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I. Program Description

Prestige Health Choice L.L.C. is dedicated to providing healthcare services exclusively to low-income families and people with disabilities. Our mission is to operate a Provider-Centric Managed Care Company with an emphasis on efficient-cost effective, quality of care in community markets. Prestige Health Choice L.L.C. serves eligible Medicaid members. Medicaid is the state and federal partnership that provides health coverage for selected categories of people with low incomes. Its purpose is to improve the health of people who might otherwise go without medical care for themselves and their children. Medicaid is different in every state. Our goal is to provide high quality service, support and expertise to member organizations and to act as a vehicle for strategic efforts that strengthen our community health partners.

Prestige Health Choice is a step ahead of the rest with the FQHC "medical home" model. We strive to improve preventive primary care services and early prenatal care by closing the gaps in a fragmented service system building a personalized care management program for unmanaged health problems. In addition:

- Encouraging stable, long-term relationships between providers and members;
- Discouraging medically-inappropriate use of specialists and emergency rooms;
- Committing to community-based safety-nets and community outreach;
- Enhancing quality improvement mechanisms;
- Involving providers in an integrated healthcare delivery system; and,
- Encouraging the provider network to become involved with positive health outcome measures and regular measurement of member satisfaction.

We are dedicated to the vision of improving access to care for our members and partnering with our providers to build a better healthcare model. Prestige Health Choice brings extensive experience in Medicaid managed care operations and is committed to supporting our providers in every aspect of providing high, quality care to its Members.

II. Provider Assistance

A provider may contact Prestige Health Choice's Provider Services Department where dedicated staff is available to answer questions, assist in filing a provider complaint, inquire about claim status and help resolve any other issues. Provider Services Representatives are available anytime between 8 a.m. to 7 p.m. Eastern Time, Monday through Friday, excluding State Holidays. A message can also be left after hours that will be returned on the next business day. The Provider Services telephone contact information is as follows:

Provider Services at 1-800-617-5727

III. Covered Services

All services must be provided according to the Florida Medicaid Services Coverage and Limitations Handbooks and Prestige Health Choice Provider Manual.

Any modification to covered services will be distributed via a provider update by mail, fax, provider newsletter, provider manual addendums and/or contractual amendments. Covered services include the following list:

- Child Health Check-Up
- Limited Adult Dental Services – See page 10 for description of service limitations
- Family Planning Services
- Freestanding Dialysis Centers
- Hearing Services
- Home Health Services and Durable Medical Equipment
- Independent Laboratory and X-Ray Services
- Inpatient Hospital Services
- Obstetrical Services
- Outpatient Hospital and Emergency Services
- Physician Services
- Prescribed Drug Services
- Therapy Services
- Vision Services
A. Behavioral Health Services

Prestige Health Choice provides behavioral health services for members through PsychCare. For complete information regarding behavioral health services, please contact PsychCare directly at 888-642-7567. For eRegistrations online, go to www.psychcare.com.

B. Excluded Services

Enrollees who require services available through Medicaid but not covered under Prestige Health Choice may receive the services through the Medicaid fee-for-service system. Providers may refer to Prestige Provider Services who will make the determination of need and subsequent referral to the appropriate service provider. This includes all children’s dental services and some adult dental services including dentures.

Enrollees who need assessment and referral for long-term care institutional services, institutional services for persons with developmental disabilities, or state hospital services must be disenrolled and referred by Prestige Health Choice to the appropriate service provider.

C. Moral or Religious Objections

If a provider elects not to provide counseling or referral service because of an objection on moral or religious grounds, the provider must notify Prestige Health Choice in writing within 5 working days after signing the provider contract of those services he is unable or unwilling to provide.

D. Emergency Service Responsibilities

Prestige Health Choice members are not required to obtain prior approval for emergency services, including emergency room (ER) visits and emergency admissions. ER services are available to our members 24 hours a day, seven days a week. Enrollees can seek care from a participating or non-participating provider for emergency care.

An “emergency” or “emergency condition” refers to a severe medical or behavioral health condition or symptoms, the onset of which is sudden. The condition is characterized by symptoms of sufficient severity (including severe pain) that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to:

- Place the health of the afflicted person in serious jeopardy, or in the case of a behavioral health condition, place the health of the afflicted person or others in serious jeopardy;
- Cause serious impairment to the afflicted person’s bodily functions;
- Cause serious dysfunction of any bodily organ or part of the afflicted person; or

If a member is admitted following an emergency room visit, the hospital is required to notify Prestige Health Choice of the emergency hospital admission within the next business day.

E. Urgent Care

Primary Care Providers (PCP) are expected to provide care for members who experience an illness or injury that is less serious than an emergency, but requires prompt services to avoid significant impairment of health and well-being. If the primary care physician is not available, Enrollees may seek care for acute, urgent conditions at “urgent care” Centers.

F. Out of Area Urgent Care

Prestige will reimburse providers for urgent care provided outside of the Prestige Health Choice service area. Urgently needed services are covered in the United States (U.S.), the Commonwealth of Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands. Providers must furnish their specialty, license number and date of birth when billing for services and submit claims using the appropriate forms.

G. Financial Responsibility

When Prestige Health Choice or a delegated entity of Prestige (such as the member’s PCP, a participating specialist, or a contracted vendor) refers a member for any covered service from a participating or non-participating provider, the member is, by law, exempt from any financial liability. If Prestige determines that a referral was inappropriate, Prestige is required to address the situation directly with the referring provider but to hold the member harmless.

H. Child Health Check-Up Program Services and Standards

A Child Health Check-up (CHCUP) should be performed by a physician to assess the health status of a Medicaid recipient under the age of 21 in order to identify any existing medical conditions and to coordinate indicated treatment or therapeutic services.

The CHCUP should include a comprehensive health and developmental history, comprehensive unclothed physical examination, developmental assessment; laboratory testing (including blood lead testing), nutritional assessment, health education,
(including anticipatory guidance), dental screening (including the fluoride varnish from birth to three(3) years including the fluoride varnish from birth to three(3) years and including a direct referral to a dentist for Enrollees beginning at three (3) years of age or earlier), vision screening, including objective testing as required, hearing screening, diagnosis and treatment, and referral and follow-up as appropriate.

Lead screenings for all members must be done at twelve (12) and twenty-four (24) months of age. In addition, if there is no record of lead screening, members between the ages of 24 months and 72 months of age should also be screened. Members who’ve been identified with abnormal levels of lead must be provided case management follow-up services.

The CHCUP Program also includes immunizations, depending on the age and history of the child. Prestige Health Choice suggests the appropriate immunizations according to the Recommended Childhood Immunization Schedule for the United States.

In addition to the check-up, PCPs should:
- Inform the member when the check-up is due in accordance with the periodicity schedule specified in the Medicaid CHCUP Handbook.
- Refer the member as indicated by the result of the check-up to the appropriate provider for further assessment and/or treatment within four (4) weeks of these examinations.
- Offer assistance in the appointment schedule, e.g., obtaining state-provided transportation or interpretation services.

I. Quality Benefit Enhancement Services

Prestige shall make a good faith effort to work with the following agencies and community organizations to coordinate access to already established Quality Enhancement (QE) services:

- Healthy Start Coalitions
- Children’s Health Department
- Early Intervention Programs
- Local domestic violence agencies
- United Way
- Human Services Coalition
- Community Hospitals
- Federally Qualified Health Centers

Providers can contact Provider Services at 1-800-617-5727 to receive information on obtaining these services for their members. Members may contact Member Services directly at 1-888-611-0786 to receive information on obtaining these services. QE services shall be made available to all Members, regardless of age or gender. Examples of such services include: Stop Smoking, Drug and Alcohol Abuse, and Domestic Violence.

Providers will receive annual training from the Provider Relations Department concerning the availability of QE services. Also, please visit our website www.prestige-healthchoice.com for additional information and updates.

J. Expanded Coverage Services

Prestige Health Choice has elected to provide the following Covered Services that exceed those required under the AHCA contract requirements.

I. Expanded Dental Benefits – available to PHC Enrollees ages 21 and over ONLY

a. Benefits:
   i. Scheduled oral examinations and cleanings – 2 per year
   ii. Dental X-rays – one set each two years
   iii. Amalgam Restorations:
      1. One surface
      2. Two surfaces
      3. Three surfaces – Limited to one per year
   iv. Extractions
      1. Simple – Limit four per year
      2. Surgical – Limit two per year

b. These services are obtained by calling Managed Care of North America (MCNA) at 1-877-495-6262.

c. Covered benefits are limited to the listed in-office procedures performed by MCNA network dentists.

d. Unlisted procedures may be obtained through the MCNA Network at a 25% discount off usual and customary fees. These fees are the responsibility of the enrollee and are not covered by PHC.

e. Specialty dental services (oral surgeon, endodontist, periodontist, and orthodontist) may be obtained through the MCNA Network at a 25% discount off usual and customary fees. These fees are the responsibility of the enrollee and are not covered by PHC.

II. Expanded Outpatient Facility Therapy Benefits

a. Benefits: PHC Enrollees ages 21 and over are eligible to receive the same outpatient facility therapy benefits (speech, occupational and physical) covered for those enrollees under the age of 21.

b. Coverage is subject to a determination of medical necessity.

c. These services are obtained by faxing a prior authorization request to Prestige Utilization Management at 1-800-338-4195.

III. Over-the-counter expanded drug benefit, not to exceed twenty dollars ($20.00) per household, per month.

a. This benefit is limited to nonprescription drugs containing a national drug code (“NDC”) number, first aid supplies and birth control supplies.

b. Qualifying items can be obtained from all network pharmacies.

c. Qualifying items are to be obtained from the pharmacy counter and will be processed through the prescription adjudication system.

IV. Newborn Circumcisions

a. Newborn circumcisions are covered during inpatient delivery stay.
IV. Provider Complaint System

A. Submission of Provider Complaints

Prestige Health Choice participating providers may register a complaint by phone or in writing.

*There are three types of provider complaints with different filing requirements:*

1) Policy-related Complaints

All complaints disputing the policies, procedures or any aspect of the administrative functions of Prestige Health Choice must be submitted in writing. The written complaint must be filed no later than 45 calendar days from the date the provider becomes aware of the issue generating the complaint.

Provider policy-related complaints may be filed in writing to:

**Prestige Health Choice, LLC.**
Attn: Provider Services Department
P.O. Box 6019
Hauppauge, NY 11788

2) Utilization Management-related Complaints

Providers have 30 days from the original utilization management decision to file a complaint regarding the utilization management decision. These complaints must be filed in writing and sent to:

**Prestige Health Choice, LLC.**
Attn: Provider UM Complaints
4944 Parkway Plaza Blvd. Suite 110
Charlotte NC, 28217

3) Claims-related Complaints

Providers have 120 days from a claim denial to file a provider complaint. Complaints filed after that time will be denied for untimely filing. There is no second level consideration for cases denied for untimely filing. If the provider feels they have filed their case within the appropriate time frame, they may submit proof. Acceptable proof of timely filing will only be in the form of a registered postal receipt signed by a representative of Prestige Health Choice, or similar receipt from other commercial delivery services.

There are two types of claims-related provider complaints – those requiring review for medical necessity and those dealing only with claims payment issues.

All complaints concerning claims payment issues must be filed in writing.

a. Medical-necessity related provider complaints about claims

If the provider complaint regarding claims payment requires review for medical necessity, all medical records and supporting documentation necessary for the review should be sent directly to:

**Prestige Health Choice, LLC.**
Attn: Provider Claims Complaints
4944 Parkway Plaza Blvd. Suite 110
Charlotte NC, 28217

The decision on the complaint will be based entirely on the submitted medical records – Prestige will not request additional records or information to evaluate the complaint.

b. Claims Payment Complaints

Any provider complaint regarding claims payment that does not require review for medical necessity must be sent to the Provider Services Department at the following address:

**Prestige Health Choice, LLC.**
Attn: Provider Services Department
P.O. Box 6019
Hauppauge, NY 11788

All provider complaints will be thoroughly investigated using applicable statutory, regulatory and contractual provisions, collecting all pertinent facts from all parties and applying Prestige Health Choice’s written policies and procedures. Prestige Health Choice will also ensure that the appropriate decision makers with the authority to implement corrective action are involved in the provider complaint process. Prestige Health Choice shall provide a written notice of the outcome of the review to the provider.

A provider may also contact Prestige Health Choice’s Provider Services Department where dedicated staff is available to answer questions, assist in filing a provider complaint and resolve any issues. They are available anytime between 8 a.m. to 7 p.m. Eastern Time, Monday through Friday, excluding State Holidays, or leave a message after hours that will be returned on the next business day. The Provider Services telephone contact information is as follows:

Provider Services at 1-800-617-5727

Prestige Health Choice is not responsible for payment for medical records generated as a result of a provider complaint. Any invoices received by Prestige Health Choice for such charges will be redirected to the provider.

Complaints received without the necessary documentation will be denied for lack of information.

Prestige Health Choice will send an acknowledgement letter upon receipt of a letter of complaint. Prestige Health Choice has 45 days to review the complaint for medical necessity and conformity to Plan guidelines and contractual obligations. During this time, Prestige Health Choice may request additional information from the provider in order to complete a review of the complaint. At the conclusion of the review, the provider will receive a written decision with an explanation for the decision.
B. Submission of Provider Termination Appeal Request

If a provider termination is initiated by Prestige Health Choice, regardless of whether the termination is for cause or not, Prestige Health Choice will notify the provider of the termination decision in writing, via certified mail, citing the reason for the termination (if any). Prestige will notify the Provider at least 60 days in advance of the effective date of a contract termination “without cause” unless a longer time frame is specified in the provider’s contract. Providers will be informed as to their right to appeal the action and the process and timing for reconsideration of the termination decision. The appeal request must be filed within 30 days of receipt of Prestige Health Choice’s termination notice. Prestige Health Choice will send an acknowledgement letter to the provider within five business days of receipt of the appeal request.

Prestige Health Choice may request additional information from the provider in order to review the appeal. If this is the case, the provider has 10 business days to submit the required documentation. If not received within 10 business days, Prestige Health Choice will continue to process the appeal. A panel will review the appeal request and upon determination send an outcome letter to the provider stating that the appeal has been overturned or upheld.

C. Termination Overturn

If Prestige Health Choice overturns the termination of the provider, Prestige Health Choice will ensure that there is no lapse in the period of the provider’s participation with Prestige Health Choice.

D. Termination Upheld

If Prestige Health Choice upholds its termination of the provider, Prestige Health Choice will notify the member 30 days prior to and no later than five business days after the termination effective date of their assigned PCP. The members will be requested to select a new PCP within 30 days. If a member does not respond, a new PCP will be assigned to the member. The member will be notified in writing of their new PCP and given a choice to change their PCP by contacting Member Services.

Prestige Health Choice will also notify members who have been seen two or more times within the past 12 months, of the termination of a participating hospital, specialist or a significant ancillary provider within the service area 30 days prior to and no later than five business days after the termination effective date.

E. Provider Dispute Claim Resolution

If a provider does not agree with the final decision of Prestige Health Choice, they have the right to request a review by the Florida Provider and Managed Care Organization Claim Dispute Resolution Program for all claims with date(s) of service after October 1, 2000. Currently, the contracted review agency is Maximus. Information regarding the Florida Appeals Process is available through their toll-free telephone number 1-800-356-8151.

V. Enrollee Grievance System

Prestige Health Choice maintains a member and provider grievance system that includes:

- An appeal process (standard & expedited),
- A grievance process, and
- Access to the Medicaid fair hearing system.

An appeal is a request for review of some action taken by or on behalf of Prestige Health Choice. For a member appeal, the member may file the appeal, or a provider, acting on behalf of the member and with the member’s written consent, may file an appeal.

Examples of actions that can be appealed include, but are not limited to, the following:

- Denial or limited authorization of a requested service, including the type or level of service;
- The reduction, suspension or termination of a previously authorized service;
- The denial, in whole or in part, of payment for a service; and,
- The failure to provide services in a timely manner, as defined by the state.

A grievance is a complaint about any matter other than an action that can be appealed. A member may file a grievance and a provider, acting on behalf of the member and with the member’s written consent, may file a grievance. Under no circumstances, will Prestige Health Choice take any negative action towards anyone filing an appeal or grievance.

Prestige Health Choice will ensure that decision-makers on grievances and appeals were not involved in previous levels of review or decision making. These decision makers are health care professionals with clinical expertise in treating the member’s condition/disease, or have sought advice from providers with expertise in the field of medicine related to the request, when deciding any of the following:

- An appeal of a denial based on lack of medical necessity
- A grievance regarding denial of expedited resolution of an appeal
- A grievance or appeal involving clinical issues
A. Appeals Submission Process

1. A member or provider (acting on behalf of the member) must submit a request either verbally or in writing within thirty (30) calendar days of the date of the notice of action to Prestige Health Choice.

2. If Prestige Health Choice did not issue a written notice of action, then the member or provider (acting on behalf of the member) may file an appeal within one (1) year of the date of the action.

3. If filed verbally, the request must then be followed up with a written, signed appeal submitted to Prestige Health Choice within 10 working days.

4. For verbal filings, the time frames for resolution begin on the date the verbal filing was received by Prestige Health Choice.

5. If the member wishes to use a representative (including the physician), then he/she must complete an Appointment of Representative statement. This form is located in the Forms section of this manual.

6. The member and the person who will be representing the member must sign the statement.

Prestige Health Choice will make a determination on an appeal within the following time frames:

- **Expedited Request**: 72 hours
- **Standard Request**: 30 calendar days
- **Retrospective Request**: 45 calendar days

Appeals must be submitted in writing to:

Prestige Health Choice
Grievance and Appeal Department
P.O. Box 19709
Charlotte, North Carolina 28219-9709

Or by Toll-free Telephone to:

888-611-0786

Or by Toll-free Fax to:

800-338-4195

B. Continuation of Benefits Process

Members have the right to request continuation of benefits during an appeal or Medicaid Fair Hearing. The member may be liable for the cost of any continued benefits if Prestige Health Choice’s action is upheld.

Prestige Health Choice will continue the member’s benefits if the appeal is filed timely, meaning on or before the later of any of the following:

- **Within 10 calendar days of the date on the Notice of Action** (add five calendar days if the Notice is sent via U.S. mail);
- **The intended effective date of Prestige Health Choice’s proposed action**;

AND:

- The appeal involves the termination, suspension or reduction of a previously authorized course of treatment;
- The services were ordered by an authorized provider;
- The authorization period has not expired; and
- The member requests extension of benefits.

