicaid eligible.

- It is important to validate the enrollee’s eligibility for the PMHP at every visit. A enrollee’s PMHP status may have changed since their last visit. You can easily check eligibility by calling 800-327-5542.

- Each member will have an ID card.
### Details of the Prepaid Mental Health Program – Covered Services

<table>
<thead>
<tr>
<th>Mandatory Services</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Inpatient hospital services and crisis stabilization unit (CSU) services</strong></td>
<td>Inpatient psychiatric services are medically necessary mental health care services provided in a general hospital or specialty hospital setting under the direction of a licensed physician with the appropriate Medicaid specialty requirements; CSU services are provided in licensed CSUs</td>
</tr>
<tr>
<td><strong>B. Outpatient hospital services</strong></td>
<td>Outpatient hospital services are medically necessary mental health care services provided in a hospital setting under the direction of a licensed physician that are paid at a line-item rate for covered outpatient revenue center codes.</td>
</tr>
</tbody>
</table>
Details of the Prepaid Mental Health Program – Covered Services…continued

<table>
<thead>
<tr>
<th>C. Physician services</th>
<th>Physician services are those services rendered by a licensed physician who possesses the appropriate Medicaid specialty requirements including specialty consultations and coordination of care with the primary care physician.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>D. Community mental health services</td>
</tr>
<tr>
<td></td>
<td>1. individualized treatment plan development and modification</td>
</tr>
<tr>
<td></td>
<td>2. evaluation and assessment services, including Comprehensive Behavioral Health Assessment</td>
</tr>
<tr>
<td></td>
<td>3. medical and psychiatric services</td>
</tr>
<tr>
<td></td>
<td>4. mental health counseling/therapy services</td>
</tr>
<tr>
<td></td>
<td>5. psychosocial rehabilitative services</td>
</tr>
<tr>
<td></td>
<td>6. therapeutic behavioral onsite services</td>
</tr>
<tr>
<td></td>
<td>7. crisis intervention mental health services and post-stabilization care services</td>
</tr>
<tr>
<td></td>
<td>Community mental health services encompass a continuum of services that are provided for the maximum reduction of the enrollee’s disability and restoration to the best possible functional level.</td>
</tr>
<tr>
<td>E. Mental health targeted case management</td>
<td>Targeted case management services are provided to children with serious emotional disturbances (SEDs) and incorporate the principles of a strengths-based approach that stresses building on the strengths of individuals that can be used to resolve current problems and issues</td>
</tr>
<tr>
<td>F. Specialized therapeutic foster care</td>
<td>Specialized therapeutic foster care services are intensive treatment services provided to children with emotional disturbances who reside in a state licensed foster home.</td>
</tr>
</tbody>
</table>
### Details of the Prepaid Mental Health Program – Covered Services…continued

<table>
<thead>
<tr>
<th>G. Therapeutic Group Care</th>
<th>Therapeutic group care services are community-based psychiatric residential treatment services designed for children and adolescents with moderate to severe emotional disturbances and provided in a licensed residential group home.</th>
</tr>
</thead>
<tbody>
<tr>
<td>H. Respite services for parents/ caregivers of children with SED at risk for acute hospitalization</td>
<td>In/out-of-home respite - community/ home-based services, provided in a variety of settings. Respite services - short-term environmental/ symptom stabilization related to MH symptoms. Services intended to be used for one to three continuous 24-hour periods, not to exceed 72 hrs. Services provided by professional or paraprofessional staff in safe environment. In /out-of-home respite can be planned or in response to an urgent need for an environmental intervention.</td>
</tr>
</tbody>
</table>
| Downward substitution from inpatient hospitalization | **Magellan Health Services**

*Getting Better All the Time*
Details of the Prepaid Mental Health Program – Non Covered Services by Magellan, however may be covered by the Medicaid FFS Plan

- Drug or alcohol abuse services
- Behavioral Health Overlay Services (BHOS)
- Statewide Inpatient Psychiatric Programs (SIPP)
- Prescription Drugs
- Services provided in long-term care institutions
- State Mental Health Facilities
- Nursing Homes
- Institutions for the developmentally disabled
- Suitability Assessments for Children done by the Qualified Evaluator Network
- Transportation
- Medical and Surgical Interventions
Details of the Prepaid Mental Health Program – How Enrollees Access Mental Health Care

- Generally, the CBC case manager will make referrals for care and will call Magellan for authorization on behalf of the provider.
- Magellan is available by phone 24/7, throughout the entire year.
- Enrollees may self-refer to any network provider.
- Enrollees may access providers with the help of Magellan by phone at 800-327-5542, web site.
- Enrollees will be supportively linked to enrollees to providers based on the enrollees’ clinical needs, their preferences for providers (e.g., gender, language), geographic location, characteristics and expertise of our providers and most importantly, the choice of the enrollee.
Details of the Prepaid Mental Health Program – Access to Care Standards for Providers to Note

The Prepaid Mental Health Plan has specific access standards that must be met.

- **Crisis Services**: Enrollees will have access to a crisis hotline 24 hours per day, seven days per week. Crisis hotline services will be provided by Magellan clinicians.

- **Emergency Services**: Mental health services and post-stabilization care services will be provided **immediately**. In life threatening emergencies, Magellan staff will urge the enrollee to go to the closest Provider or emergency facility.
Details of the Prepaid Mental Health Program – Appointment Access Standards

Access Standards for Magellan Providers:

- **Urgent Appointments** provided within **23 hours** when requested by Magellan.

- **Routine Appointments** and other non-urgent services provided within **7 days** (for initial assessment) and within **14 calendar days** (for follow-up). Magellan providers must adhere to this standard.

- Ambulatory follow up appointments provided within **7 days** of discharge from inpatient or CSU care.
Details of the Prepaid Mental Health Program – Administrative Details for Seeing an Enrollee.

- Information should be obtained before the first visit to ascertain the enrollee’s correct coverage.
- Confirm enrollee’s name and Medicaid ID number /Control Number on ID card.
- Call 800-327-5542 to verify eligibility for Magellan and authorize those services that require authorization.
Details of the Prepaid Mental Health Program – Administrative Details for Seeing an Enrollee…continued.

The First Visit:

- On the first visit, make a copy of the enrollee’s ID card – front and back – to put in the enrollee’s file.
- The billing person or service will need this information also!
- Medicaid enrollees covered through the Magellan of Florida program are not subject to co-payments or deductibles.
Collection of fees directly from a Medicaid enrollee may result in termination as a participating Provider. This includes charges for non-covered services, and missed appointments.

The exception to this rule would be if the enrollee understands the service he or she is requesting is not a service covered by Magellan of Florida and agrees, in writing, to pay for this service.
Details of the Prepaid Mental Health Program – Expectation for Organizations to become Accredited

- It is a requirement of AHCA for contracted organizational providers to be accredited within two years of initiation of the contract.
- Start now – it usually takes a year or more to go through the entire process.
- Magellan will assist those organizations who are not currently accredited
Transition of Care & Authorization Procedures
Child Welfare Prepaid Mental Health Plan
Transition of Care - Inpatient and CSU

- Care Management will identify enrollees currently in treatment by obtaining list from AHCA.
- Care Managers will do outreach to hospitals and CSUs to assist with discharge planning and management transition to Magellan of Florida.
- Care Managers will offer prospective authorizations for cases likely to continue beyond February 1.
- Care Management staff can be reached at 800-327-5542 beginning February 1.
Transition of Care – STFC and TGC

- All requests for authorization of STFC and TGC must be made by the CBC
- Care Managers will do outreach to CBCs in February and March to:
  - conduct concurrent reviews
  - assist with discharge planning
  - manage transition to the PMHP
  - review children who are on wait lists
Transition of Care-Community Mental Health Services – TBOS, PR, TCM

- Providers/CBCs submit Transition Review Forms (TRFs) according to the following schedule:
  - TBOS: February
  - PR: March
  - TCM: May
- This form can be faxed to 443-896-1550
- Care Managers review the TRFs and enter authorizations
- Authorization letters sent to provider
- All claims will be paid without an authorization for enrollees in that service prior to February 1 until the end of the month in which the TRFs are due
Transition of Care-Routine Outpatient Services

- Routine outpatient services do not require authorization when provided by a network provider.
- Magellan will identify enrollees who are currently in treatment with out-of-network providers to develop transition plans to in-network providers.
Authorization Procedures-Enrollees Beginning Treatment on or after February 1