If Prestige Health Choice continues or reinstates member benefits while the appeal is pending, the member’s benefits will be continued until one of following occurs:

- The member withdraws the appeal;
- Ten (10) calendar days pass from the date of Prestige Health Choice’s adverse plan decision and the member has not requested a Medicaid Fair Hearing with continuation of benefits until a Medicaid Fair Hearing decision is reached. (add five calendar days if the Notice is sent via U.S. mail);
- A Medicaid Fair Hearing decision adverse to the member is made; or,
- The authorization expires or authorized service limits are met.

C. Request for Determinations for Appeals

1. Expedited

A request for an expedited determination may be made verbally by calling the Grievance and Appeal Department telephone number or by writing to the Grievance and Appeal Department.

The request must state that it is a request for “an expedited process” and list reasons why the case should be expedited.

A provider, acting on behalf of the member, may file a verbal request for an expedited determination without the necessity to submit the written consent of the member.

In order to meet criteria for expedited review, it must be shown that applying the standard review timeframes could seriously jeopardize the member’s life, health or ability to regain maximum function.

A request for payment of a service already provided to a member is not eligible to be reviewed as an expedited reconsideration. Prestige Health Choice will make a determination within 72 hours from receipt of the request for an expedited appeal. Prestige Health Choice will make reasonable efforts to notify the member verbally and will also notify the member in writing of the disposition of their request.

2. Denial of Expedited Request

If Prestige Health Choice denies the request for the expedited determination, then Prestige Health Choice will automatically transfer the request to the standard process and then make its determination as expeditiously as the member’s health condition requires but no later than 45 calendar days from the date Prestige Health Choice received the request for expedited reconsideration.
3. Request for Standard Determination
In the event a provider wishes to file an appeal on behalf of a member, the provider and member must complete an Appointment of Representative statement, which can be found in the Forms section of the Provider Manual, to request a standard determination.

Prestige Health Choice will make a determination and provide written notice of the resolution of the Appeal within 45 calendar days from the date of receipt of the standard request.

4. Request for Retrospective Determination
The provider and member must complete an Appointment of Representative statement, which can be found in the Forms section of the Provider Manual, to file a request for a retrospective determination.

Prestige Health Choice will make a determination and provide written notification within 45 calendar days from the date of receipt of the retrospective request.

5. 14-Day Extension
The Expedited, Standard and Retrospective Determination periods may be extended by up to 14 calendar days, if the member requests an extension or if Prestige Health Choice justifies a need for additional information and documents how the extension is in the interest of the member.

If an extension had not been requested by the member, Prestige Health Choice will provide the member with written notice of the reason for the delay.

6. Denial Upheld
If Prestige Health Choice upholds its initial action and/or denial, then the member, member’s representative or provider will be notified in writing of the decision as well as any additional appeal rights that are available.

7. Reversal of Denial
If Prestige Health Choice overturns its initial action and/or denial, it will notify the member and provider verbally and in writing. Prestige Health Choice will authorize or provide the disputed services promptly, and as expeditiously as the member’s health condition requires, if the services were not furnished while the appeal was pending and the decision is to reverse a decision to deny, limit, or delay services. Prestige Health Choice will also pay for disputed services, in accordance with state policy and regulations, if the services were furnished while the appeal was pending and the disposition reverses a decision to deny, limit or delay services.

8. Grievance Submission Process
A member or provider, acting on behalf of the member, may file a grievance either verbally or in writing within one year following the event leading to the grievance. A verbal request may be followed up with a written request, but the time frame for resolution begins the date Prestige Health Choice receives the verbal filing.

If the member wishes to appoint another person as his/her representative, he/she must complete an Appointment of Representative statement. The member and the person who will be representing the member must sign the statement. This form is located in the Forms section of the Provider Manual. Prestige Health Choice will ensure that punitive action is not taken against a provider who files or supports a grievance on a member’s behalf.

Prestige Health Choice will send an acknowledgement letter upon receipt of a grievance and must make a determination on the grievance within the following time frames:

- Standard Request: 60 calendar days
- Prestige Health Choice will give members reasonable assistance in completing forms and other procedural steps, including but not limited to, providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability. Members will be provided reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing.

Grievances must be submitted in writing to:

Prestige Health Choice
Grievance and Appeal Department
P.O. Box 19709
Charlotte, North Carolina 28219-9709

Or by Toll-free Telephone to:

888-611-0786

Or by Toll-free Fax to:

800-338-4195

9. Grievance Determination
A grievance will be investigated, determination made and closure letter sent to the complainant, and AHCA upon request, within 60 calendar days of receipt of the request.

The closure letter will include the results and date of the grievance resolution, and for decisions not wholly in the member’s favor, will include:

- Notice of the right to request a Medicaid Fair Hearing within 90 days;
- Information on how to request a Medicaid Fair hearing, including the Department of Children and Families (DCF) address for pursuing a fair hearing, which is Office of Public Assistance Appeals Hearings, 1317 Winewood Boulevard, Building 5, Room 203, Tallahassee, FL 32399-0700;
- Notice of the right to continue to receive benefits pending a hearing;
- Information about how to request the continuation of benefits;
- Notice that if Prestige Health Choice’s action is upheld in a hearing, the member may be liable for the cost of any continued benefits;
- Notice that if the appeal is not resolved to the satisfaction of the member, the member has one year in which to request review of Prestige Health Choice’s decision concerning the appeal by

Prestige Health Choice
10. Grievances Filed Against Provider

If a member files a grievance against a provider in reference to the quality of care or service provided, Prestige Health Choice will fax and mail a request to the provider for a response. The provider is given 10 business days to respond and submit medical records for review. If a provider has not responded within 10 business days, a second fax and letter is sent giving an additional five business days to respond.

Continued failure to respond may result in the provider's panel being closed to new patients and/or will be interpreted that the provider does not disagree with the member's issue.

The Chief Medical Officer, together with the Director of Quality Management and others as appropriate, will make a determination as to whether the grievance merits further investigation and referral to the Credentials/Peer Review Committee. Quality Management staff may be instructed to obtain additional information in reference to the allegations (such as medical records) to assist in this determination.

Prior to referral to the Credentials/Peer Review Committee, the CMO will inform the Provider that an allegation has been made, the facts alleged, and that the matter is going to be considered by the Credentials/Peer Review Committee. The provider will be given an opportunity to submit a written response to the allegations.

If no quality issue is identified, the case is entered into Prestige Health Choice's database for tracking and trending purposes.

11. 14-Day Extension

The Grievance determination period noted above may be extended by up to 14 calendar days, if the member requests an extension or if Prestige Health Choice justifies a need for additional information and documents how the extension is in the interest of the member. If an extension is not requested by the member, Prestige Health Choice will provide the member with written notice of the reason for the delay.

D. Medicaid Fair Hearing

The member has the right to request a Medicaid Fair Hearing in addition to pursuing Prestige Health Choice's grievance process. If the Medicaid Fair Hearing Process is chosen, the member waives his/her further rights to appeal to the Beneficiary Assistance Program. The provider, acting on behalf of the member and with the member's written consent, may also request a Medicaid Fair Hearing.

Parties to the Medicaid Fair Hearing are Prestige Health Choice staff, the member and his/her representative or the representative of a deceased member's estate and state staff. The member, the representative or provider may only request a Medicaid Fair Hearing within 90 days of the date of the notice of action and/or denial. The request must be sent to DCF at the following address:

**Office of Public Assistance Appeals Hearings**
1317 Winewood Boulevard
Building 5, Room 203
Tallahassee, FL 32399-0700

Prestige Health Choice will continue the member’s benefits while the Medicaid Fair Hearing is pending if:

1. The Medicaid Fair Hearing is filed timely, meaning on or before the latter of the following:
   a. Within 10 calendar days of the date on the notice of action (add five calendar days if the notice is sent via U.S. mail).
   b. The intended effective date of Prestige Health Choice's proposed action.

2. The Medicaid Fair Hearing involves the termination, suspension or reduction of a previously authorized course of treatment;
3. The services were ordered by an authorized provider;
4. The authorization period has not expired; and
5. The member requests extension of benefits.

If Prestige Health Choice continues or reinstates the member’s benefits while the Medicaid Fair Hearing is pending, the benefits will be continued until one of the following occurs:

1. The member withdraws the request for Medicaid Fair Hearing.
2. Ten days pass from the date of Prestige Health Choice's adverse plan decision and the member has not requested a Medicaid Fair Hearing with continuation of benefits until a Medicaid Fair Hearing decision is reached (add five days if the notice is sent via U.S. mail).
3. A Medicaid fair hearing decision adverse to the member is made.
4. The authorization expires or authorized service limits are met.

Prestige Health Choice will authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires, if the services were not furnished while the Medicaid Fair Hearing was pending and the Medicaid Fair Hearing officer reverses a decision to deny, limit, or delay services.

Prestige Health Choice will pay for disputed services, in accordance with state policy and regulations, if the services were furnished while the Medicaid Fair Hearing was pending and the Medicaid Fair Hearing officer reverses a decision to deny, limit, or delay services.

Prestige Health Choice will not take punitive action against a provider who requests a Medicaid Fair Hearing on the member's behalf or supports a member's request.

E. Beneficiary Assistance Program

The member may, after completing Prestige Health Choice's Grievance and Appeal process, appeal to AHCA or the
VI. Fraud And Abuse

Examples of Fraud and Abuse include requesting authorization or billing for services that are not medically necessary; billing for services that were not provided; or providing services in type or amount that were not medically necessary.

If you know or suspect fraud or abuse has occurred, please let us know. Call the Prestige Fraud and Abuse Line toll free at 1-866-337-2821 at any time and leave a message. Or write to us at PO Box 19709, Charlotte, NC 28219-9709.

The Bureau of Medicaid Program Integrity at the Agency for Health Care Administration audits and investigates providers suspected of overbilling or defrauding Florida’s Medicaid program, recovers overpayments, issues administrative sanctions, and refers cases of suspected fraud for criminal investigation.

VII. Medical Necessity Standards And Practice Guidelines

Medical Necessity Standards

Services that include medical or allied care, goods or services furnished or ordered to:

1. Must be provided under the following conditions:
   • Be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain;
   • Be individualized, specific and consistent with symptoms or confirm diagnosis of the illness or injury under treatment and not in excess of the patient’s needs;
   • Be consistent with the generally accepted professional Medical standards as determined by the Medicaid program, and not be experimental or investigational;
   • Be reflective of the level of service that can be furnished safely and for which no equally effective and more conservative or less costly treatment is available statewide; and

2. Medically necessary or medical necessity for those services furnished in a hospital on an inpatient basis cannot, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

3. The fact that a provider has prescribed, recommended or approved medical or allied goods or services does not, in and of itself, make such care, goods or services medically necessary, a medical necessity or a covered service/benefit.

VIII. Practice Protocols And Clinical Guidelines

Prestige Health Choice providers will adopt practice guidelines that meet the following requirements:

• Are based on valid and reliable clinical evidence or a consensus of Health Care Professionals in a particular field;
• Consider the needs of the Enrollees;
• Are adopted in consultation with Providers; and
• Are reviewed and updated periodically, as appropriate (see 42 CFR 438.236(b)).

The guidelines are reviewed and updated on a periodic basis by the Quality Performance and Improvement Committee. The following Clinical Practice Guidelines will be used:

• Adult Health Maintenance Standards;
• Pediatric Health Maintenance Standards – Child/Teen;
• Pre/Post-Natal Care Standards; and
• Disease-specific care guidelines.
IX. Authorization Procedures During A Declared Disaster

Prestige is committed to delivering medically necessary services to its members during a disaster. In the event a member presents to a provider during such time, the following rules apply:

- All covered medical services, if ordered or recommended by a participating provider, will be approved and claims for these services paid during a time in which the member and/or provider was unable to contact Member Services.
- Most “urgent” or “emergent” hospital admissions will be approved and claims for these services paid during a time in which the member and/or provider was unable to contact Member Services regardless of whether or not the hospital was a contracted provider.
- Early refill of prescriptions (an additional two weeks supply in most cases or up to 30 days if ordered by AHCA) and a waiver of prior authorization pre and post the disaster.

X. Primary Care Provider Responsibilities

The network primary care provider (PCP) is responsible for the complete care of his or her members, whether providing directly or by referral to the appropriate provider of care within the network and as such, accepts all associated case management responsibilities.

1. The PCP is the coordinator of all care. Therefore, the PCP agrees to ensure continuity of care to Prestige Health Choice members and arranges for the provision of services when the PCP’s office is not open. Documentation of ER visits, hospital discharge summaries or operative reports are to be obtained by the PCP and maintained in the medical record.

2. The PCP or OB Provider is responsible for notifying the Prestige Utilization Management Department by fax at 800-338-4195 when they identify a pregnant member. The fax notification should include the member’s name, ID number, and due date. A sample form that can be faxed is included in the forms section of this manual.

3. All providers must provide 24 hour a day/7 days a week coverage, and regular hours of operation must be clearly defined and communicated to the members, including arranging for on-call and after-hours coverage. Such coverage must consist of an answering service, call forwarding, provider call coverage or other customary means approved by AHCA. The after hours coverage must be accessible using the medical office’s daytime telephone number and the call must be returned within thirty (30) minutes of the initial contact.

4. All financial arrangements must be made between the PCP and covering physician. The PCP is also responsible for notifying Prestige Heath Choice in writing (two weeks prior to his/her absence) of the duration of the absence and the physician who will be providing the coverage. The covering physician must be a network physician.

5. The provider agrees to practice in his/her profession ethically and legally, provide all services in a culturally competent manner, accommodate those with disabilities and not discriminate against anyone based on his/her health status.

6. All Florida Healthy Kids PCPs must be board-certified pediatricians or family practice physicians.

7. The PCP must conduct a health assessment of all new enrollees within 90 days of the effective date of enrollment. The PCP is responsible for notifying Prestige if unable to contact the member to arrange the initial assessment with 90 days.

8. When clinically indicated, the provider agrees to contact Prestige Health Choice members regarding appropriate follow-up of identified problems, abnormal laboratory, radiological or other diagnostic findings.

9. The PCP must establish office procedures to facilitate the follow-up of member referrals and consultations. The PCP is responsible for obtaining and maintaining in the medical record, the results or findings of consultant referrals. If findings were communicated through telephonic consultation, a summary of the findings and name of the specialist must be documented.

10. The provider agrees to submit an encounter for each visit where the provider sees the member or the member
receives a HEDIS (Health Plan Employer Data and Information Set) service.

11. The provider must participate in any system established by Prestige Health Choice to facilitate the sharing of medical records (subject to applicable confidentiality requirements in accordance with 42 CFR, Part 431, Subpart F, including a minor’s consultation, examination and drugs for STDs in accordance with Section 384.30 (2), F.S.).

12. The provider agrees that when the need arises to contact Prestige Health Choice regarding interpretive services via AT&T or other service for members who may require the service.

13. If a new provider is added to a group, Prestige Health Choice must approve and credential the provider before the provider may treat members. Notification of changes in the provider staff is the responsibility of the provider’s office and must be communicated to Prestige Health Choice in writing.

14. The provider agrees to maintain a ratio of members to full time equivalent (FTE) physicians as follows:
   - One physician shall not exceed a comprehensive patient load of 1,500; each physician extender (ARNP or PA) may increase comprehensive patient load by 750 patients, not to exceed 3000 patients per physician. The PCP must certify to Prestige Health Choice whether or not his or her active member load exceeds 3,000 during the application and re-credentialing process.

15. The provider agrees to participate and cooperate with Prestige Health Choice in quality management, utilization review, continuing education, peer review and other similar programs established by Prestige Health Choice.

16. The provider agrees to participate in and cooperate with Prestige Health Choice’s grievance and appeal procedures when Prestige Health Choice notifies the provider of any member complaints or grievances.

17. Balance billing for a covered service is not permitted.

18. A member may not be billed for co-payments, nor may a provider charge a member of Prestige Health Choice for missed appointments.

19. In the event that a provider’s agreement with Prestige Health Choice is terminated, the provider must continue care in progress during and after the termination period for up to six months until a provision is made by Prestige Health Choice for the reassignment of members. Pregnant members can continue receiving services through postpartum care. Payment for covered services under this continuity of care period will be made in accordance with the rates effective in the provider’s participating agreement at the time of termination.

20. PCPs are required to maintain malpractice insurance acceptable to Prestige Health Choice, which will protect the PCP and his/her employees. This information is verified by obtaining a copy of the malpractice insurance fact sheet from the PCP or from the malpractice insurance carrier. If not carrying malpractice insurance (“going bare”) the PCP must conform to the notification requirements contained in Section 458.320, F.S.

21. The provider must comply with all applicable federal and state laws regarding the confidentiality of member records.

22. The provider agrees to develop and have an exposure control plan in compliance with OSHA standards regarding blood borne pathogens.

23. The provider agrees to establish appropriate policies and procedures to fulfill obligations under the Americans with Disabilities Act (ADA).

24. The provider agrees to support and cooperate with Prestige Health Choice’s Quality Management Program to provide quality care in a responsible and cost-effective manner.

25. The PCP agrees to provide HIV counseling and offer HIV testing to all members of childbearing age.

26. The PCP agrees to refer pregnant women or infants to Healthy Start and WIC programs.

27. The PCP agrees to provide counseling and education in support of Medicaid Quality and Benefit Enhancement (QBE) services which include: children's programs, domestic violence, pregnancy prevention (including abstinence), prenatal/postpartum care, smoking cessation and substance abuse. The PCP agrees to include information on the programs and community resources encouraged by Prestige Health Choice.

28. The PCP agrees to provide counseling and offer the recommended anti-retroviral regimen to all pregnant women who are HIV-positive and to refer them and their infants to Healthy Start programs, regardless of their screening scores.

29. The PCP agrees to offer screening for Hepatitis B surface antigen to all women receiving prenatal care. If they test positive, the PCP agrees to refer them to Healthy Start regardless of their screening score and to provide Hepatitis B Immune Globulin and the Hepatitis B vaccine series to children born to such mothers.

30. The provider agrees to inform Prestige Health Choice if he/she objects to the provision of any counseling, treatments or referral services on religious grounds.

31. The provider agrees to treat all members with respect and dignity, to provide them with appropriate privacy,
and to treat member disclosures and records confidentially, giving the members the opportunity to approve or refuse their release in accordance with HIPAA and applicable state laws.

32. The provider agrees to provide to the members complete information concerning their diagnosis, evaluation, treatment and prognosis, and to give members the opportunity to participate in decisions involving their healthcare, regardless of whether the member has completed an advance directive, except when contraindicated for medical reasons.

33. The provider agrees to an adequate and timely communication among providers and the transfer of information when members are transferred to other healthcare providers.