- **Inpatient/CSU**
  - All authorizations are completed between the provider and Magellan
  - Preauthorization is required, please contact 800-327-5542
  - Concurrent reviews will be conducted telephonically

- **STFC/TGC**
  - All authorizations are completed between the CBC and Magellan
  - Preauthorization is required
  - Concurrent reviews will be conducted telephonically

- **TBOS/Psych Rehab/Targeted Case Management**
  - Preauthorization is required
  - Continued care requests are completed using the web-based Request for Rehab Auth form

- **Routine OP**
  - No authorization required
Utilization Management
Utilization Management – Services that Require Authorization

- Acute Inpatient Hospitalization
- Crisis Stabilization Unit
- Specialized Therapeutic Foster Care
- Therapeutic Group Care
- Psychiatric Electroshock Therapy
- Psychological Testing
- Targeted Case Management
- Psychosocial Rehabilitative Services
- TBOS
- Respite
Utilization Management – Services that Do Not Require Authorization

- Outpatient Hospital Care
  - Emergency Room
  - Psychiatric Clinic
  - Psychiatric Visit/Individual Therapy

- Outpatient Mental Health Services
  - ITP Development and Modification
  - Evaluation and Assessment Services, including CBHA
  - Medical and Psychiatric Services
  - Mental Health Counseling/Therapy Services
  - Crisis Intervention and Post Stabilization Care Services
Utilization Management – How Are Non-Authorizations Communicated?

- Our care managers authorize services based on medical necessity; if they do not believe the request meets medical necessity, they will discuss with the CBC; if Magellan and the CBC do not agree, they refer to one of our Physician Advisors (PA).
- The PA will contact the attending physician to discuss the case and get more information. After reviewing the care manager’s information and talking with the attending physician, the PA will render a decision.
- This decision is provided verbally (if an acute service) and in writing. Written notification of a non-auth decision for services requiring telephonic review are sent within 72 hours or 1 business day (whichever is shorter).
Utilization Management- Medical Necessity Criteria

- Services by a provider to identify or treat an illness that has been diagnosed or suspected. The services are:
  - Consistent with the diagnosis and treatment of a condition; and the standard of good medical practice.
  - Required for other than convenience and
  - The most appropriate supply or level of service.
Utilization Management-Medical Necessity Criteria…continued

- For Inpatient Services:
  - “medically necessary” requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care be effectively furnished more economically on an outpatient or by an inpatient provider of a different type.
Utilization Management – What if I Don’t Agree With the Non-Auth Decision?

There is an appeals process

- Magellan supports the right of enrollees and their providers acting on the enrollee’s behalf to appeal adverse clinical determinations.
- Magellan notifies enrollees of how to appeal and offers assistance in completing forms or other procedural steps.
- Magellan of Florida will ensure that punitive action is not taken against a provider who files an appeal on an enrollee’s behalf.
Utilization Management – How to Begin the Appeals Process:

- The enrollee or provider may file an appeal orally by calling Magellan of Florida at 800-327-5542 or in writing to:

  Magellan of Florida
  7400 NW 19th Street
  Suite C
  Miami, Fl 33126
Utilization Management – The Appeal Process – What Happens After An Appeal Is Filed?

- An Appeal must be filed with Magellan within 30 days when Magellan sends a written notice of action.
- An appeal can be filed within one year if Magellan does not send a written notice of action.
- The Appeal will be immediately forwarded to the Magellan of Florida Grievance and Appeals Coordinator for investigation and resolution.
- Clinical issues will be referred to the Medical Director, Physician Advisor not previously involved in the case.
- The Appeal process can be expedited for urgent appeals, with resolution no more than 72 hours after receipt of the expedited request. This may be extended by up to 14 calendar days if the enrollee requests the extension or Magellan documents that there is need for additional information and that the delay is in the enrollee’s interest. Urgent appeals may be requested by calling Magellan of Florida at 800-327-5542.
Utilization Management – Psychological Testing

- Psych Testing Requires Pre-Authorization.
- Psych Testing Authorization Process and Guidelines are available on the website at www.magellanhealth.com
- Psych Testing Request form and instructions are available on the website
- Testing Request forms may be faxed to 443-896-1550 or mailed to Magellan of Florida at 7400 NW 19st St., Suite C, Miami, FL 33126
- Authorization for Psych Testing will be based on Medical Necessity.
Utilization Management - Treatment Record Review