34. The provider agrees to obtain a signed and dated release allowing for the release of information to Prestige Health Choice and other providers involved in the member’s care.

35. The PCP agrees to physically screen members taken into the Protective Custody, Emergency Shelter or Foster Care programs by the Department of Children and Families (DCF) within 72 hours or immediately, if required.

36. The provider agrees that provisions will be made to minimize sources and transmission of infection.

37. The provider agrees to maintain communication with the appropriate agencies such as local police, social services agencies and poison control centers to provide quality member care.

38. The provider agrees that any notation in a member’s clinical record indicating diagnostic or therapeutic intervention as part of clinical research will be clearly contrasted with entries regarding the provision of non-research related care.

39. The PCP is encouraged to participate with Florida’s Immunization Registry (SHOTS).

40. The PCP agrees to provide immunization information to the DCF upon receipt of member’s written permission and DCF’s request for members requesting temporary cash assistance from the DCF.

41. The PCP agrees to attempt to obtain medical records on any member(s) receiving services from a non-network provider using the proper release signed by the member. These services include, but are not limited to: family planning, preventive services and sexually transmitted diseases.

42. The PCP agrees to maintain vaccines safely and in accordance with specific guidelines, to provide member immunizations according to professional standards and to maintain up-to-date member immunization records.

43. The PCP for Medicaid members must use their Vaccines for Children Program (VFC) supply. The VFC program covers children from birth to 18 years of age. Florida Medicaid requires vaccines for Medicaid children from birth through 20 years of age. Members 19 through 20 years of age should receive their vaccinations from their PCP and will be reimbursed at the applicable Medicaid rate.

XI. Responsibilities Of Specialists

Specialists are responsible for treating Plan members referred to them by the PCP and communicating with Prestige Health Choice for any necessary authorizations. Specialists may not refer to another Plan specialist.

A. Specialist as a PCP

Under certain circumstances, a specialist may be approved by Prestige Health Choice to serve as a member’s PCP when a member requires the regular care of the specialist. The criteria for a specialist to serve as a member’s PCP include the existence of a chronic, life-threatening illness or condition of such complexity whereby:

- The need for multiple hospitalizations exists;
- The majority of care needs to be given by a specialist; and
- The administrative requirements arranging for care exceed the capacity of the PCP. For example, this would include members with complex neurological disabilities, chronic pulmonary disorders, HIV/AIDS, complex hematology/oncology conditions or cystic fibrosis.

- In the event the specialist becomes the primary care provider, they must adhere to primary care HEDIS requirements.

The specialist must meet the requirements for PCP participation (including contractual obligations and credentialing), provide access to care 24 hours a day/7 days a week and coordinate the member’s healthcare including preventive care. When such a need is identified, the member or specialist must contact Prestige Health Choice’s Care Management Department and complete a Specialist as PCP Request Form.

A Prestige Health Choice case manager will review the request and submit it to the Prestige Health Choice Chief Medical
Office. Prestige Health Choice will notify the member and the provider of its determination in writing within 30 days of receiving the request. Should Prestige Health Choice deny the request, Prestige Health Choice will provide written notification to the member and provider the reason(s) for the denial of the request within one day. Specialists serving as PCPs will continue to be paid their contracted rate while serving as the member’s PCP. The designation cannot be retroactive. For further information, see the Specialist as PCP Request Form in the “Forms” section of the manual.

B. Open Access Specialist Providers

Members may self-refer to the network providers listed below without a PCP referral. These providers should establish processes for the identification of member’s PCP and forward information concerning the member’s evaluation and treatment to the PCP after obtaining consent from the member, as appropriate under legal requirements. The number of visits and services that can be provided without authorization may be limited. Check with Prestige Health Choice for specific information.

- Chiropractors
- Podiatrists
- Dermatologists
- Gynecologists for annual Well Woman Exam, any Gynecologic-related complaint and medically necessary follow-up

XII. Use Of Hospitalists

Hospitalists provide attending physician coverage in selected regions for members admitted to contracted hospitals. Hospitalists provide the following services:

- Emergency room assessment of a member;
- Direct admissions to facilities where the PCP may not provide that service;
- Manage care as needed throughout the inpatient medical admission for members, excluding obstetrical cases; and
- Refer members to the PCP upon discharge for follow-up care and communicating the treatment or discharge plan verbally within 24 hours and in writing within seven days.
- Any PCP may manage his own hospitalized patients by informing Prestige Health Choice of this decision.

XIII. Responsibilities Of All Providers

The remainder of this section of the Manual is an overview of responsibilities for which all Plan providers are accountable. Please refer to the Provider Agreement or contact a Provider Relations representative for clarification of any of the following.

Physicians must, in accordance with generally accepted professional standards:

1. Use physician extenders appropriately. Physician assistants (PA) and advanced registered nurse practitioners (ARNP) should provide direct member care within the scope or practice established by the rules and regulations of the state of Florida and Plan guidelines.
2. Assume full responsibility to the extent of the law when supervising physician extenders whose scope of practice should not extend beyond statutory limitations.
3. Clearly identify their titles on their badge or uniform, such as ARNPs and PAs, to members as well as to other health care professionals.
4. Honor at all times any member request to be seen by a physician, rather than a physician extender.
5. Provide treatment for any member in need of health care services within their scope of practice.
6. Refer Plan members with problems outside of his or her normal scope of practice for consultation and/or care to appropriate specialists contracted with Plan.
7. Refer members to participating physicians or providers, except when they are not available, or in an emergency.
8. Admit members only to participating hospitals and other inpatient care facilities, except in an emergency.
9. Respond promptly to Plan requests for medical records in order to comply with regulatory requirements.
10. Inform Prestige Health Choice in writing within 24 hours of any revocation or suspension of his or her DEA number, and/or suspension, limitation or revocation of his or her license, certification or other legal credential authorizing him/her to practice in the state of Florida.
11. Inform Plan in writing immediately of changes in licensure status, tax identification numbers, telephone numbers, addresses, status at participating hospitals, loss of liability insurance and any other change which would affect his or her status with Plan.

12. Not seek compensation or have any recourse against any Plan member for non-covered services furnished on a “fee-for-service” basis, unless a written agreement has been rendered between the member and the provider. Non-covered services are services not covered provided under Florida Medicaid Guidelines.

13. Treat all member records and information confidentially, and do not release such information without the written consent of the member, except as indicated herein, or, or as allowed or needed for compliance with state and federal law.

14. Apply for a Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable.

15. Maintain quality medical records and adhere to all Plan policies governing the content of medical records as outlined in Prestige Health Choice’s Quality Improvement Guidelines. All entries in the member record must identify the date and the provider.

16. Maintain an environmentally safe office with equipment in proper working order to comply with city, state and federal regulations concerning safety and public hygiene.

17. Utilize either disposable equipment or proper sterilization methods for instruments used to perform procedures.

18. Ensure the office staff is trained on the proper use of safety, emergency and fire-extinguishing equipment.

19. Maintain a comprehensive emergency preparedness and evacuation plan on which all office personnel is instructed. Provider should include a provision for the safe evacuation of patients from the premises, particularly those lacking mobility. The emergency plan should also address techniques for cardiopulmonary resuscitation (for organizations where it is appropriate) that are formally reviewed with office staff four times per year. Documentation of such resuscitation drills should be available for at least one of the four performed per year.

20. Have emergency medications on hand (i.e., Epi-pen and Ambu bag at a minimum) in case an emergency occurs while a member is in the office.

21. Communicate clinical information between Plan providers in a timely fashion. Documentation of communication will be evaluated during medical chart review. Upon request, provide timely transfer of clinical information to Prestige Health Choice, the member or the requesting party, at no charge, unless otherwise agreed upon.

22. Preserve member dignity and observe the rights of members to know and understand the diagnosis, prognosis and expected outcome of recommended medical surgical, and medication regimens.

23. Not discriminate in any manner between Plan members and non-Plan members.

24. Fully disclose to members their treatment options and allow them to be involved in treatment planning.

25. Inform member of specific health care needs which require follow-up and provide, as appropriate, training in self-care and other measures members may take to promote their own health.

26. Identify members that are in need of services related to children’s health, domestic violence, pregnancy prevention, prenatal or postpartum care, smoking cessation or substance abuse. If indicated, providers must refer members to plan-sponsored or community-based programs.

27. The provider must document the referral to plan-sponsored or community-based programs in the member’s medical record and provide the appropriate follow-up to ensure the member received the services needed.

28. Maintain eligibility to participate in the Florida Medicaid program, and supply Prestige with Florida Medicaid provider number and complete any forms required by AHCA. Provider understands that Prestige is authorized to take all necessary steps to ensure provider is recognized by Medicaid as a plan provider.

29. A member may not be billed for co-payments, nor may a provider charge a member of Prestige Health Choice for missed appointments.

30. Work with Prestige to comply with all AHCA requirements for complete and accurate encounter data in the ACHA required format.

31. Encourage your staff to promote safety and report any incidents involving our members to us at our Member Services line (1-888-611-0786).

XIV. Interpretive Services

Interpreters and alternative communication systems are available, free of charge, for all foreign languages and vision and hearing impairments when language barriers exist and assistance is needed to effectively communicate the required information to an individual who is visually impaired, hearing impaired or otherwise handicapped; and, the individual was not institutionalized in a correctional facility, mental hospital or other rehabilitative facility. Assistance with interpreter arrangements may be obtained through our Member Services Department. There shall be no charge to the enrollee for translation services.
XV. Covering Physicians

In the event participating providers are temporarily unavailable to provide care or referral services to Plan members, providers should make arrangements with another Plan-contracted and credentialed physician to provide services on their behalf, unless there is an emergency.

In non-emergency cases, should you have a covering physician who is not contracted and credentialed with Prestige Health Choice, contact Prestige Health Choice for approval. The physician should be credentialed by Prestige Health Choice, must sign an agreement accepting the negotiated rate and agree not to balance bill Plan members. For additional information, please contact the Provider Relations Department at 1-800-617-5727.

XVI. Appointment Scheduling

Providers must adhere to the following criteria to comply with state and/or federal availability and access standards:

**Primary Care Providers:**
- Provide medical coverage 24 hours a day, seven days a week.
- See scheduled appointments within 30 minutes of the appointment time.
- Schedule and see emergent appointments immediately.
- Schedule and see urgent appointments within one day.
- Schedule and see routine “sick” care appointments within one week.
- Schedule and see “well” care visits within 30 days of a member’s request.

**Specialty Care Providers:**
- Schedule and see emergent referral appointments immediately.
- Schedule and see routine “sick” care appointments within one week.
- Schedule and see “well” care visits within 30 days of a member’s request.
- Schedule and see urgent referral appointments within one day.
- Schedule and see routine “sick” care appointments within one week.
- Schedule “well” care visits within 30 days of a member’s request.

**Missed Appointments**

The provider will document and follow up on appointments missed and/or canceled by the member. Members who miss three consecutive appointments within a six-month period may be considered for disenrollment from a provider’s panel. Such a request must be submitted at least 30 calendar days prior to the requested effective date. The provider agrees not to charge a member for missed appointments.

XVII. Marketing By Providers

Health Care Providers must adhere to following marketing requirements:

- Health Care Providers may display PHC-specific materials in their own offices.
- Health Care Providers cannot orally or in writing compare Benefits or provider networks among Health Plans, other than to confirm Health Plan network participation.
- Health Care Providers may announce a new affiliation with PHC or give a list of Health Plans with which they contract to their patients.
- Health Care Providers may co-sponsor events, such as Health Fairs, and advertise with the Health Plan in indirect ways; such as television, radio, posters, fliers, and print advertisement.
- Health Care Providers shall not furnish lists of their Medicaid recipients to PHC staff or volunteers, with which they contract, or any other entity, nor can Providers furnish other Health Plans’ membership lists to PHC, nor can Providers assist with PHC Enrollment.
- Health Care Providers may distribute information about non-Health-Plan-specific health care services and the provision of health, welfare and social services provided by the State of Florida or local communities as long as any inquiries from prospective enrollees are referred to the member services section of the health plan or the Agency’s Choice Counselor/Enrollment Broker.
- Health Care Providers may co-sponsor events, such as health fairs and cooperatively market and advertise with Prestige Health Choice in indirect ways, such as TV, radio, posters, fliers, and print ads.
XVIII. Advanced Directives

Members have the right to control decisions relating to their medical care; including the decision to have withheld or taken away the medical or surgical means or procedures to prolong their life. The law provides that each Prestige Health Choice member (age 18 years or older of sound mind) should receive information concerning this provision and have the opportunity to sign an Advance Directive Acknowledgement Form to make their decisions known in advance. This allows members to designate another person to make a decision should they become mentally or physically unable to do so.

Advance Directive forms should be made available in provider’s offices and discussion with the member as well as the completed forms should be documented and filed in the member’s medical record. A provider shall not, as a condition of treatment, require a member to execute or waiver an advance directive.

Sample Living Will and Designation of Health Care Surrogate (Power Of Attorney for Health Care Decisions) forms are included in the Forms section.

XIX. Confidentiality Of Member Information And Release Of Records

All consultations or discussions involving the member, or his or her case, should be conducted discreetly and professionally in accordance with all applicable state and federal laws including the HIPAA Privacy and Security regulations.

All physician practice personnel should be trained on HIPAA Privacy and Security regulations. The practice should ensure that there is: (i) a Privacy Officer on staff; (ii) a policy and procedure in place for confidentiality of members’ Protected Health Information; and (iii) that the practice is following those procedures and/or obtaining appropriate authorization from members to release Protected Health Information as required by applicable state and federal law.

Policies and procedures should include protection against unauthorized/inadvertent disclosure of all confidential medical information to include Protected Health Information.

All members have a right to confidentiality, and any health care professional or individual person who deals directly or indirectly with the member or his or her medical record must honor this right. Every practice is required to provide to members their Notice of Privacy Practice. Employees who have access to member records and other confidential information are required to sign a confidentiality statement.

Some examples of confidential information include:

- Any communication between a member and a physician;
- All Protected Health Information as defined under the federal HIPAA Privacy regulations;
- Any communication with other clinical persons involved in the member’s health, medical and mental care (i.e., diagnosis, treatment and any identifying information such as name, address, Social Security number (SSN, etc.)
- Member transfer to a facility for treatment of drug abuse, alcoholism, mental or psychiatric problem; and
- Any communicable disease (such as Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) testing that is protected under federal or state law.

When an individual enrolls in Prestige Health Choice, federal law permits the health care provider permission to release his or her medical records to Prestige Health Choice, members of the provider network, or agencies conducting regulatory or accreditation reviews, and business associates. The Notice of Privacy Practice (NPP) informs the patient or member of their member rights under HIPAA and how the provider and/or health plan may use or disclose the members’ protected health information (PHI). HIPAA regulations require each provider and health plan to provide a NPP to each new patient or member accordingly.

XX. Care Management

Prestige Health Choice has available case management program services for all members who are at risk for health compromise, have chronic conditions, or have complex conditions that could benefit from the intervention of case management services. Prestige collaborates with members and their health care providers to develop health care plans that will focus on improving and/or maintaining the member’s health status. Referrals can be made by contacting our Care Management Section at 1-888-611-0784 or caremanagement@prestigehealthchoice.com.
The PCP is responsible for determining whether a referral for specialty care or ancillary service is appropriate. Referrals may be required when the member fails to respond to current medical treatment, to confirm or establish a member’s diagnosis and/or treatment modality, or to provide diagnostic studies, treatments, procedures or equipment that ranges beyond the scope of availability of the PCP’s services. Prestige Health Choice does not require an authorization as condition of payment for referrals to network specialists and for routine laboratory testing (laboratory and plain X-rays performed at non-hospital-based outpatient facilities). Certain in-office diagnostic tests and procedures that are considered by the health plan to be a routine part of an office visit may be conducted as part of the initial visit without authorization.

When the PCP determines that a member should be referred to a specialist, the PCP should review the current specialty provider listing to select a Prestige Health Choice network specialist. To authorize the referral, an electronic referral form located on the Prestige Website (http://www.prestige-healthchoice.com/) is completed. If the office does not have access to the on-line version, paper forms are available. A copy of the paper form is included in the forms section of this manual.

The referral form indicates all the services approved to be done by the specialist as well as the number of visits authorized and the duration of the approval.

A copy of this form is provided to the member and a second copy is mailed or otherwise delivered to the specialist’s office. If the specialist must perform testing or procedures that is to be performed outside of their office and/or requires prior authorization, the specialist requests authorization from Prestige UM Department by fax (1-800-338-4195). The Specialist is required to fax a copy of the initial PCP referral for to the UM department along with the prior authorization request.

When the PCP or specialist determines that a member should be referred for a diagnostic procedure, the PCP or specialist should review the current ancillary provider listing to select a network free-standing diagnostic provider. Prestige Health Choice will not authorize coverage of a routine diagnostic procedure performed at a hospital when a free-standing facility is available.

Prior authorization is the process of obtaining approval in advance of a planned inpatient admission or rendering of an outpatient service. Prestige Health Choice will make an authorization decision based on the clinical information provided in the request. Prestige Health Choice may request additional information that may include a medical record review.

Reasons for requiring authorization may include:
- Review for medical necessity
- Appropriateness of rendering provider
- Appropriateness of setting
- Case and disease management considerations

Prior Authorization is required for elective or non-urgent services as designated by Prestige Health Choice. Guidelines for prior authorization requirements by service type and/or code are available by calling Prestige Health Choice, or by referring to the Benefit Grid found in the Providers area of the Prestige Health Choice Website at: http://www.prestige-healthchoice.com/

The prior authorization request should include the patient’s diagnosis (ICD-9), and the CPT code describing the anticipated procedure. If the procedure performed and billed is different from that on the request, but within the same family of services, a revised authorization is not required.

- The attending physician or designee is responsible for obtaining the prior authorization for the elective or non-urgent procedure or admission.
- An authorization is the approval necessary to be granted payment for covered services and is provided only after Prestige Health Choice agrees the treatment is necessary and a covered benefit.
- An Authorization Request form must be completed by the provider in order to obtain an authorization from Prestige Health Choice. A copy of this form is included in the Forms section of the manual. This form may be faxed to 800-338-4195
- This form must be filled out completely and legibly in order to be processed quickly.
- A current and operating fax number with area code must be included in order to receive an authorization number by return fax.

Providers may request a “stat” authorization (for services that are urgent in nature) by:
- Calling Prestige Health Choice (have the member’s name, ID number, diagnosis and service available when calling) at 888-611-0784.
C. Services Requiring No Authorization

Prestige Health Choice has determined that many routine in-office procedures and diagnostic tests may be performed without medical review to facilitate timely and effective treatment of members.

Certain diagnostic tests and procedures that are considered by Prestige Health Choice to be routinely part of an office visit, such as sigmoidoscopy, EKG and plain film x-rays (see Benefit grid - posted on web site).

Any services performed by a County Health Department (CHD), a migrant health center or a community health center for the following:

- Diagnosis and treatment of sexually transmitted diseases and other communicable diseases, such as tuberculosis and human immunodeficiency syndrome;
- Provision of immunizations;
- Family planning and related pharmaceuticals;
- School health services listed above and for services rendered on an urgent basis by such providers; and,
- In the even that a vaccine-preventable disease emergency is declared, any claim from the CHD for the cost of administering the vaccines.

D. Second Opinions

A member or the member’s PCP or specialist may request a second opinion for serious medical conditions or elective surgical procedures. The conditions and/or procedures include, but are not limited to, the following:

- Treatment of serious medical conditions, such as cancer.
- Elective surgical procedures such as hernia repair (simple) for adults (age 18 or older), hysterectomy (elective procedure), spinal fusion (except for children under age 18 with a diagnosis of scoliosis) and laminectomy (except for children under 18 years old with a diagnosis of scoliosis).
- Other medically necessary conditions, including exceptions listed above, as medically necessary.

The second opinion must be obtained from a network provider (see Provider Referral Directory) or a non-network provider, if a network provider is not available, at no additional cost to the member. Prestige Health Choice must pre-authorize the use of a non-network provider for a second opinion. Once approved, the PCP will notify the member of the date and time of the appointment and forward copies of all relevant records to the consulting provider. The PCP will notify the member of the outcome of the second opinion.

Prestige Health Choice may request a second opinion at its own discretion. This may include, but is not limited to, the following reasons:

- Whenever there is a concern about care expressed by the member or the provider;
- Whenever a potential risk or outcome related to the recom-
mended or requested care are discovered by Prestige Health Choice during the regular course of business;
- Before initiating a denial of coverage of service;
- When denied coverage is appealed.

When Prestige Health Choice requests a second opinion, Prestige Health Choice will make the necessary arrangements for the appointment, payment and reporting. Prestige Health Choice will inform the member and the PCP of the results of the second opinion including the consulting provider’s conclusions and recommendation(s).

E. Concurrent Review

Concurrent review activities involve the evaluation of a continued hospital, skilled nursing or acute rehabilitation stay for medical appropriateness, using recognized criteria (such as InterQual). The Concurrent Review Nurse follows the clinical status of the member through telephonic or onsite chart review and communication with the attending physician, hospital UM, Case Management staff or hospital clinical staff involved in the member’s care.

Concurrent review is initiated as soon as Prestige Health Choice is notified of the admission. Subsequent reviews are based on the severity of the individual case, needs of the member, complexity, treatment plan and discharge planning activity. The continued stay will be authorized based on medical appropriateness using InterQual™ criteria including:

- Services provided in a timely and efficient manner;
- Assuring established standards of quality care are met;
- Implementing timely and efficient transfer to lower level of care when clinically indicated and appropriate;
- Implementing timely and effective discharge planning; and
- Identification of cases appropriate for case management.

The concurrent review process incorporates the use of InterQual™ criteria to assess quality of care and the appropriate level of care for continued medical treatment. Reviews are performed by licensed nurses under the direction of Prestige Health Choice’s medical director.

To ensure the request is completed in a timely manner, providers must submit relevant clinical information along with the request for authorization and upon request of Prestige Health Choice’s review nurse. Failure to submit necessary documentation for concurrent review may result in denial of payment for all or part of a hospital or other facility stay.

F. Discharge Planning

Discharge planning begins on admission, and is designed for early identification of medical/psycho-social issues that will need post-hospital intervention. The Concurrent Review Nurse works with the attending physician, hospital discharge planner, ancillary providers and/or community resources to coordinate care and post-discharge services, and facilitate a smooth transfer of the member to the appropriate level of care.
G. Retrospective Review

Retrospective review is performed when a service has been provided, the claim has been submitted and no authorization had been given. Determinations for payment involving health care services that have been delivered will be made within 45 calendar days of receipt of necessary information.

All services are subject to retrospective review. Prior authorization or concurrent review decisions will not be reversed unless Prestige Health Choice receives information that contradicts the information given when the initial determination was made.

H. Criteria for Review Decisions

The Prestige Health Choice uses review criteria that is nationally recognized and based on sound scientific medical evidence to ensure consistent application of review criteria for authorization decisions. Prestige’s Quality and Performance Improvement Committee includes physicians with an unrestricted license in the state of Florida with professional knowledge and/or clinical expertise in the area who actively participate in the discussion, adoption and application of all utilization decision-making criteria on an annual basis.

Prestige Health Choice uses numerous sources of information including, but not limited to, the following criteria when making coverage determinations:

- medical necessity
- member benefits
- local and federal statutes and laws
- InterQual™
- Prestige’s Contract with AHCA
- Medicaid Coverage and Limitations Handbooks

The nurse reviewer and/or medical director apply medical necessity criteria in context with the member’s individual circumstance and capacity of the local provider delivery system. When the above criteria do not address the individual member’s needs or unique circumstance, the medical director will use clinical judgment in making the determination. Providers may request a copy of the criteria used for a specific determination of medical necessity.

I. Standard Prior Authorization

Prestige Health Choice is committed to a 48-hour turn-around-time on requests for prior authorization or pre-certification authorizations. Authorization responses will be sent via fax to the providers’ fax number(s) that are included on the authorization request form. However, by contract, Prestige Health Choice has up to 14 calendar days from receipt of request to determine whether a member’s request for non-urgent services is a medically appropriate and covered service.

An extension may be granted for an additional 14 calendar days if the member or the provider requests an extension or if Prestige Health Choice justifies to the Agency for Health Care Administration (AHCA) a need for additional information and the extension is in the member’s best interest.

For members who voluntarily enrolled or who were automatically re-enrolled after regaining Medicaid eligibility Prestige Health Choice will honor any written documentation of prior authorization of ongoing covered services for a period of 30 business days after the effective date of enrollment or until Prestige Health Choice’s PCP assigned to that member reviews the member’s treatment plan, whichever comes first.

For mandatory assigned Medicaid members, Prestige Health Choice will honor any written documentation of prior authorization of ongoing covered services for a period of one month after the effective date of enrollment or until the PCP assigned to that member reviews the member’s treatment plan, whichever comes first.

Written documentation of prior authorization of ongoing services includes the following, provided that the services were arranged prior to the enrollment with Prestige Health Choice:

1. Prior existing orders
2. Provider appointments, e.g. dental appointments, surgeries, etc. and prescriptions (including non-participating pharmacies)

Prestige Health Choice will not delay Service Authorization if written documentation is not available in a timely manner. Prestige Health Choice is not required to approve claims for which it has not received written documentation.

J. Expedited Service Authorization

In the event the provider indicates, or Prestige Health Choice determines that following the standard time frame could seriously jeopardize the member’s life or health, Prestige Health Choice will make an expedited authorization determination and provide notice within three working days. Prestige Health Choice may extend the three working days time period up to 14 calendar days if the member or the provider requests an extension, or if Prestige Health Choice justifies to AHCA a need for additional information. Requests for expedited decisions for prior authorization should be requested by telephone, not fax.

Members and providers may submit an oral or written request for an expedited decision. To submit an oral or written request the provider needs to notify or call Prestige Health Choice at 888-611-0784 and request an expedited review. For additional contact information, please refer to the Benefit Grid posted in the Provider’s area of the Prestige web site.
The following authorization requests have special requirements required by the state of Florida.

**A. Sterilizations**

The following conditions must be met:

- The individual must be at least 21 years old at the time consent is obtained.
- The member is mentally competent.
- The individual voluntarily gave informed consent in accordance with the provisions of this section, and the properly executed “Sterilization Consent Form” form is filed in the member’s medical record.
- At least 30 calendar days, but not more than 180 calendar days, have passed between the date of informed consent and the date of the sterilization, except in the case of premature delivery or emergency abdominal surgery.
- An individual may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery if at least 72 hours have passed since informed consent for sterilization was signed. In the case of premature delivery, the informed consent must have been given at least 30 calendar days before the expected date of delivery (the expected date of delivery must be provided on the consent form).

**B. Hysterectomies**

The following conditions must be met:

- The properly executed Hysterectomy Acknowledgement form is filed in the member’s medical record.
- The individual is informed, verbally and in writing, prior to the hysterectomy that she will be permanently incapable of reproducing (this does not apply if the individual was sterile prior to the hysterectomy or in the case of an emergency hysterectomy).
- Prior to the hysterectomy, the member/individual and the attending physician must sign and date the Exceptions to Hysterectomy Acknowledgement form except in the case of prior sterility or emergency hysterectomy. This informed consent must be obtained regardless of diagnosis or the member’s (individual’s) age.

Regardless of whether the requirements listed above are met, a hysterectomy shall not be covered under the following circumstances:

- Performed solely for the purpose of rendering a member permanently incapable of reproducing;
- Performed for more than one purpose, but their primary purpose was to render the member permanently incapable of reproducing; or
- Performed for the purpose of cancer prophylaxis.

**C. Abortions**

Abortions are covered services if the provider certifies that the abortion is medically necessary to save the life of the mother or if pregnancy is the result of rape or incest. Prestige Health Choice will cover treatment of medical complications occurring as a result of an elective abortion and treatments for spontaneous, incomplete or threatened abortions and for ectopic pregnancies.

Abortions are not covered if used for family planning purposes.

An Abortion Certification form certifying the above situation must be properly executed is filed in the member’s medical record.

The Sterilization Consent form, the Hysterectomy Acknowledgement form, the Exceptions to Hysterectomy Acknowledgement form and Abortion Certification Form are located in the Forms section. These forms are the forms required by the State of Florida for the reimbursement of sterilizations, hysterectomies and abortions.

NOTE: The forms for Abortions, Sterilization and Hysterectomy are not required for claims reimbursement but may be a Federal requirement for your documentation and medical records.

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**XXIII. Medical Records Standards**

All Prestige Health Choice Providers must maintain Medical Records for each Enrollee in accordance with the standards as listed below:

1. The Enrollee’s identifying information, including name, identification number, and other information as appropriate must be on each page of the medical record;
2. Each record must be legible and maintained in detail;
3. A summary of significant surgical procedures, past and current diagnoses or problems, allergies, untoward reactions to drugs and current medications must be maintained;
4. All entries must be dated and signed by the appropriate party;
5. All entries must indicate the chief complaint or purpose of the visit, the objective, diagnoses, medical findings or impression of the provider;

6. All entries must indicate studies ordered (e.g., laboratory, x-ray, EKG) and referral reports;

7. All entries must indicate therapies administered and prescribed;

8. All entries must include the name and profession of the provider rendering services (e.g., MD, DO, OD), including the signature or initials of the provider. All notes written by physician extenders (ARNPs or PAs) must be co-signed by the assigned PCP, indicating his/her review and approval of the care rendered.

9. All entries must include the disposition, recommendations, instructions to the Enrollee, evidence of whether there was follow-up and outcome of services;

10. All records must contain an immunization history;

11. All records must contain information relating to the Enrollee's use of tobacco products and alcohol/substance abuse;

12. All records must contain summaries of all Emergency Services and Care and Hospital discharges with appropriate medically indicated follow up;

13. Documentation of referral services must be in Enrollee's Medical Records. This is to include but not necessarily be limited to, family planning services, preventive services and services for the treatment of sexually transmitted diseases;

14. All records must reflect the primary language spoken by the Enrollee and any interpretive needs of the Enrollee;

15. All records must identify Enrollees needing communication assistance in the delivery of health care services; and,

16. All records must contain documentation that the Enrollee was provided with written information concerning the Enrollee's rights regarding Advance Directives (written instructions for living will or power of attorney) and whether or not the Enrollee has executed an Advance Directive. Providers can not, as a condition of treatment, require the Enrollee to execute or waive an Advance Directive.

17. Example of the Prestige Health Choice Medical Record Review Form is available in the Forms section of this Provider Manual – page 63.

18. Provider shall prepare, maintain, and dispose all appropriate medical, administrative and financial records covering health care services provided to each Member pursuant to the State and Federal laws.

Confidentiality of Medical Records
Providers will ensure the confidentiality of all medical records in accordance with 42 CFR, Part 431, Subpart F and relevant HIPAA requirements. The confidentiality of a minor's consultation, examination, and treatment for a sexually transmissible disease must be maintained in accordance with s. 384.30(2), F.S.

XXIV. Claims Submission Protocols And Standards

Prestige Health Choice will reimburse providers for the delivery of covered services as follows:

1. Claims are considered received on the date the claims are received by Prestige.

2. Providers must mail or electronically transfer (submit) the claim to Prestige Health Choice within the time frame allowed by their contract (generally 90 days for physicians and 180 days for hospitals)

3. Non-contracted providers must mail or electronically transfer (submit) the claim to Prestige Health Choice within six (6) months of:
   a. The date of service or discharge from an inpatient setting; or,
   b. The date that the provider has been furnished with the Enrollee's correct name and address.

Electronic Claims Submission
Providers have the option of submitting claims electronically through Electronic Data Interchange (EDI). The advantages of electronic claims submission are as follows:

- Facilitated, expedient claims payment
- Acknowledged receipt of claims electronically (through EMDEON -formerly known as WebMD and ProxyMed)
- Improved claims tracking
- Improved claims status reporting
- Improved turnaround time for timely reimbursement
- Eliminated paper
- Improved cost effectiveness
To initiate the electronic claims submission process or obtain additional information please contact EMDEON at 1-800-845-6592.

Prestige Health Choice Payor ID # 45056

Paper Claims Submission
Prestige Health Choice
PO Box 6018
Hauppauge, NY 11788

Prestige Health Choice will reimburse providers for Medicare deductibles and co-insurance payments for Medicare dually eligible members according to the lesser of the following:
1. The rate negotiated with the provider; or,
2. The reimbursement amount as stipulated in s.409.908, F.S.

In accordance with s.409.912, F.S., Prestige Health Choice will reimburse any hospital or physician that is outside its authorized geographic service area for Prestige Health Choice authorized services provided by the hospital or physician to Enrollee:
1. At a rate negotiated with the hospital or physician; or,
2. The lesser of the following:
   a. The usual and customary charge made to the general public by the hospital or physician;
   b. The Florida Medicaid reimbursement rate established for the hospital or physician; or
   c. The local State Medicaid reimbursement rate established for the hospital or physician for out-of-state services.

For appropriate filing information, see “CMS 1500 Claim Forms Instructions” and “UB 04 (or its successor) Claim Form Instructions.” Failure to provide any of the required information can result in payment being delayed.

Prestige Health Choice will ensure that all claims are processed and payment systems comply with the federal and State requirements set forth in 42 CFR 447.45, 42 CFR 447.46, and Ch. 641.3155, F.S., as applicable. These guidelines are designed to be in compliance with the industry standards, as defined by the CPT-4, ICD-9 and the RBRVS handbooks.

XXV. Encounter Data Submission Protocols

If a provider is paid on a capitated basis, encounter data must be submitted to the Plan according to the claim submission standards noted above.

This requirement is mandated to meet the reporting requirements of the Plan, as well as those established by regulatory agencies and the Balanced Budget Act. Under capitation, encounter data is generally submitted in the form of a claim, and such claims are usually referred to as encounter data.

The Plan will record the encounter data received. The Plan recognizes these services as under a capitated contract and will not make payment to the provider.

A capitated provider who does not submit encounter data is subject to corrective action measures and penalties under applicable state and federal law and could be terminated from the Plan.

XXIV. Enrollee Rights And Responsibilities

The Member Services Department is comprised of a multi-lingual staff whose primary responsibility is to help members understand their rights and responsibilities, and the benefits of Prestige Health Choice participation. Some of the department’s key responsibilities include:

- Helping members choose the right primary care physician (PCP)
- Counseling members on the importance of establishing a long-term relationship with their PCP
- Investigating and resolving member inquiries and complaints

Member Services also provides information to members about other programs, such as WIC, food stamps, family counseling and child birth.

Plan members have specific rights and responsibilities. These must be posted in your office for all members to see. Contact a Provider Relations representative for a copy of the Patient Rights and Responsibilities document.

Responsibilities of Enrollee

- Consult their primary care physician for their health care needs, and go to the emergency room only if emergency care is needed.
- Contact their PCP within 48 hours if emergency care is received at a non-participating hospital.
- Keep scheduled appointments or cancel them at least 24 hours in advance.
- Treat medical and administrative staff with courtesy and respect.
- Give accurate medical information to providers so they may render necessary care.
- Follow treatment programs agreed upon with their provider(s).
- Inform Prestige Health Choice about any problems with Prestige Health Choice’s clinical or administrative staff.
- Inform Prestige Health Choice of any change(s) in their contact address or telephone number.

Prestige Health Choice
XXVII. Cultural Competency Plan

Prestige Health Choice understands the importance of meeting the cultural and linguistic needs of our enrolled members. Our cultural competency plan focuses on the assessment of our Members needs and attempts to tailor our network and their encounter experience to those needs. Educational and informational materials about Prestige are available to enrollees and potential enrollees in English and in other languages. Translation services are also available. Other formats for written materials, such as large print, audio tape or Braille, will be available when requested through the Member Services Department - 888-611-0786. Prestige will routinely collect and maintain information on each enrollee when a cultural or linguistic barrier is identified so that alternative communication methods can be made available. This information will be readily available to the Medical/Care Management staff, who will also be trained to ensure effective communication between enrollees and providers.

A complete copy of the Prestige Health Choice Cultural Competency Plan is available through the provider portal of the PHC website. Training tools are available through the HHS, Office of Minority Health, including CEU credits for nurses and physicians. www.omhrc.gov/templates/browse.aspx?lvl=1&lvlID=3

XXVIII. Infection Control Policies

Prevention of the transmission of infection in the physician’s office is an important component of patient care and is of concern to health care providers and patients. Infection Control is an integral component of quality patient care and as such is the responsibility of each employee in provider offices and facilities. Administration shall establish and administer guidelines for the practice setting that facilitate employee compliance. Ambulatory care settings where invasive procedures are performed such as outpatient surgery, endoscopy, dentistry, dialysis and parental therapy may require additional measures. Practices must be tailored to the level of care being provided and the patient population served. Factors that may influence the risk of transmission include patients who are unable to appropriately handle their respiratory secretions, who lack immunity to the infecting agent, who are ill, debilitated or immunocompromised, who have infected open wounds or skin lesions and/or patients with diarrhea who are in diapers or incontinent. The risk of transmission of infection may be less than in a hospital setting but patients may remain in crowded, common waiting rooms for a prolonged period of time and it may not be recognized that a patient has a contagious illness.