- Records are randomly selected for review.
- Request for records are sent via mail to practitioner.
- Records are blinded to ensure HIPPA compliance.
- TRR tool used for review, data collection.
- TRR tools are available on the Magellan website.
- Records are reviewed and scored; practitioners are sent their score via mail.
- CAP (Corrective Action Plan) will be requested if provider scores below 70%.
- Consultation provided to practitioner.
- Records shredded.
Enrollee Rights and Responsibilities:

- Can be found on the web at www.Magellanhealth.com under “I’m a provider/forms”.
- Must be signed by the enrollee and in the record.
- Must be posted visibly in your office.
- Enrollees have been sent their Enrollee handbook which also has a version of the Enrollee Rights and Responsibilities.
Utilization Management – Advance Directives

- Follow Magellan and Medicaid policy
- Providers must maintain written policy and procedures concerning advance directives with respect to individuals receiving medical care by or through the contractor. This is a state mandate.
- Florida providers can access this document via the Dept of Children and Families website: http://www.dcf.state.fl.us/mentalhealth/laws/mhadvdir.pdf
- Keep copy of advance directive in the enrollee’s record, a copy is also included in your packet.
Utilization Management – Clinical Practice Guidelines

Clinical Practice Guidelines provide network providers with the most current standards for evidence-based practices. There are eight CPG’s in which PMHP providers must comply:

- Acute Stress Disorder & Post-Traumatic Stress Disorder
- ADHD
- Bipolar
- Depression
- Eating Disorders
- Managing Suicidal Patients
- Treatment of Obesity
- Panic Disorder, Schizophrenia and Substance Use Disorders.
How to Submit Clean Insurance Claims
Claim Tips -DO-

- Do Give Complete Information on the Member
  - Provide complete information for items such as the member’s name, birth date, sex. Verify that this information matches the patient’s ID card. Watch out for name variations and changes. Errors and omissions of these items can cause an unnecessary delay in processing the claim.

- Do Give Complete Information on You, the Provider
  - Provide complete information regarding the provider, including the names of both the treating provider and the billing entity. The taxpayer identification number for the billing entity must be given for the claim to be processed correctly. The billing or remittance address must be accurate for the check and/or Explanation of Benefits to be sent to the correct party. Medicare encounter reporting standards require us to collect and report the UPIN of the rendering provider. The degree level of the provider of service is needed to determine reimbursement amounts.
Claim Tips -DO-

- **Do be sure that the Claim Form is Signed by the Treating Provider**
  - It is important that the treating provider sign the claim form to verify that the services performed by the provider are accurately reflected in the services reported. The provider is legally responsible for the contents of the claim once the claim form is signed. Do not give a signed claim form to the member to complete.

- **Do include the Complete Diagnosis**
  - If the patient has more than one Axis I diagnosis, please be sure to report all diagnoses on the claim. The diagnosis must match the authorization and the revenue code (for facilities) or CPT codes (for professional services).

- **Do list each Date of Service for each Procedure Code**
  - Since we link the dates of care authorized with the dates given on the claim, we cannot accept dates of service combined together under “from” and “through” dates. Each date of service must be shown separately. It is permissible to use “from” and “through” date fields for two dates of care only, such as:

    | FROM | THROUGH | #DAYS/UNITS |
    |------|---------|-------------|
    | 4/1/06 | 4/2/06 | 2           |

  - By doing so, we are able to see each date of service. Any more than two service dates on one line will delay processing.
Claim Tips -DON’T-

- Don’t use Invalid Procedure or Diagnosis Codes
  - Only use current code sets (CPT, HCPCS, Revenue, and ICD-9) and select the code and diagnosis that most accurately describe the service provided.

- Don’t forget to include the Authorization Number
  - Always be sure to include the authorization number that appears on the authorization letter. If the billed services involve more that one authorization, be sure to list all the applicable authorization numbers and specify which billing dates pertain to each authorization.

- Don’t reduce your charge by the Co-Payment or Co-Insurance amounts paid by the member
  - Always show the full charge on the claim. The amount that is reimbursed is based on the lesser of the billed charge of the applicable fee schedule.