Infection prevention and control programs should include the following:

- a hand hygiene program;
- a system of precautions to reduce the risk of transmission of infectious agents (i.e. Standard Practices, Transmission-based Precautions);
- continuing education for health care providers in infection prevention and control;
- a system for detection, investigation and control of health care-associated outbreaks;
- infection prevention and control policies and procedures;
- review of care policies and procedures for practices impacting on infection prevention and control;
- elements of an occupational health program for health care providers related to transmission of microorganisms;
- reportable disease reporting to public health authorities;
- active participation in all phases of facility design and construction/renovation;
- product review and evaluation;
- review of practices for reprocessing of equipment;
- review of practices for environmental cleaning.

RESPONSIBILITY

The responsibility for the implementation of an Infection Control Plan rests with Prestige Health Choice contracted providers, facilities and delegated vendors. Provider Operations will distribute the Infection Control Plan to network providers to use as a reference at initial orientation and at a minimum annually during monthly onsite meetings.
Transmission of Organisms

Four main routes spread organisms

Contact

- **Direct Contact** – transmission occurs when microorganisms are transferred from one infected person to another person without a contaminated intermediate object or person.

- **Indirect Contact** – transmission involves the transfer of an infectious agent through a contaminated intermediate object or person. Contaminated hands of healthcare personnel, equipment and toys are important contributors to indirect contact transmission.

- **Droplet** – respiratory droplets carrying infectious pathogens transmit infection when they travel directly from the respiratory tract of the infectious individual to susceptible mucosal surfaces of the recipient, generally over short distances, necessitating facial protection.

- **Airborne** – transmission occurs by dissemination of either airborne droplet nuclei or small particles from the respiratory tract containing infectious agents that remain infective over time and distance (e.g., spores of *Aspergillus* spp and *Mycobacterium tuberculosis*). Microorganisms carried in this manner may be dispersed over long distances by air currents and may be inhaled by susceptible individuals who have not had face-to-face contact with (or been in the same room with) the infectious individual.

- **Vehicle** an example of vehicle borne transmission is through the use of multi-dose vials.

- **Vectorborne** – transmitted by insects and not likely to be of relevance in a physician office setting.

Standard Practices:

Three principles are inherent in standard practices:

- Hand hygiene
- Personal protective equipment (PPE)
- Safe handling and disposal of sharps

**Hand Hygiene:**

Wash with plain or antimicrobial soap and water:

- When hands are visibly soiled or contaminated with body fluids
- When caring for a patient with diarrhea, including suspected or confirmed *Clostridium difficile* infection

Disposable liquid soap containers are recommended to minimize contamination. If soap containers are reusable they should never be topped up, instead should be washed, rinsed and dried thoroughly prior to refilling. Use of bar soap is discouraged because organisms can grow on the soap and in the water that pools under the soap.

**Personal Protective Equipment:**

Personal Protective Equipment (PPE) includes gloves, gowns, masks and eye protection and is selected based on anticipated exposure. These items are worn to protect the health care worker and the patient and are not to be reused between patients.

**Gloves:** Gloves should be worn for any contact with patients or contaminated articles when direct exposure to blood, body fluids, mucous membranes, non-intact skin and/or undiagnosed rashes may occur. Gloves are **not** necessary for routine activities when contact is limited to intact skin. Allergic reactions to latex have been reported and powdered gloves lead to an increased risk of latex allergy. Patients should also be queried at each visit regarding any known allergies including latex. In the event that the healthcare worker or the patient has an allergy to latex, latex-free gloves must be available.

Non-sterile gloves are used for routine patient care, better fitting ones for procedures that require tactile sensation and sterile gloves should be used for invasive procedures. Gloves must be worn only once and discarded in regular garbage after each patient and/or procedure and hands hygiene performed after glove removal.
Gowns: Gowns are required in the event that secretions, excretions, blood or body fluids are likely to soil the clothing of the healthcare worker.

Masks: Surgical masks that cover the user's nose and mouth provide a physical barrier to fluids and particulate matter. Surgical masks are used to protect either the patient or the health care worker from droplets or splashes. During invasive procedures surgical masks decrease the risk of contaminating the site with droplet- borne organisms from the health care personnel's nostrils and protect the worker from patient infections spread by large droplets.

N95 respirators provide a tight facial seal and filter approximately 95% of particles one micron in size or smaller and maximize protection against airborne infectious agents such as chicken pox and tuberculosis where surgical masks will not.

Eye Protection: Eye protection can be in the form of safety glasses, goggles, splash guards or face shields. Eyeglasses do not provide appropriate protection.

**Safe Handling and Disposal of Sharps**

Needles and other sharp instruments are to be handled with care during use and disposal.

Never recap needles.

Discard needles at the point of use in a puncture-proof, leak-proof container at the point of service.

Replace sharps containers when the fill line is reached.

Sharp containers are to be available where injections or venipunctures are performed, be kept out of the reach of children and should not be overfilled.

Report any injuries with needles or other sharp objects and follow the needle stick policy for post-exposure.

**Injection Safety Policy:**

Failure to adhere to strict safe injection practices during patient care can result in serious consequences such as transmission of blood borne viruses such as hepatitis C, hepatitis B and human immune deficiency virus (HIV) to patients.

Never administer medications from the same syringe to more than one patient, even if the needle is changed.

Never enter a vial with a syringe or needle that has been used for a patient.

Never use a single dose vial for more than one patient.

Multi-use vials to be assigned to one patient if at all possible.

Never use bags of intravenous fluid as a common source of supply for more than one patient.

Adhere to strict infection control protocols when preparing and administering injections.

Date a multidose vial when opened to facilitate discarding within 28 days.

Handle multidose vials to maintain sterility of contents and discard multidose vials if contamination is suspected.

Restrict multidose vials to a centralized medication area if used.

**Environment:**

Medical offices are to be cleaned at the end of the day to include cleaning and disinfecting surfaces, toys and objects with a low-level disinfectant approved for healthcare. Frequently touched surfaces such as examination tables, sinks, light switches, door knobs and telephones are included in the daily schedule. Cloth or plush toys should not be in physician offices because they cannot be cleaned or disinfected. Carpets are not recommended for high traffic areas, waiting rooms, examination or procedure rooms. Cleaning articles soiled with body fluids or body fluid spills requires special attention.

Examining tables should be discovered with disposable paper or cloth that is changed between patients and must be cleaned between patients if soiled.

Separate surfaces/areas for the assembly of clean equipment and the handling of contaminated equipment. Clean equipment must be stored where it will not become contaminated. Each office must identify the tools and equipment used and employees must be trained according to policies and procedures for disinfection, sterilization and cleaning.

Manufacturer’s instructions for appropriate use of cleaning supplies and disinfectants should be followed. Employees should be trained on appropriate use and precautions to prevent hazardous conditions during product application. The products, material safety data sheets (MSDS) provide this information as well as first aid measures in the event of an exposure and must accompany the product and accessible to employees for easy consultation.
Waste Disposal:

Regulated Medical Waste:

Regulated Medical Waste includes:

- Human liquid blood or semi-liquid blood and blood products
- Items that would release liquid or semi-liquid blood if compressed
- Personnel body fluids contaminated with blood, excluding urine and feces
- Sharp objects including needles, needles attached to syringes and blades
- Broken glass or other materials capable of causing punctures or cuts which have come into contact with human blood or body fluids.

General Office Waste: includes all other garbage not listed above and requires no special disposal or removal method.

Recommendations for Medical and Office Waste:

All garbage containers must be waterproof, puncture-resistant and have tight fitting lids, preferably operated with a foot pedal.

Line wastebaskets with the appropriate colored plastic bags.

Do not overfill garbage containers.

Do not place sharp or heavy objects into plastic bags that would cause them to break.

Medical waste must be disposed of regularly to avoid accumulation.

Store medical waste safely in a well-ventilated area that is inaccessible to pests until transported to an appropriate facility for disposal.

Arrange transportation of medical waste to ensure health and environmental safety as per federal, state and local regulations.

Health of Personnel:

Employers are responsible for implementing reasonable measures to minimize the risk of employees acquiring or spreading infection. Health care personnel are susceptible to contracting illnesses from patients and steps should be in place to minimize this from occurring such as but not limited to:

- Triage patients appropriately.
- Practice standard precautions, including hand hygiene before and after each patient contact.
- Use transmission based precautions when appropriate.

Clean and disinfect office space and medical equipment per office policy.

Discard sharps at the point of use and never recap needles.

Encourage up to date immunizations for all employees on vaccine preventable diseases.

Pre-employment tuberculin testing and if negative repeat annually, for known exposure to infectious tuberculosis and if there are clinical symptoms suggesting active tuberculosis.

Employees who are ill must take appropriate action to prevent patients from becoming infected. Scrupulous hand hygiene is essential.

Colds and minor respiratory tract infections are not necessarily criteria for exclusion from work but personnel should contain respiratory secretions and not have contact with high risk patients such as those who are immunocompromised. Employees should evaluate each illness and use good judgment along with following office policy on working with infectious diseases.

Definitions:

Cleaning: The removal of all visible dust, soil, and other foreign material, usually done using water with soaps, detergents or enzymatic products along with physical action, such as brushing. Meticulous cleaning must precede disinfection or sterilization of medical instruments.

Disinfection: A process that kills or destroys nearly all disease-producing microorganisms. Disinfectants are used on inanimate objects. There are three levels of disinfection, defined by the hardness of microorganisms that are to be killed or inactivated:

- High-level disinfection kills vegetative bacteria, tubercle bacillus, fungi, lipid, and non-lipid viruses, but not necessarily high numbers of bacterial spores.
- Intermediate-level disinfection kills vegetative bacteria, most fungi, tubercle bacilli, and most viruses; it does not kill resistant bacterial spores.
- Low-level disinfection kills most vegetative bacteria, some fungi, and some viruses, but cannot be relied on to kill mycobacteria or bacterial spores.

Hand Hygiene: The term “hand hygiene” has replaced hand washing and includes the use of plain or antimicrobial soap with running water, as well as the use of an alcohol-based hand sanitizer.
Infection Prevention and Control: Evidence-based practices and procedures that, when applied consistently in health care settings, can prevent or reduce the risk of transmission of microorganisms to health care providers, other clients/patients/residents and visitors.

Respiratory Hygiene/Cough Etiquette: A new standard of behavior for all individuals who enter any health care setting such as patients, visitors and healthcare personnel which was developed as a result of the 2003 severe acute respiratory syndrome (SARS) epidemic.

Standard Precautions (formerly Universal Precautions): This is the primary strategy for the prevention of healthcare-associated transmission of infectious agents among patients and healthcare personnel. This standard of practice should be followed for the care of all patients, regardless of diagnosis, at all times when handling blood, body fluids, secretions and excretions, mucous membranes, non-intact skin, and undiagnosed rashes. All patients may be potentially infectious, even when asymptomatic.

Sterilization: A process by which all forms of microbial life, including bacteria, viruses, spores, and fungi are destroyed or eliminated, most commonly accomplished in the ambulatory health care setting by steam pressure.

Transmission-based Precautions: These are required for patients presenting with specific clinical symptoms and until the infectious etiology has been confirmed and are determined by the methods of transmission of the microorganisms expected or know to be involved.

XXVIV. General Contact Information


Prestige Health Choice Numbers:

Provider Relations .......................... 1-800-617-5727
Claims ........................................ 1-800-617-5727
Authorizations ............................... 1-888-611-0784
Member Services ............................ 1-888-611-0786
AT&T (hearing impaired) ................. 1-800-662-1220
Care Management (9am-5pm) ........... 1-888-611-0784
Provider Portal Helpline ................. 1-800-617-5727

Other Telephone numbers:

All-Med (DME, Home Health, Home Infusion) 1-800-369-1416
QUEST (Laboratory) .......................... So FL 1-866-697-8378
............................................. No FL 1-866-697-8378
MCNA (Dental) ......................... 1-877-495-6262
Advantica (Vision) ................. 1-877-404-6090
Advanced Care Solutions (Wound Care Supplies) 1-877-748-1977
WellDyneRx (Pharmacy) ................. 1-866-473-5254
PsychCare (Behavioral Health) ........... 1-888-642-7567
Hear X (Audiology and Hearing Aids) ....... 1-800-731-3277
Vaccines for Children (VFC) .......... 1-800-483-2543
Immunization Registry (SHOTS) ........ 1-877-888-SHOT
It’s Great to Wait Pregnancy Prevention Program 1-866-232-3309
Healthy Start Program ................. 1-800-451-BABY
WIC and Nutritional Service ............ 1-800-342-3556
AHCA Complaint Hotline ............... 1-888-419-3456
Hanger (Orthotics and Prosthetics) ....... 1-877-754-6542
XXX. Forms
**MEMBER RIGHTS**

- To be given information about coverage, services, and use of the health plan.
- To receive considerate, respectful care, be treated with human dignity, be provided appropriate privacy and be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- To know the names, titles and credentials of all physicians and other health care professionals involved in your medical treatment.
- To understand your medical condition and health status, recommended course of treatment, alternatives, and risks involved.
- To actively participate in decisions regarding your medical care by having, to the degree known, complete information about your diagnosis, evaluation, treatment, and prognosis.
- When medically inadvisable, to give the information to a person you chose or the legally authorized person.
- To be informed of continuing health care requirements following discharge from the hospital or office.
- To refuse treatment, providing you choose to accept responsibility and the consequences of such a decision.
- To be furnished health care services in accordance with federal and state regulations and to refuse to participate in any medical research projects.
- To have any and all complaints forwarded to Prestige Member Services for appropriate response.
- To have access and/or copies of your medical records, have health information disclosures and records treated confidentiality and have the opportunity to approve or refuse their release, unless required by law, and to request that they be amended or corrected.
- To complete an advance directive.
- To make suggestions for improvement to Prestige.
- To appeal unfavorable medical or administrative decisions by following the established grievance procedures of Prestige and the State.
- To have all the above rights apply to the person having legal authority to make decisions regarding your health care.
- To have all health plan personnel observe your member rights.
- To exercise these rights without regard to sex, age, race, ethnic, economic, educational, or religious background.

**MEMBER RESPONSIBILITIES**

- To understand how Prestige works by reading the Prestige member handbook.
- To carry your Prestige member card and Medicaid card with you at all times. Present them to each provider (doctor, lab, hospital, pharmacy, etc) at the time services are being provided.
- To select and seek all non-emergency care by appointment through your assigned Primary Care Doctor, to obtain a referral from your doctor for specialty care, and to cooperate with all persons providing your care and treatment.
- To be on time for appointments or to notify the doctor’s office well in advance if you need to cancel or reschedule an appointment.
- To be respectful of the rights, property and environment of all health care professionals and staff, other patients, and not be disruptive.
- To be responsible for understanding and following medical advice concerning your treatment and to ask questions if you do not understand or need an explanation.
- To understand the medications you take, know what they are, what they are for, and how to take them properly.
- To provide accurate and complete medical information to all providers as may be required in the course of your treatment, including over the counter products, dietary supplements and any allergies or sensitivities.
- To make sure your current doctor has been provided with copies of all previous medical records.
- To notify Prestige within 48 hours, or as soon as possible, if you are hospitalized or receive emergency room care.
- To inform your provider about any living will, medical power of attorney, or other directive that could affect your care.

To file a complaint or to request more information call the following numbers toll-free:

AHCA Statewide Consumer Telephone Line 888-419-3456
Prestige Health Choice Member Service Line 888-611-0786
# 1 to 14 Day Child Health Check-Up Tracking Form

**Please Print**

<table>
<thead>
<tr>
<th>PERSONAL</th>
<th><em>PERIODIC</em></th>
<th><em>INTERPERIODIC</em></th>
<th><em>PARENT/ CAREGIVER REQUEST</em></th>
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<tr>
<th>NAME (Last)</th>
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<th>ID</th>
<th>DATE OF BIRTH</th>
<th>ACCOMPANIED BY:</th>
<th>RELATIONSHIP</th>
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<tr>
<td>FIRST PREGNATAL VISIT DATE</td>
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<tr>
<td>STDs (specify)</td>
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<td>WEEKS GESTATION</td>
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<tr>
<th>PERINATAL HISTORY</th>
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<tbody>
<tr>
<td>DEFORMITIES/APGAR</td>
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<thead>
<tr>
<th>INTERVAL HISTORY</th>
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<tbody>
<tr>
<td>PAST MEDICAL HISTORY WNL</td>
</tr>
<tr>
<td>DEVELOPMENTAL HISTORY WNL</td>
</tr>
<tr>
<td>BEHAVIORAL HEALTH STATUS WNL</td>
</tr>
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<table>
<thead>
<tr>
<th>NUTRITIONAL ASSESSMENT</th>
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<tbody>
<tr>
<td><em>BREAST</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PHYSICAL EXAM</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEIGHT</td>
</tr>
<tr>
<td>Are the following normal?</td>
</tr>
</tbody>
</table>

### Appearance
- Skin
- Head
- Eyes
- Ears
- Nose
- Mouth/Throat/Teeth/Gums
- Nodes
- Heart
- Lungs
- Abdomen inc. cord
- Fem. Pulse
- Ext. Gen.
- Hip Abduc.
- Extremities
- Spine
- Neuro
- Other

<table>
<thead>
<tr>
<th>LAB TESTS</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>SENSORY SCREEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>NORMAL VISION? (red reflex) <em>YES</em> <em>NO</em> <em>REFERRED</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DEVELOPMENT ASSESSMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>IS DEVELOPMENT NORMAL AGE AND CULTURE? (prone-lifts head, moves arms/legs equally, regards face, moro reflex) <em>YES</em> <em>NO</em> <em>REFERRED</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HEALTH EDUCATION, ANTICIPATORY GUIDANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>INFANT CAR SEAT</em> <em>TALK TO BABY</em> <em>FEVER EDUCATION</em> <em>SAFETY- ROLLING OVER</em> <em>OTHER</em></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>DIAGNOSIS</th>
<th>PLAN</th>
<th>SIGNATURE</th>
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Prestige Health Choice
# 2 Weeks to 2 Month Child Health Check-Up Tracking Form

**Please Print**

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<th>__PERIODIC</th>
<th>__INTERPERIODIC</th>
<th>__PARENT/ CAREGIVER REQUEST</th>
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<tbody>
<tr>
<td>NAME</td>
<td>(Last)</td>
<td>(First)</td>
<td>ID</td>
</tr>
<tr>
<td>DATE</td>
<td>AGE</td>
<td>ACCOMPANIED BY</td>
<td>RELATIONSHIP</td>
</tr>
</tbody>
</table>

## INTERVAL HISTORY

- **PAST MEDICAL HISTORY WNL**
  - Yes
  - No (If no, describe)

- **DEVELOPMENTAL HISTORY WNL**
  - Yes
  - No (If no, describe)

- **BEHAVIORAL HEALTH STATUS WNL**
  - Yes
  - No (If no, describe)

## NUTRITIONAL ASSESSMENT

- __ BREAST__
- __ FORMULA:__
- WIC
  - Yes
  - No
  - Referred
- __ VITAMINS __ IRON __ SOLIDS__

## PHYSICAL EXAM

<table>
<thead>
<tr>
<th>HEIGHT</th>
<th>WEIGHT</th>
<th>HEAD CIRCUMFERENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Are the following normal? Yes No Comments

### Appearance

- Skin
- Head
- Eyes
- Ears
- Nose
- Mouth/Throat/Teeth/Gums
- Nodes
- Heart
- Lungs
- Abdomen inc. cord
- Fem. Pulse
- Ext. Gen.
- Hip Abduc.
- Extremities
- Spine
- Neuro
- Other

### LAB TESTS

### SENSORY SCREEN

- NORMAL VISION? (red reflex)
  - Yes
  - No
  - Referred

- NORMAL HEARING? (responds to noise/startles)
  - Yes
  - No
  - Referred

### DEVELOPMENT ASSESSMENT

- IS DEVELOPMENT NORMAL AGE AND CULTURE?
  - Prone-lifts head, moves arms/legs equally, regards face, moro reflex
  - Yes
  - No
  - Referred

- IMMUNIZATIONS
  - Current
  - Deferred
  - Provided: List

### HEALTH EDUCATION, ANTICIPATORY GUIDANCE

- __ INFANT CAR SEAT __ TALK TO BABY __ FEVER EDUCATION __ SAFETY- ROLLING OVER __ OTHER__

### DIAGNOSIS

<table>
<thead>
<tr>
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# 2 to 4 Month Child Health Check-Up Tracking Form

**Please Print**

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</thead>
<tbody>
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<td>NAME (Last) (First)</td>
<td>ID</td>
</tr>
<tr>
<td>DATE</td>
<td>AGE</td>
</tr>
</tbody>
</table>

**INTERVAL HISTORY**

- **PAST MEDICAL HISTORY WNL** __YES__ __NO__ (If no, describe)
- **DEVELOPMENTAL HISTORY WNL** __YES__ __NO__ (If no, describe)
- **BEHAVIORAL HEALTH STATUS WNL** __YES__ __NO__ (If no, describe)

**NUTRITIONAL ASSESSMENT**

- __BREAST__
- _FORMULA:_
- WIC __YES__ __NO__ __REFERRED__
- _VITAMINS__ _IRON__ _SOLIDS_

**PHYSICAL EXAM**

- **HEIGHT**
- **WEIGHT**
- **HEAD CIRCUMFERENCE**

**LAB TESTS**

**SENSORY SCREEN**

NORMAL VISION? (red reflex) _yes _no _referred
NORMAL HEARING? (responds to noise/startles) _yes _no _referred

**DEVELOPMENT ASSESSMENT**

IS DEVELOPMENT NORMAL AGE AND CULTURE? (prone-lifts chest, hands at midline, smiles spontaneously, rolls over one way, grasps rattle) _yes _no _REFERRED
IMMUNIZATIONS _CURRENT__ _DEFERRED__ _PROVIDED: LIST

**HEALTH EDUCATION, ANTICIPATORY GUIDANCE**

- __SOLID FOODS__
- __CHOKING, ASPIRATION__
- __FALLS__
- __TEETHING__
- __BABY-PROOF HOME__
- __“BACK TO SLEEP”__

**DIAGNOSIS**

<table>
<thead>
<tr>
<th>PLAN</th>
<th>SIGNATURE</th>
</tr>
</thead>
</table>

**Comments**

- Appearance
- Skin
- Head
- Eyes
- Ears
- Nose
- Mouth/Throat/Teeth/Gums
- Nodes
- Heart
- Lungs
- Abdomen inc. cord
- Fem. Pulse
- Ext. Gen.
- Hip Abduc.
- Extremities
- Spine
- Neuro
- Other
### 4 to 6 Month Child Health Check-Up Tracking Form

**Please Print**

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<th><em>INTERPERIODIC</em></th>
<th><em>PARENT/CAREGIVER REQUEST</em></th>
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<tbody>
<tr>
<td>DATE</td>
<td>AGE</td>
<td>ACCOMPANIED BY:</td>
<td></td>
</tr>
<tr>
<td>ID</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DATE OF BIRTH</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**INTERVAL HISTORY**

- **Past Medical History WNL**
  - _YES_  __NO_ (If no, describe)
- **Developmental History WNL**
  - _YES_  __NO_ (If no, describe)
- **Behavioral Health Status WNL**
  - _YES_  __NO_ (If no, describe)

**Nutritional Assessment**

- _Breast_  __Formula:_
- _WIC_  __Yes_  __No_  __Referred_
- _Vitamins_  _Iron_  _Solids_

**Physical Exam**

- **Height**
- **Weight**
- **Head Circumference**

Are the following normal?  Yes  No  Comments

- Appearance
- Skin
- Head
- Eyes
- Ears
- Nose
- Mouth/Throat/Teeth/Gums
- Nodes
- Heart
- Lungs
- Abdomen inc. cord
- Fem. Pulse
- Ext. Gen.
- Hip Abduc.
- Extremities
- Spine
- Neuro
- Other

**Lab Tests**

- _Lead Screen_ (blood @ 12 & 14 mo., @ 36-72 mo., if not previously screened, verbal @ 6 mo.-6yrs.)  __Other_ (specify as indicated)
- _Sensory Screen_ (red reflex, follows, covers/uncover test, follows)  _Yes_  _No_  _Deferred_
- _Normal Hearing_ (responds to sound/repeat sounds)  _Yes_  _No_  _Deferred_

**Development Assessment**

- _Is Development Normal Age and Culture?_ (prone-i.e. rolls over, reaches for objects, laughs, squeals)
  - _Yes_  _No_  _Deferred_
- **Immunizations**
  - _Current_  _Deferred_  _Provided: List_

**Health Education, Anticipatory Guidance**

- _Cup, Finger Foods_  _No Bottle in Bed_  _Teething_  _Pool & Public Safety_  _Poisons_  _Other_

**Diagnosis**

<table>
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<tr>
<th>PLAN</th>
<th>SIGNATURE</th>
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**Prestige Health Choice**
### 6 to 12 Month Child Health Check-Up Tracking Form

**Please Print**

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<th>__PARENT/ CAREGIVER REQUEST</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME</td>
<td>(Last)</td>
<td>(First)</td>
<td>ID</td>
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<table>
<thead>
<tr>
<th>DATE</th>
<th>AGE</th>
<th>ACCOMPANIED BY:</th>
<th>RELATIONSHIP</th>
</tr>
</thead>
</table>

#### INTERVAL HISTORY

- **Past Medical History**: WNL __YES__ __NO__ (If no, describe)
- **Developmental History**: WNL __YES__ __NO__ (If no, describe)
- **Behavioral Health Status**: WNL __YES__ __NO__ (If no, describe)

#### Nutritional Assessment

- __Breast__ __Formula__
- WIC __YES__ __NO__ __Referred__
- __Vitamins__ __Iron__ __Solids__ __Flouride__

#### Physical Exam

<table>
<thead>
<tr>
<th>Appearance</th>
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<th>No</th>
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<tbody>
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<td>Eyes</td>
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<tr>
<td>Ears</td>
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<tr>
<td>Nose</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mouth/Throat/Teeth/Gums</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nodes</td>
<td></td>
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<tr>
<td>Heart</td>
<td></td>
<td></td>
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<tr>
<td>Lungs</td>
<td></td>
<td></td>
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<tr>
<td>Abdomen inc. cord</td>
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<tr>
<td>Fem. Pulse</td>
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<td>Ext. Gen.</td>
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<tr>
<td>Hip Abduc.</td>
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<td>Extremities</td>
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<td>Spine</td>
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<tr>
<td>Neuro</td>
<td></td>
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<tr>
<td>Other</td>
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</tbody>
</table>

#### Lab Tests

- __Hgb Hct__ (9mm adolescent females & as indicated)
- __Lead Screen__ (blood @ 12 & 14 mo., @ 36-72 mo., if not previously screened, verbal @ 6 mo.-6yrs.)
- __Other__ (specify as indicated)

#### Sensory Screen

<table>
<thead>
<tr>
<th>Normal Vision?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal Hearing?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Development Assessment

- **Developmental Normal Age and Culture?** (by 9 mo. plays peek-a-boo, gets to sitting, pulls self to stand, thumb-finger grasp, bangs two toys together; by 12 mo. plays pat-a-cake, neat pincer grasp, stands momentarily, walks holding on, points) __YES__ __NO__ __Referred__

#### Immunizations

- __Current__ __Deferred__ __Provided: List__

#### Health Education, Anticipatory Guidance

- __Baby-Proof Home, Pool__ __Self-Feeding__ __Talk to Child__ __Talk to & Name Objects__ __Sleeping__ __Discipline, Praise__ __Shoes-Protect, Not Support__ __Sun Protection__ __Dental Hygiene__ __Other__

#### Diagnosis

<table>
<thead>
<tr>
<th>Plan</th>
<th>Signature</th>
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*Prestige Health Choice*
# 12 to 18 Month Child Health Check-Up Tracking Form

**Please Print**

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<th><em>INTERPERIODIC</em></th>
<th><em>PARENT/CAREGIVER REQUEST</em></th>
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<tbody>
<tr>
<td>NAME (Last) (First)</td>
<td>ID</td>
<td>DATE OF BIRTH</td>
<td></td>
</tr>
<tr>
<td>DATE</td>
<td>AGE</td>
<td>ACCOMPANIED BY:</td>
<td>RELATIONSHIP</td>
</tr>
</tbody>
</table>

## INTERVAL HISTORY

- PAST MEDICAL HISTORY WNL: _YES_ _NO_ (If no, describe)
- DEVELOPMENTAL HISTORY WNL: _YES_ _NO_ (If no, describe)
- BEHAVIORAL HEALTH STATUS WNL: _YES_ _NO_ (If no, describe)

## NUTRITIONAL ASSESSMENT

- _BREAST_ _WHOLE MILK:_ _CUP_ _BOTTLE_ _TABLE FOODS_
- _WIC:_ _YES_ _NO_ _REFERRED_
- _VITAMINS_ _IRON_ _SOLIDS_ _FLOURIDE_

## PHYSICAL EXAM

<table>
<thead>
<tr>
<th>HEIGHT</th>
<th>WEIGHT</th>
<th>HEAD CIRCUMFERENCE</th>
</tr>
</thead>
</table>

Are the following normal? _Yes_ _No_ Comments

- **Appearance**
  - Skin
  - Head
  - Eyes
  - Ears
  - Nose
  - Mouth/Throat/Teeth/Gums
  - Nodes
  - Heart
  - Lungs
  - Abdomen inc. cord
  - Fem. Pulse
  - Ext. Gen.
  - Hip Abduc.
  - Extremities
  - Spine
  - Neuro
  - Other

## LAB TESTS

- _LEAD SCREEN_ (blood @ 12 & 24 mo, @ 36-72 mo, if not previously screened, verbal @ 6 mo-6yrs) _OTHER_ (specify as indicated)

## SENSORY SCREEN

- NORMAL VISION? (red reflex, follows, follows, cover/uncover) _YES_ _NO_ _REFERRED_
- NORMAL HEARING? (by 12 mo responds to "no," follows simple commands, gives objects upon request, 1-3 words; by 18 mo reacts to music, points to named objects, 2-3 words other than mama-dada, points to one named body part) _YES_ _NO_ _REFERRED_

## DOES PARENT FEEL SPEECH & HEARING ARE NORMAL FOR AGE? _YES_ _NO_

## DEVELOPMENT ASSESSMENT

- IS DEVELOPMENT NORMAL AGE AND CULTURE? (by 12 mo. plays pat-a-cake, neat pincer grasp, stands momentarily, walks holding on, points; by 18 mo. uses spoon, kicks/throws ball, walks alone) _YES_ _NO_ _REFERRED_

## IMMUNIZATIONS

- _CURRENT_ _DEFERRED_ _PROVIDED LIST_

## HEALTH EDUCATION, ANTICIPATORY GUIDANCE

- _SAFETY_ _DISCIPLINE/LIMITS_ _TANTRUMS_ _EATING_ _SLEEPING_ _READ TO CHILD_ _ASPIRATION_ _NO BOTTLE_ _SNACKS_ _TOILET TRAINING_ _DENTAL HYGIENE_ _OTHER_ _SUN PROTECTION_ _SIBLING INTERACTION_

## DIAGNOSIS

<table>
<thead>
<tr>
<th>PLAN</th>
<th>SIGNATURE</th>
</tr>
</thead>
</table>
# 18 Month to 3 Year Child Health Check-Up Tracking Form

**Please Print**

<table>
<thead>
<tr>
<th>PERSONAL</th>
<th><em>PERIODIC</em></th>
<th><em>INTERPERIODIC</em></th>
<th><em>PARENT/ CAREGIVER REQUEST</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME (Last) (First)</td>
<td>ID</td>
<td>DATE OF BIRTH</td>
<td></td>
</tr>
<tr>
<td>DATE</td>
<td>AGE</td>
<td>ACCOMPANIED BY:</td>
<td>RELATIONSHIP</td>
</tr>
</tbody>
</table>

**INTERVAL HISTORY**

<table>
<thead>
<tr>
<th>PAST MEDICAL HISTORY WNL</th>
<th><em>YES</em></th>
<th><em>NO</em> (If no, describe)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DEVELOPMENTAL HISTORY WNL</td>
<td><em>YES</em></td>
<td><em>NO</em> (If no, describe)</td>
</tr>
<tr>
<td>BEHAVIORAL HEALTH STATUS WNL</td>
<td><em>YES</em></td>
<td><em>NO</em> (If no, describe)</td>
</tr>
</tbody>
</table>

**NUTRITIONAL ASSESSMENT**

<table>
<thead>
<tr>
<th>WNL</th>
<th><em>YES</em></th>
<th><em>NO</em> (If no, describe)</th>
</tr>
</thead>
<tbody>
<tr>
<td>WIC</td>
<td><em>YES</em></td>
<td><em>NO</em></td>
</tr>
<tr>
<td>FLOURIDE</td>
<td><em>REFERRED</em></td>
<td></td>
</tr>
</tbody>
</table>

**PHYSICAL EXAM**

<table>
<thead>
<tr>
<th>HEIGHT</th>
<th>WEIGHT</th>
<th>HEAD CIRCUMFERENCE</th>
</tr>
</thead>
</table>

Are the following normal? _Yes_ _No_ Comments

**Appearance**

<table>
<thead>
<tr>
<th>Skin</th>
<th>Head</th>
<th>Eyes</th>
<th>Ears</th>
<th>Nose</th>
</tr>
</thead>
</table>

**Mouth/ Throat/ Teeth/ Gums** _DENTAL REFERRAL AGE 3 AND UP REQUIRED_

<table>
<thead>
<tr>
<th>Nodes</th>
<th>Heart</th>
<th>Lungs</th>
<th>Abdomen inc. cord</th>
</tr>
</thead>
</table>

|------------|----------|------------|-------------|

<table>
<thead>
<tr>
<th>Spine</th>
<th>Neuro</th>
<th>Other</th>
</tr>
</thead>
</table>

**LAB TESTS**

<table>
<thead>
<tr>
<th>LEAD SCREEN (blood @ 12 &amp; 24 mo, @ 36-72 mo, if not previously screened, verbal @ 6 mo-6yrs)</th>
<th><em>OTHER</em> (specify as indicated)</th>
</tr>
</thead>
</table>

**SENSORY SCREEN**

<table>
<thead>
<tr>
<th>NORMAL VISION? (red reflex, follow, follows, fixation test, cover/ uncover)</th>
<th><em>YES</em> <em>NO</em> <em>REFERRED</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>NORMAL HEARING? (2 yr uses some understandable speech, combines 2 words, names objects, 3 yr uses 3-4 word sentences)</td>
<td><em>YES</em> <em>NO</em> <em>REFERRED</em></td>
</tr>
<tr>
<td>DOES PARENT FEEL SPEECH &amp; HEARING ARE NORMAL FOR AGE?</td>
<td><em>YES</em> <em>NO</em></td>
</tr>
</tbody>
</table>

**DEVELOPMENT ASSESSMENT**

<table>
<thead>
<tr>
<th>IS DEVELOPMENT NORMAL AGE AND CULTURE? (? (by 18 mo uses spoon, kicks/ throws ball, walks alone; by 3yr jumps in place, knows name, age, and sex, copies a circle)</th>
<th><em>YES</em> <em>NO</em> <em>REFERRED</em></th>
</tr>
</thead>
</table>

**IMMUNIZATIONS**

<table>
<thead>
<tr>
<th>CURRENT</th>
<th>DEFERRED</th>
<th>PROVIDED LIST</th>
</tr>
</thead>
</table>

| _DECREASED APPETITE_ _READ TO CHILD_ _TOILET TRAINING_ _TEETH BRUSHING_ _CONTROL TV VIEWING_ _SAFETY CARS & POOL_ _SUN PROTECTION_ _OTHER_ |
|----------------|-------------|----------------|

**DIAGNOSIS**

<table>
<thead>
<tr>
<th>PLAN</th>
<th>SIGNATURE</th>
</tr>
</thead>
</table>

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**Prestige Health Choice**
## 3 to 5 Year Child Health Check-Up Tracking Form

**Please Print**

### PERSONAL

<table>
<thead>
<tr>
<th>(Last)</th>
<th>(First)</th>
<th>ID</th>
<th>DATE OF BIRTH</th>
</tr>
</thead>
</table>

### INTERVAL HISTORY

1. **PAST MEDICAL HISTORY WNL**
   - __YES__ __NO__ (If no, describe)
2. **DEVELOPMENTAL HISTORY WNL**
   - __YES__ __NO__ (If no, describe)
3. **BEHAVIORAL HEALTH STATUS WNL**
   - __YES__ __NO__ (If no, describe)

### NUTRITIONAL ASSESSMENT

- WNL __YES__ __NO__ (If no, describe)
- __REFERRED__
- WIC __YES__ __NO__
- FLUORIDE __REFERRED__