- Don’t omit information on the claim because you have already provided it on the treatment plan
  - For confidentiality purposes, claims examiners do not have access to member treatment plans; therefore, it is necessary for you to give information on the claim that you may have already provided on the treatment plan. To assist with prompt claims processing, please be sure to provide all information required on the claim form. Do not submit treatment plans with claim forms. Treatment plans must be sent to the CMC that authorized the services.
Claim Forms

- Claims for inpatient services and facility programs are to be submitted on a UB 92.
- Claims for individual professional procedures and services are to be submitted on a CMS 1500.
- Standard data elements are required for both of these forms.
Unclean claim denials

- The top four reasons claims are denied as unclean are:
  - Missing CPT code
  - Missing DX code
  - Missing Place of service code
  - Missing Name & degree level of provider
- Missing DX Code (field 21)
- Missing Place of Service Code (field 24B)
- Missing CPT Code (field 24D)
- Missing Name & Degree Level of Provider (field 31)
UB 92 Claim Form

- Missing DX Code (field 67)
- Missing Name & Degree Level of Provider (field 83)
Reminders – quick list

- Send your claim form to the Magellan address listed on the member’s ID card or check with the Care Management Center for correct address.
- Make sure member’s name appears just as it is on the ID card.
- Include member ID number.
- Make sure dates of service are within authorization period.
- Make sure the number and type of sessions submitted for payment are within the authorization parameters.
- Make sure diagnosis and CPT codes are correct and match the services authorized and rendered.
- Identify the service provider including degree level.
- File claim within timely filing limits.
Electronic Submissions
Child Welfare Prepaid Mental Health Plan
Electronic Submission Options

- **Clearinghouses**
  - Act as middle man between the provider and Magellan, can transform non-HIPAA compliant format to compliant 837.
  - Questions regarding rejected claim issues other than items related to member, provider or PO Box - call clearing house’s help desk. Questions related to member, provider, PO Box number, or understanding rejection reports, contact Magellan at 800-450-7281 or the Magellan number listed on the back of the member’s ID card.
  - Magellan accepts 837 transactions from the following clearinghouses:
    - PayerPath MedAvant (ProxyMed)
    - THIN Emdeon (WedMD)
    - Navimedix
    - And any clearinghouse who submits to one of these five.
  - There may be charges from the Clearinghouse.

- **Claims Courier**
  - Web Based data entry application for providers submitting professional claims at Magellanhealth.com
  - Contracted Magellan provider can gain access to the online claim submission application by clicking the “New User” link and following the instructions. If the application fails to recognize the provider, contact the Provider Services Line at 1-800-788-4005.
  - Questions regarding rejected claim issues or rejection reports, contact Magellan at 800-450-7281. Questions regarding claims adjudication, contact Magellan at the number listed on the back of the member’s ID card.
  - Streamlines the process by eliminating the middle man and there is no charge.

- **Direct Submit**
  - HIPAA compliant 837 files can be sent directly to Magellan.
  - Magellan is developing a web based application for self-service certification of 837 files.
  - Streamlines the process by eliminating the middle man.
  - Questions regarding rejected claim issues or rejection reports can contact Magellan at 800-450-7281. Questions regarding claims adjudication should phone Magellan at the number listed on the back of the member’s ID card.
  - No charge.
Tips for successful submission

- In addition to your TIN, include your MIS numbers.
- The same mail-in PO Box number listed on the member’s ID card is also utilized when submitting a claim via the Web Based Claim’s Courier application.
- The rendering provider and or group/facility name must match exactly with information loaded in Magellan’s system to avoid delays and possible rejection.
- Use HIPAA compliant 837 format
- Use HIPAA compliant codes (ICD-9, CPT, POS, modifier)
- Verify member eligibility against Magellan website
- Work your exception reports. If a claim is rejected, it has not been accepted by Magellan. Proof of submission of a rejected claim is not proof of timely filing.
Clearinghouse Contact Information

- **Payerpath**
  Address: 9030 Stony Point Pkwy Suite 440
  Richmond, VA 23235
  Phone: 877-623-5706
  Website: [www.payerpath.com](http://www.payerpath.com)

- **MedAvant Healthcare Solutions (formerly ProxyMed)**
  Address: 1854 Shackelford Court, #200
  Norcross, GA 30093
  Phone: 800-586-6870
  Website: [www.medavanthealth.com](http://www.medavanthealth.com)

- **THIN**
  PO Box 833905
  Richardson, TX 75083-3905
  Phone: 877-334-8446
  Website: [www.thinedi.com](http://www.thinedi.com)