### PHYSICAL EXAM

- HEIGHT
- WEIGHT
- BLOOD PRESSURE

<table>
<thead>
<tr>
<th>Are the following normal?</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appearance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Head</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ears</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nose</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mouth/ Throat/ Teeth/ Gums</td>
<td></td>
<td></td>
<td>__ DENTAL REFERRAL AGE 3 AND UP REQUIRED</td>
</tr>
<tr>
<td>Nodes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lungs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdomen inc. cord</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fem. Pulse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ext. Gen.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hip Abduc.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extremities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neuro</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### LAB TESTS

- __U/A__ (5 yrs. & as indicated)
- __LEAD SCREEN__ (blood @ 12 & 24 mo, @ 36-72 mo, if not previously screened, verbal @ 6 mo-6yrs)
- __OTHER__ (specify as indicated)

### SENSORY SCREEN

- NORMAL VISION? __yes__ __no__ __referred__
- NORMAL HEARING? __NORMAL__ __ABNORMAL__ (RIGHT __LEFT__)
- __REFERRED__

### DEVELOPMENT ASSESSMENT

- DOES PARENT FEEL SPEECH & HEARING ARE NORMAL FOR AGE? __YES__ __NO__

### IMMUNIZATIONS

- CURRENT __DEFERRED__ PROVIDED: LIST

### HEALTH EDUCATION, ANTICIPATORY GUIDANCE

- __NO PLAYING WITH MATCHES__ __SEAT BELTS__ __STREET SAFETY__ __PRESCHOOL__ __SEXUAL CURIOSITY__

### DIAGNOSIS PLAN

**SIGNATURE**
## 5 to 9 Year Child Health Check-Up Tracking Form

**Please Print**

<table>
<thead>
<tr>
<th>PERSONAL</th>
<th><em>PERIODIC</em></th>
<th><em>INTERPERIODIC</em></th>
<th><em>PARENT/ CAREGIVER REQUEST</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME (Last)</td>
<td>(First)</td>
<td>ID</td>
<td>DATE OF BIRTH</td>
</tr>
<tr>
<td>DATE</td>
<td>AGE</td>
<td>ACCOMPANIED BY:</td>
<td>RELATIONSHIP</td>
</tr>
</tbody>
</table>

### INTERVAL HISTORY

- **Past Medical History WNL**
  - _YES_  _NO_ (If no, describe)
- **Developmental History WNL**
  - _YES_  _NO_ (If no, describe)
- **Behavioral Health Status WNL**
  - _YES_  _NO_ (If no, describe)

### Nutritional Assessment

- **WNL**
  - _YES_  _NO_ (If no, describe)
  - __REFERRED__
  - __WIC__
  - _YES_  _NO_  _Flouride  _REFERRED

### Physical Exam

- **Height**
- **Weight**
- **Blood Pressure**

<table>
<thead>
<tr>
<th>Are the following normal?</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
</table>

- **Appearance**
- **Skin**
- **Head**
- **Eyes**
- **Ears**
- **Nose**
- **Mouth/ Throat/ Teeth/ Gums**
  - __DENTAL REFERRAL AGE 3 AND UP REQUIRED__
- **Nodes**
- **Heart**
- **Lungs**
- **Abdomen inc. cord**
- **Fem. Pulse**
- **Ext. Gen.**
- **Hip Abduc.**
- **Extremities**
- **Spine**
- **Neuro**
- **Other**

### Lab Tests

- **U/A** (5 yrs. & as indicated)
- **Lead Screen** (blood @ 12 & 24 mo, @ 36-72 mo, if not previously screened, verbal @ 6 mo-6 yrs)
- **Other** (specify as indicated)

### Sensory Screen

- **Normal Vision?**
  - _Yes_  _No_  _referred_
- **Normal Hearing?**
  - **Normal**  **Abnormal**  _Right___  _Left___  _REFERRED_

- **Does Parent Feel Speech & Hearing Are Normal For Age?**
  - _Yes_  _No_

### Development Assessment

- **Is Development Normal Age and Culture?**
  - _Yes_  _No_  _REFERRED_

### Immunizations

- **Current**  **Deferred**  **Provided: List**

### Health Education, Anticipatory Guidance

- **Dental Hygiene**  **Peer Relations**  **Limit Setting**  **Nutrition**  **Communication**  **Parental Role Model**  **Regular Physical Activity**  **School Performance**  **Safety: Water, Seat Belts, Skate Board, Bicycle**

### Diagnosis

<table>
<thead>
<tr>
<th>PLAN</th>
<th>SIGNATURE</th>
</tr>
</thead>
</table>
# 9 to 13 Year Child Health Check-Up Tracking Form

**Please Print**

<table>
<thead>
<tr>
<th><strong>PERSONAL</strong></th>
<th><strong>PERIODIC</strong></th>
<th><strong>INTERPERIODIC</strong></th>
<th><strong>PARENT/CAREGIVER REQUEST</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>NAME</strong> (Last)</th>
<th>(First)</th>
<th>ID</th>
<th><strong>DATE OF BIRTH</strong></th>
<th><strong>ACCOMPANIED BY</strong></th>
<th><strong>RELATIONSHIP</strong></th>
</tr>
</thead>
</table>

**INTERVAL HISTORY**

<table>
<thead>
<tr>
<th><strong>PAST MEDICAL HISTORY</strong> WNL</th>
<th><strong>YES</strong></th>
<th><strong>NO</strong></th>
<th>(If no, describe)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DEVELOPMENTAL HISTORY</strong> WNL</td>
<td><strong>YES</strong></td>
<td><strong>NO</strong></td>
<td>(If no, describe)</td>
</tr>
<tr>
<td><strong>BEHAVIORAL HEALTH STATUS</strong> WNL</td>
<td><strong>YES</strong></td>
<td><strong>NO</strong></td>
<td>(If no, describe)</td>
</tr>
</tbody>
</table>

**NUTRITIONAL ASSESSMENT**

<table>
<thead>
<tr>
<th>WNL</th>
<th><strong>YES</strong></th>
<th><strong>NO</strong></th>
<th>(If no, describe)</th>
<th>WIC</th>
<th><strong>YES</strong></th>
<th><strong>NO</strong></th>
<th><strong>FLOURIDE</strong></th>
<th><strong>REFERRED</strong></th>
</tr>
</thead>
</table>

**PHYSICAL EXAM**

<table>
<thead>
<tr>
<th><strong>HEIGHT</strong></th>
<th><strong>WEIGHT</strong></th>
<th><strong>BLOOD PRESSURE</strong></th>
</tr>
</thead>
</table>

Are the following normal? **Yes** **No** **Comments**

- Appearance
- Skin
- Head
- Eyes
- Ears
- Nose
- **Mouth/Throat/Teeth/Gums** __DENTAL REFERRAL AGE 3 AND UP REQUIRED__
- Nodes
- Heart
- Lungs
- Abdomen inc. cord
- Fem. Pulse
- Ext. Gen.

**Tanner Staging:**

- Hip Abduc.
- Extremities
- Spine
- Neuro
- Other

**LAB TESTS**

**SENSORY SCREEN**

<table>
<thead>
<tr>
<th><strong>NORMAL VISION?</strong></th>
<th><strong>YES</strong></th>
<th><strong>NO</strong></th>
<th><strong>REFERRED</strong></th>
<th><strong>NORMAL HEARING?</strong></th>
<th><strong>NORMAL</strong></th>
<th><strong>ABNORMAL</strong></th>
<th>(RIGHT_____)</th>
<th>(LEFT_____)</th>
<th><strong>REFERRED</strong></th>
</tr>
</thead>
</table>

**DOES PARENT FEEL SPEECH & HEARING ARE NORMAL FOR AGE?** __YES__ __NO__

**DEVELOPMENT ASSESSMENT**

<table>
<thead>
<tr>
<th><strong>IS DEVELOPMENT NORMAL AGE AND CULTURE?</strong></th>
<th><strong>YES</strong></th>
<th><strong>NO</strong></th>
<th><strong>REFERRED</strong></th>
</tr>
</thead>
</table>

**IMMUNIZATIONS**

__CURRENT__ __DEFERRED__ __PROVIDED: LIST__

**HEALTH EDUCATION, ANTICIPATORY GUIDANCE**

__DENTAL HYGIENE__ __SEXUAL INFO__ __BICYCLE SAFETY__ __PEER PRESSURE__ __NUTRITION__ __COMMUNICATION AFFECTION__ __SCHOOL PERFORMANCE__ __SMOKING, ALCOHOL, DRUGS__ __OTHER__

**DIAGNOSIS**

**PLAN**

**SIGNATURE**
# 13 to 21 Year Child Health Check-Up Tracking Form

**Please Print**

### Personal Information
- **NAME**: (Last) (First)
- **ID**: 
- **DATE OF BIRTH**: 
- **DATE**: 
- **AGE**: 
- **ACCOMPANIED BY**: 
- **RELATIONSHIP**: 

### Interval History
- **Past Medical History**: WNL __YES__ __NO__ (If no, describe)
- **Developmental History**: WNL __YES__ __NO__ (If no, describe)
- **Behavioral Health Status**: WNL __YES__ __NO__ (If no, describe)

### Nutritional Assessment
- **WNL**: __YES__ __NO__ (If no, describe)
- **WIC**: __YES__ __NO__
- **Flouride**: __YES__ __NO__

### Physical Exam
- **Height**: 
- **Weight**: 
- **Blood Pressure**: 

### Are the following normal?
- **Yes**: 
- **No**: 
- **Comments**: 

#### Appearance
- **Skin**: 
- **Head**: 
- **Eyes**: 
- **Ears**: 
- **Nose**: 
- **Mouth/Throat/Teeth/ Gums**: __DENTAL REFERRAL AGE 3 AND UP REQUIRED__
- **Nodes**: 
- **Heart**: 
- **Lungs**: 
- **Abdomen inc. cord**: 
- **Fem. Pulse**: 
- **Ext. Gen.**: 
- **Tanner Staging**:  

#### Extremities
- **Spine**: 
- **Neuro**: 
- **Other**: 

### Lab Tests
- **Hgb/Hct**: (9 mo, adolescent females & as indicated) __OTHER__ (specify as indicated)

### Sensory Screen
- **Normal Vision?**: __Yes__ __No__ __Referred__
- **Normal Hearing?**: __Normal__ __Abnormal__ (Right _____ Left _____)
- **Results**: Right _____ Left _____ Both _____
- **Does Parent Feel Speech & Hearing are Normal for Age?**: __Yes__ __No__

### Development Assessment
- **Is Development Normal Age and Culture?**: __Yes__ __No__ __Referred__

### Immunizations
- **Current** __Deferred__ __Provided: List__

### Health Education, Anticipatory Guidance
- **Car/Seat Belt Safety**: 
- **Sexual Ed & STD's**: 
- **Physical Activity**: 
- **Pregnancy Prevention**: 
- **Nutrition**: 
- **Comm. Affection**: 
- **Motorcycle/Helmet Safety**: 
- **Smoking, Alcohol, Drugs**: 
- **School Performance**: 
- **Breast or Testicular Self-Exam**: 

### Diagnosis
- **Plan**: 
- **Signature**: 

---

*Prestige Health Choice*
**ADULT HEALTH HISTORY FORM**

PATIENT'S NAME:__________________________________________  DATE:_______________________

PURPOSE OF INITIAL VISIT:______________________________________________________________________________________

**ALLERGIES**

DRUG:_______________________________________________

FOOD:_______________________________________________

OTHER:______________________________________________

**CURRENT MEDS**

PRESCRIPTION: __ No __Yes

-Please list:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

**FAMILY HISTORY**

Use check mark for Yes answers (√)

<table>
<thead>
<tr>
<th>Father</th>
<th>Mother</th>
<th>Father’s Parents</th>
<th>Mother’s Parents</th>
<th>Siblings</th>
<th>Children</th>
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</thead>
<tbody>
<tr>
<td>Cancer</td>
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<tr>
<td>Diabetes</td>
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<tr>
<td>Epilepsy/Convulsion</td>
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<tr>
<td>Glaucoma</td>
<td></td>
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<tr>
<td>Heart Disease</td>
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<td>High Blood Pressure</td>
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<td>Kidney Disease</td>
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<td>Mental Illness</td>
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<tr>
<td>Stroke</td>
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<tr>
<td>Thyroid Disease</td>
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<tr>
<td>Drug or Alcohol</td>
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<tr>
<td>Addiction</td>
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</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**PAST MEDICAL HISTORY AND REVIEW OF SYSTEMS**

*Please circle if you have had problems with or are presently complaining of any of the following:*

1. High blood pressure
2. Diabetes
3. Cancer
4. Heart disease
5. Chest pain/tightness
6. Shortness of breath
7. Swollen ankles
8. Palpitations
9. Lightheadedness
10. Frequent Urination
11. Rheumatic Fever
12. Asthma
13. Bronchitis
14. Pneumonia
15. Persistent
16. Tuberculosis
17. Abdominal discomfort
18. Hay Fever
19. Indigestion
20. Nausea
21. Vomiting
22. Constipation
23. Diarrhea
24. Blood in stool
25. Ulcers
26. Gout
27. Hemorrhoids
28. Gall bladder disease
29. Unexplained weight gain/loss
30. Colitis
31. Hepatitis or jaundice
32. Thyroid disease
33. Head or neck radiation
34. Headache
35. Kidney diseases
36. Kidney stones
37. Difficulty urinating
38. Arthritis
39. Low back problems
40. Skin diseases
41. Blood disorders
42. Venereal diseases
43. Anxiety
44. Depression
45. Anemia
46. Alcohol abuse
47. Drug abuse
48. Change in bowel habits
49. _____________
50. _____________
ADULT HEALTH HISTORY FORM

PLEASE LIST AND SUPPLY THE DATES OF THE FOLLOWING:

OPERATIONS:  _ No  _Yes –Please list: ________________________________

HOSPITALIZATIONS OTHER THAN FOR SURGERY:  _ No  _Yes –Please list: ________________________________

TRANSFUSIONS:  _ No  _Yes –Please list: ________________________________

IMMUNIZATION HISTORY: HAVE YOU HAD:

PNEUMOVAX?  _ No  _Yes When? ________________________________
TETANUS?  _ No  _Yes When? ________________________________
HEPATITIS B?  _ No  _Yes When? ________________________________
OTHER?  _ No  _Yes When? ________________________________
FLU IMMUNIZATION?  _ No  _Yes When? ________________________________

PATIENT’S NAME: ________________________________

DATE: ________________________________

WHEN WAS YOUR LAST:

Complete Physical Date: _________ Results: ________________________________
Cholesterol Check Date: _________ Results: ________________________________
Eye Exam Date: _________ Results: ________________________________
Hearing Test Date: _________ Results: ________________________________
Stool Check for Blood Date: _________ Results: ________________________________

FOR WOMEN ONLY:

GYNECOLOGICAL AND OBSTETRIC HISTORY

TB Test Date: _________ Results: ________________________________
Pap Smear Date: _________ Results: ________________________________
Mammogram Date: _________ Results: ________________________________
Breast Exam Date: _________ Results: ________________________________
Prostate Exam Date: _________ Results: ________________________________
AGE AT ONSET OF PERIODS: __________________ FREQUENCY: __________________
LENGTH OF PERIOD __________________
PREGNANCIES: _____ BIRTHS: _____ MISCARRIAGES: ______
ABORTIONS: __________________
PROLONGED OR ABNORMAL BLEEDING:  _ No  _Yes Describe: __________________

LEAKAGE OF URINE:  _ No  _Yes Describe: __________________

PELVIC PAIN:  _ No  _Yes Describe: __________________

ABNORMAL DISCHARGE:  _ No  _Yes Describe: __________________

HISTORY OF ABNORMAL PAP SMEAR:  _ No  _Yes Type of Treatment: __________________

PREVENTION

DO YOU WEAR SEAT BELTS?  _ No  _Yes  If no, why not? ________________________________

DO YOU WEAR A BIKE HELMET?  _ No  _Yes  N/A

DO YOU DRINK BEVERAGES WITH CAFFEINE?  _ No  _Yes  If yes, how many per day? ________________

DO YOU SMOKE?  _ No  _Yes  If yes, how many packs per day? ________________

DO YOU DRINK ALCOHOL?  _ No  _Yes  If yes, how much per week? ________________

DO YOU USE DRUGS? (Marijuana, cocaine, crack, etc.)  _ No  _Yes  If yes, explain: ________________________________

IS THERE A GUN IN YOUR HOME?  _ No  _Yes

IS IT UNLOADED AND OUT OF CHILDREN’S REACH?  _ No  _Yes  N/A

RISK HISTORY

CURRENTLY SEXUALLY ACTIVE?  _ No  _Yes

HOW MANY PARTNERS IN PAST 5 YEARS? ________________

HAVE YOU EVER EXPERIENCED:

SEX WITH INJECTING DRUG USER?  _ No  _Yes
SEX WITH SAME-SEX PARTNER(S)?  _ No  _Yes
SEX WITH PERSON WITH HIV/AIDS?  _ No  _Yes
SEX WHILE USING DRUGS?  _ No  _Yes
SEX WITH PERSON OF OTHER SEX FOR DRUGS/MONEY?  _ No  _Yes
HIV/AIDS RISK?  _ No  _Yes
EVER BEEN A VICTIM OF SEXUAL ASSAULT?  _ No  _Yes

CONTRACEPTIVE METHOD LAST USED/ NOW USING:

HISTORY – OTHER METHODS USED: ________________________________

PROBLEM(S) WITH METHODS: ________________________________

HAVE YOU BEEN IN CONTACT WITH PERSONS WITH CONFIRMED TB?
_ No  _Yes  If yes, explain: ________________________________

ARE YOU FROM OR HAVE YOU RECENTLY TRAVELED TO REGIONS OF THE WORLD WITH HIGH TV PREVALENCE?  _ No  _Yes  If yes, explain:

ARE YOU IN CONTACT WITH THE FOLLOWING:

_ HIV+ persons  _ Migrant farm workers
_ Residents of nursing homes  _ Institutionalized/ incarcerated persons
_ Homeless persons  _ IV/ street drug users

If yes, explain: ________________________________

HAVE YOU EVER WORKED WITH CHEMICALS, PAINTS, ASBESTOS, OR OTHER HAZARDOUS MATERIAL?  _ No  _Yes  If yes, please explain: ________________________________

ARE YOU IN A RELATIONSHIP IN WHICH YOU HAVE BEEN PHYSICALLY HURT (E.G. SLAPPED, KICKED, PUNCHED, OR BRUISED) BY YOUR PARTNER?  _ No  _Yes  N/A