- **Emdeon (formerly WebMD)**
  One Century Place
  26 Century Blvd, Suite 601
  Nashville TN 37214
  Phone: 615-885-3700
  Website: [www.webmdenvoy.com](http://www.webmdenvoy.com)

- **NaviNet**
  Address: 4001 Office Court Drive Building 200
  Santa Fe, NM 87507
  Phone: 1-800-526-7276
  Fax: 505-982-3904
  Website: [www.navinetclaims.com](http://www.navinetclaims.com)
Additional Information

- Magellan’s EDI website: www.edihippa@magellanhealth.com
- Contacts
  - EDI Help Line 800-450-7281 ext 75890
  - Provider Line 800-788-4005
Website Overview
Welcome

This website makes it easier for providers to find the information they need most. Here you can access everything you had through MagellanProvider.com and more.

Online Tools:
The following forms and tools are available without Sign In.

- Request More Sessions Online
- Download Provider Practice Info Form (141K PDF)
- Adobe Reader is required to view PDF files.

Available exclusively to Magellan in-network providers, you can now:

- Check Member Eligibility
- Check Authorizations
- Submit a Claim Online
- Check Claims Status
- Check Credentialing Status
- Check Contract Status
- Check Rates
- Display/Edit Practice Info

Sign in is required.
Self Service Tool Functions

- Eligibility Inquiry
- Authorization Inquiry
- Claims Inquiry
- Claims Courier (CMS 1500 Submission)
- Service Request Form (SRF)
  - Will be available soon!
- Provider Data Change Form
User ID and Passwords

- Contracted Groups and Agencies:
  - User ID: 9 digit Group MIS number
  - Default Password at Initial Login: The year 2003 + last four digits of Tax ID. (Example, if the last four digits of your TIN are 1234 your initial login will be 20031234)
  - Default Password after Initial Login: Group Administrator 4 digit Birth Year + last four of Tax ID.
User ID and Passwords

- Individually Contracted Providers
  - User ID: 9 digit MIS number
  - Default Password: 4 digit Birth Year + last four of Tax ID.
User ID and Passwords

- Group Providers & Other Office Staff:
  - Have Group Administrator grant access for additional users under “Administrator Setup”
  - UserID: Assigned by Administrator
  - Default Password: 4 Digit Birth Year + Key Number (last four of SSN recommended)

- Passwords can be reset on-line or by a network representative at 800-297-7821.
Check Member Eligibility

You are logged in as an internal user to view this account. No data in any application will be submitted.

Check Member Eligibility (Eligibility Inquiry):

Search to determine if a member is eligible for your services.

NOTE: Payment of benefits is subject to the member's eligibility on the date of service and any other contractual provisions of the plan. To assure compliance with state mandates, please follow the pre-authorization instructions on the member's health insurance card.

First Name: *  Last Name: *  Date of Birth: (MM/DD/YYYY)
Member Number

Search

Return to MyPractice Page
Check Claims Status
Check Claims Status

Check Claims Status (Claim Report) ::

This screen displays claims that matched your search criteria. View Details and Help offer more information.

Search Criteria
Provider TIN No.: 340129578
Service From: 1/1/2004
Service To: 5/31/2004

47 Records Found

<table>
<thead>
<tr>
<th>Magellan Claim No.</th>
<th>Member Name</th>
<th>Provider Name</th>
<th>Dates of Service</th>
<th>Total Billed Amt</th>
<th>Total Paid Amt</th>
</tr>
</thead>
<tbody>
<tr>
<td>VRN7091770 View Details</td>
<td>PATTY OFURNITURE</td>
<td>Martin John Storey</td>
<td>05/01/2004 05/02/2004</td>
<td>$1,275.00</td>
<td>$175.00</td>
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<tr>
<td>VRN7091401 View Details</td>
<td>JOHNNY COSMICO</td>
<td>Martin John Storey</td>
<td>03/31/2004 03/31/2004</td>
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<td>CARI ONSIR</td>
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<td>JANE OKAMPER</td>
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**Check Claims Status**

### Magellan Claim No.: VRN7091770

**Member Information**
- **Member Name:** PATTY OFURTURE
- **Member DOB:** 06/24/1947
- **Gender:** M
- **Member No.:** 001234567

**Subscriber Information**
- **Subscriber Name:** PATTY OFURTURE
- **Subscriber No.:** 001234567

**Provider Information**
- **TIN No.:** 340129570
- **Billing:** Rendering
- **Provider Name:** Martin John Storey

**Client/Plan Information**
- **Name:** NEW YORK VERIZON (CTE) PATRIOT V PLEX PLAN

### Claim Summary Information
- **Claim Number:** VRN7091770
- **Total Billed Amt.:** $1,275.00
- **Total Paid Amt.:** $175.00
- **Adjudication Date:** 04/09/2004
- **Provider Check No.:** 157063
- **Check Date:** 04/10/2004
- **Payment Method:** Check

### Line 1 of 1
- **Line Number:** 5
- **Beginning Date:** 05/01/2004
- **End Date:** 05/31/2004
- **Procedure Code:** 50853
- **Status Category Code:** E1
- **Status Code:** 104
- **Status Date:** 04/10/2004
- **Deductible:** $200.00
- **Copay/Cos/Per Diem Amt.:** $5.00
- **Interest Amt.:** $0.00
- **Other Ins Paid Amt.:** $0.00
- **Total Paid Amt.:** $35.00
- **Provider Paid Amt.:** $35.00
- **Subscriber Paid Amt.:** $0.00
- **Procedure:** 50853
- **Modifiers:** A3
- **Diagnosis Code:** 003.90
- **Units:** 1
- **Reason Code:** 00, 00, 00
- **Revenue Code:**
Check Claims Status

- View EOB -- New Function
  - Adobe Reader version of actual EOB & Check.
  - Applies to claims processed after 12/1/2004.
Submit A Claim Online

Magellan is pleased to offer professional claim submission for professional services. This online application is designed as a tool to both submit and manage claims submitted through the Claims Courier.

- Magellan will only accept claims for which Magellan both manages and pays claims.
- We cannot accept institutional claims (UB92) or data feeds from provider billing software through this website. If you wish to use your billing software or if you wish to submit institutional claims (UB92) electronically, please contact one of our contracted clearinghouses.
- If you wish to view adjudicated claims status, you can check claims status through My Claims.
Submit A Claim Online

Submit a Claim (Claims Courier):

The P.O. Box to which you would submit paper claims is **required** for proper payment. If you are unsure of the appropriate P.O. Box for this claim, please refer to your authorization letter.

If the P.O. Box to which you submit claims is not accepted by Claims Courier, it is likely the claim may be paid by a payer other than Magellan.

Identify Provider TIN/MIS Association

Provider TIN/MIS: 340129578 STOREY, MARTIN JOHN (111111000)

Enter the P.O Box to which you would submit a paper claim.

P.O. Box No.: 2008  Verify

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<thead>
<tr>
<th>P.O. Box</th>
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<tr>
<td>2008</td>
<td>Blue Cross Blue Shield of Georgia (BCBS GA)</td>
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Continue  Clear Form

Return to Welcome Page | Submitted Claims List
Submit A Claim Online
[View Submitted Claims Option]
Check Contract Status

Displayed below are the most recent versions of your Magellan agreements and amendments.

STOREY, MARTIN JOHN 11111 000

<table>
<thead>
<tr>
<th>Contract</th>
<th>Effective Date</th>
<th>Expiration Date</th>
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<tbody>
<tr>
<td>Magellan Individual Agreement</td>
<td>05/24/2004</td>
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<tr>
<td>Magellan Group Agreement</td>
<td>06/28/2004</td>
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<tr>
<td>PhysAdv Agreement</td>
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<td>03/01/2004</td>
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Child Welfare PMHP Contacts

- Care Management/Customer Service: 800-327-5542
- Murphy Leopold/General Manager: 305-717-5315
- Gail Reyes/Sr Area Contract Manager: 423-843-2002
  - grreyes@magellanhealth.com
- April Sharpe/Network Manager: 305-717-5343
  - aysharpe@magellanhealth.com
- Collette Cummings/Regional Network Director: 678-319-3836; cxcummings@magellanhealth.com
- Dan England/Account Manager: 239-573-7455
- 800# Provider line 800-297-7821 for Website training
Provider Orientation On Line

- Additional provider orientation materials are available online at
- Providers who take this on-line orientation will receive a free CPT code book