DO YOU EVER FEEL AFRAID OF YOUR PARTNER?  _ No  _Yes  N/A

DO YOU HAVE A “LIVING WILL”?  _ No  _Yes

(If yes, please provide a copy)

DO YOU HAVE A DONOR CARD?  _ No  _Yes

SIGNATURE: ________________________________
**ORAL LEAD RISK FORM (English)**

*At birth, a blood lead test is required regardless of risk.*

**Answer “Y” for Yes and “N” for No**

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<th>4Y</th>
<th>5Y</th>
<th>6Y</th>
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<tr>
<td>1. Since the last oral risk assessment, have there been any significant changes in day care, your home, hobbies, or occupations?</td>
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<td>2. Has the mother of the infant worked where she has been exposed to lead?</td>
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<tr>
<td>3. a. Does the child live in or frequently visit (once weekly or more) a house that was built before 1960? Was the child’s day care/preschool/sitter’s home built before 1960? b. Does the house have peeling or chipping paint inside or outside? Is there old furniture or painted woodwork that the child can chew on (crib, banisters)?</td>
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<td>4. Does the child live in a house built before 1980 with recent, ongoing or planned renovation or remodeling?</td>
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<tr>
<td>5. a. Does the child live in or frequently visit a home near a heavily traveled major highway where soil and dust may be contaminated with lead? b. Is the child’s day care/preschool/sitter’s home near a busy roadway?</td>
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<td>6. Does the child regularly eat from ceramic or pewter dishes? Is food stored in tin cans, ceramic ware, or pottery?</td>
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<td>7. Have any of the child’s siblings or their playmates had lead poisoning?</td>
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<td>8. a. Does the child frequently come into contact with an adult who works with lead (examples: construction, welding, pottery, other locally practiced trades)? b. Does anyone in the household have a hobby that uses lead? (examples: fishing weights, casting ammunitions, toy soldiers, making stained glass, making pottery, refinishing furniture, burning lead-painted wood)</td>
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<td>9. Does the child live near a smelter, battery recycling plant, or other industry likely to release lead? Does the child live near a source of current industrial pollution or on the site of old industry or mining?</td>
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<td>10. Does the child receive any home or folk remedies that may contain lead (examples: Alarcon, Alcohol, Azarcon, BaliGoli, Coral, Ghasard, Greta, Liga, Pay-loo-ah, and Rudea)?</td>
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<td>11. Does the child live in a home with plumbing that has lead pipes or copper pipes with lead soldier joints? Have there been any plumbing repairs or fixtures added within the last 5 years?</td>
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**NAME:** _____________________________________________

**DATE:** ______________________
**ORAL LEAD RISK FORM (Español)**

*A blood lead test is required at 12 and 24 months of age regardless of risk. A blood lead test is required between the ages of 36 and 72 months for children who have no documentations of previous testing.*

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<th>6Y</th>
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1. ¿Desde su última evaluación de riesgo al plomo oral, ha notado algún cambio significativo en la guardería, en su casa, pasatiempos u ocupaciones?

2. ¿La madre del niño ha vivido o trabajado donde haya sido expuesta al plomo?

3. a. ¿Visita el niño frecuentemente (una o más veces en la semana) una casa construida antes de 1960? ¿La guardería infantil/preescolar/ o casa de la persona que cuida los niño fue construida antes de 1960?
   b. ¿Alguna de estas casas tienen pintura que se este despegando o pelando, por dentro o por fuera? ¿Hay muebles viejos o madera pintada que el niño pueda masticar (cuna, barandas)?

4. ¿Su niño vive en una casa construida antes de 1980 que ha sido remodelada recientemente, o planea remodelar?

5. a. ¿Su niño vive o visita frecuentemente una casa situada cerca de una carretera principal con mucho tráfico donde el terreno y polvo puede estar contaminado con plomo?
   b. ¿La guardería infantil/preescolar/ o casa de la persona que cuida al niño esta cerca de una calle con mucho tráfico?

6. ¿Su niño come regularmente en platos de cerámica o de peltre? ¿La comida es guardada en latas, envases de cerámica o de barro? ¿Su niño tiene intensos deseos de comer cosas que no se deben comer

7. ¿Alguno de sus niños o los compañeros de juegos han tenido envenenamiento con plomo?

8. a. ¿Su niño tiene contacto frecuente con algún adulto que trabaja con plomo? (Por ejemplo: construcción, soldadura, alfarería, u otro tipo de trabajo similar).
   b. ¿Alguien en la casa tiene un pasatiempo que utiliza plomo? (Por ejemplo: pesas para pescar, ensamblaje de balas, soldados de juguete, trabajos con vidrieras de colores, alfarería, tapicería, quemando madera pintada con plomo).

9. ¿Su niño vive cerca de una fábrica que derriten plomo, planta de reciclaje de baterías, u otra industria que tiene escape de plomo? ¿Su niño vive cerca de una fábrica que en el presente esta contaminada o en la local de una fábrica vieja o una mina?

10. ¿Le da usted a su niño remedios caseros que puedan contener plomo? (ejemplos: Alarcón, Alcohol, Azarcon, BaliGoli, Coral, Ghasard, Greta, Liga, Pay-loo-ah, o Rudea)?

11. ¿La plomería en su casa tiene tubos de plomo o de cobre con soldaduras en las uniones con plomo? ¿La plomería ha tenido reparos o añadiduras en los pasados 5 años?

NOMBRE DEL PACIENTE: ____________________________________________ FECHA: __________________________

*Prestige Health Choice*
WOMEN, INFANT, AND CHILDREN (WIC) REFERRAL

This is a referral to a Women, Infant and Children (WIC) provider agency. Medicaid recipients eligible for WIC benefits include the classifications listed below. Please check the category that most appropriately describes the individual that is being referred for services.

__ Pregnant woman
__ Woman who is breast feeding her infant(s) up to one year postpartum
__ Woman who is non-breast feeding up to six months postpartum
__ Infant under age one
__ Child under age five

NAME OF INDIVIDUAL BEING REFERRED:
___________________________________________________________________________________________________________

ADDRESS:
___________________________________________________________________________________________________________

TELEPHONE NUMBER:
___________________________________________________________________________________________________________

I, the undersigned, give permission for my provider to give the WIC Program any required medical information.
___________________________________________________________________________________________________________

(Signature of the patient being referred or, in the case of children and infants, signature and printed name of the parent/guardian.)

PHYSICIAN'S NAME:
___________________________________________________________________________________________________________

TELEPHONE NUMBER:
___________________________________________________________________________________________________________

DATE OF REFERRAL:
___________________________________________________________________________________________________________

SEND COMPLETED FORM TO:
___________________________________________________________________________________________________________

LOCAL WIC PROGRAM CENTER:
___________________________________________________________________________________________________________

ADDRESS:
___________________________________________________________________________________________________________

TELEPHONE NUMBER:
___________________________________________________________________________________________________________
HYSTERECTOMY ACKNOWLEDGEMENT

STATE OF FLORIDA
HYSTERECTOMY
ACKNOWLEDGMENT FORM

ACKNOWLEDGMENT OF RECEIPT OF HYSTERECTOMY INFORMATION

PART A - PHYSICIAN STATEMENT:

____________________, __________________, understand that the Florida Medicaid Program shall not allow payment for a hysterectomy unless it is performed pursuant to the federal requirements stated in 42 CFR 441, Subpart F and accordingly Parts A and B of this form are being completed.

The hysterectomy to be performed is not solely for the purpose of rendering the below mentioned recipient permanently incapable of reproducing nor is the hysterectomy for medical purposes which by themselves do not mandate a hysterectomy. The nonelective hysterectomy is therefore being performed for the following medical reasons:

____________________
(ENTER DX AND EXPLAIN IF NECESSARY)

____________________
____________________
____________________

PHYSICIAN’S SIGNATURE
DATE

PART B - PATIENT STATEMENT:

It was explained verbally before surgery and in writing by completion of this form to:

____________________
(PRINT: RECIPIENT’S FIRST NAME, INITIAL, LAST NAME, MEDICAID I.D. #)

that the hysterectomy to be performed or which was performed would render her permanently incapable of reproducing.

____________________
PATIENT’S SIGNATURE OR MARK
DATE

Patient’s mark must be witnessed by her representative.

____________________
INTERPRETER’S SIGNATURE, WHEN NECESSARY
DATE

DISTRIBUTION OF COPIES:

ORIGINAL - Retain in patient’s medical record at physician’s office.
1 COPY - To patient.
Other copies as required - See note below.

NOTE: A copy of this form shall be attached to any and all Medicaid claims submitted by providers involved in the performance of the procedure.
# APPOINTMENT OF REPRESENTATIVE

## SECTION I: APPOINTMENT OF REPRESENTATIVE

To be completed by the beneficiary:

I appoint this individual: ________________ to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the “Act”) and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my appeal, wholly in my stead. I understand that personal medical information related to my appeal may be disclosed to the representative indicated below.

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<tr>
<th>SIGNATURE OF BENEFICIARY</th>
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## SECTION II: ACCEPTANCE OF APPOINTMENT

To be completed by the representative:

I, ________________, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services; that I am not, as a current or former employee of the United States, disqualified from acting as the beneficiary’s representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a/an ________________ (PROFESSIONAL STATUS OR RELATIONSHIP TO THE PARTY, E.G. ATTORNEY, RELATIVE, ETC.)

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## SECTION III: WAIVER OF FEE FOR REPRESENTATION

Instructions: This form should be filled out if the representative waives a fee for such representation. (Note that providers or suppliers may not charge a fee for representation and thus, all providers or suppliers that furnished the items or services at issue must complete this section.)

I waive my right to charge and collect a fee for representing before the Secretary of the Department of Health and Human Services.

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## SECTION IV: WAIVER OF PAYMENT FOR ITEMS OR SERVICES AT ISSUE

Instructions: Providers or suppliers that furnished the items or services at issue must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, and could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.)

I waive my right to collect payment from the beneficiary for furnished items or services at issue involving 1879(a)(2) of the Act.

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CHARGING OF FEES FOR REPRESENTING BENEFICIARIES BEFORE
THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

An attorney, or other representative for a beneficiary, who wishes to charge a fee for services rendered in connection with an appeal before the Department of Health and Human Services (DHHS) at the Administrative Law Judge (ALJ) or Medicare Appeals Council (MAC) level is required by law to obtain approval of the fee in accordance with 42 CFR §405.910(f). A claim that has been remanded by a court to the Secretary for further administrative proceedings is considered to be before the Secretary after the remand by the court.

The form, “Petition to Obtain Representative Fee” elicits the information required for a fee petition. It should be completed by the representative and filed with DHHS. Where a representative has rendered services in a claim before DHHS, the regulations require that the amount of the fee to be charged, if any, for services performed before the Secretary of DHHS be specified. If any fee is to be charged for such services, a petition for approval of that amount must be submitted.

An approval of a fee is not required where the appellant is a provider or supplier or where the fee is for services (1) rendered in an official capacity such as that of legal guardian, committee, or similar court-appointed office and the court has approved the fee in question; (2) in representing the beneficiary before the federal district court of above, or (3) in representing the beneficiary in appeals below the ALJ level. If the representative wishes to waive a fee, he or she may do so. Section III on the front of this form can be used for that purpose. In some instances, as indicated on the form, the fee must be waived for representation.

AUTHORIZATION OF FEE

The requirement for the approval of fees ensures that representative will receive fair value for the services performed before DHHS on behalf of a claimant while at the same time giving a measure of security to the beneficiaries. In approving a requested fee, the ALJ or MAC considers the nature and type of services performed, the complexity of the case, the level of skill and competence required in rendition of the services, the amount of time spent on the case, the results achieved, the level of administrative review to which the representative carried the appeal and the amount of the fee requested by the representative.

CONFLICT OF INTEREST

Sections 203, 205 and 207 of Title XVIII of the United States Code make it a criminal offense for certain officers, employees and former officers and employees of the United States to render certain services in matters affecting the Government or to aid or assist in the prosecution of claims against the United States. Individuals with a conflict of interest are excluded from being representatives of beneficiaries before DHHS.
Non-Medicare Member Appointment of Representative Statement

SECTION I

APPOINTMENT OF REPRESENTATIVE

Member Name __________________________ Member ID Number __________________________

Name of Provider in Question __________________________ Dates of Service __________________________

$ __________________________ __________________________

Amount of Charges Requested Service (Pre-Service)

I do hereby swear that I am the above-mentioned member or have the legal authority to appoint a representative for the above-mentioned member. I do hereby appoint the following individual __________________________ to act as my representative in requesting a reconsideration from the above-referenced health plan and for the services for which the above-referenced health plan has denied payment or authorization.

Member’s Signature __________________________ Date __________________________

SECTION II

ACCEPTANCE OF APPOINTMENT

I, __________________________ hereby accept the above appointment.

(Appointed Representative)

Signature of Appointed Representative __________________________ Date __________________________

Rev. 11/03
ABORTION CERTIFICATION FORM

State of Florida
Abortion Certification Form

SECTION I

1. Recipient’s Name: __________________________________________________________________________________________

2. Address: _________________________________________________________________________________________________

3. Medicaid Identification Number: ________________________________

SECTION II

4. On the basis of my professional judgment, I have performed an abortion on the above named recipient for the following reason:

___ The woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused or arising from the pregnancy itself that would place the woman in danger of death unless an abortion is performed.

___ Based on all the information available to me, I concluded that this pregnancy was the result of an act of rape.

___ Based on all the information available to me, I concluded that this pregnancy was the result of incest.

I have documented in the patient's medical record the reason for performing the abortion; and I understand that Medicaid reimbursement tome for this abortion is subject to recoupment if medical record documentation does not reflect the reason for the abortion as checked above.

5. ___________________________ 6. ___________________________
   Physician’s Name             Physician’s Name

7. ___________________________ 8. ___________________________
   Medicaid Provider Number     Date of Signature
Date: __________________________

I, ____________________________________________,

(Physicians Name)

have discussed the Living Will and Durable Power of Attorney with

__________________________________________.

(Members Name)

____ Yes, the member has completed the Living Will and a copy will remain in his/her medical file.

____ Yes, the member has completed the Durable Power of Attorney and a copy will remain in his/her medical file.

____ No, the member declines to complete a Living Will.

____ No, the member declines to complete a Durable Power of Attorney.

Physician's Signature: ________________________________________________________________

Members' Signature: ________________________________________________________________
Fecha: ___________________________

Yo, ________________________________________________________________,  
(Nombre del Medico)

he hablado con  
_______________________________________________________________.     
(Nombre del Miembro)

sobre lo que es un Testamento en Vida y un Potestad para Cuidado De Salud.

____ Si, el miembro ha completado un Testamento en Vida y una copia se mantendra en su archive medico.
____ Si, el miembro ha completado un potestad para Cuidado De Salud y una copia se mantendra en su archive medico.
____ No, el miembro rechaza completer un testamento en Vida.
____ No, el miembro rechaza completer un Potestad para Cuidado de Salud.

FIRMA DEL MEDICO: _______________________________________________________

FIRMA DEL MIEMBRO: _______________________________________________________
LIVING WILL

Declaration made this ________ day of ______________, 200___, I, ______________________________________________,
willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that, if at any time I am incapacitated and (initial one or more of the following three conditions)

______ (initial) I have a terminal condition

or ______ (initial) I have an end-stage condition

or ______ (initial) I am in a persistent vegetative state

and if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

In the event that I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate to carry out the provisions of this declaration:

Name: ____________________________________________________________________________________________________

Address: __________________________________________________________________________________________________

______________________________________________________________________________ Phone:______________________

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Additional Instructions (optional): ______________________________________________________________________________

Signed: _________________________________________________________________  Date: _____________________________

Witnesses’ signature, address, and phone number:

1. ____________________________________________________       2. _______________________________________________

________________________________________________________________________       _________________________________________________

________________________________________________________________________       _________________________________________________

At least one witness must not be a husband or wife or a blood relative of principal

Prestige Health Choice
Designation of Health Care Surrogate

(Power Of Attorney for Health Care Decisions)

In the event that my physician determines that I am incompetent or so incapacitated as to provide expressed and informed consent for medical treatment, surgical intervention or diagnosis procedures

I, _________________________________________________________________________________________________________

(Last name)    (First Name)    (Middle Initial)

wish to designate the following person to make those decisions for me.

DESIGNEE

NAME: _________________________________________________________________________________________________________

TELEPHONE: _________________________________________________________________________________________________________

ADDRESS: _________________________________________________________________________________________________________

RELATIONSHIP (if any)

ALTERNATIVE DESIGNEE

If the person that I have named is unable to act on my behalf, I authorize the following person to act on my behalf:

NAME: _________________________________________________________________________________________________________

TELEPHONE: _________________________________________________________________________________________________________

ADDRESS: _________________________________________________________________________________________________________

RELATIONSHIP (if any)

I fully understand that this document will permit the above identified designee to support, withhold or withdraw consent for intended treatment and to do so on my behalf. That individual may also apply for public benefits to defer the cost of health care and authorize for my transfer to or from a health care facility.

I further reaffirm that this designation is not being made as a condition of treatment or admission to a healthcare facility. I understand should my judgmental incapacitation or incompetence be reversed such that I am once again considered competent to make my own decisions, such decisions will once again be mine.

I understand that I may rescind this declaration at any time so long as I am judged to be competent and capable to make such judgments

ADDITIONAL INSTRUCTIONS: __________________________________________________________________________________

___________________________________________________________________________________________________________

DO YOU HAVE A LIVING WILL DECLARATION?  __YES  __ NO

___________________________________________________________________________________________________________

SIGNATURE: _________________________________________________________________________________________________________

DATE: _________________________________________________________________________________________________________

WITNESS #1: _________________________________________________________________________________________________________

DATE: _________________________________________________________________________________________________________

WITNESS #2: _________________________________________________________________________________________________________

DATE: _________________________________________________________________________________________________________

NOTE: One witness should not be a spouse, blood relative, heir to the Estate of the designee or responsible for paying health care costs for that individual.
Designacion de Sustituto Para Decisiones Medicas

(Poder Para Decisiones De Atencion Medica)

En el caso de que mi medico determine que me encuentro incompetente e incapacitado al punto de no poder expresar e informar consentimiento para tratamientos medicos, intervenciones quirurgicas o procedimientos de diagnostico

Yo, ______________________________________________________________________________________________________

(Last name)    (First Name)    (Middle Initial)

deseo designar a la siguiente persona para toman estas decisiones por mi.

DESIGNADO

NOMBRE:     TELEFONO:       

DIRECCION:       RELACION

DESIGNADO ALTERNO

Si la persona que he designado (nombrado) es incapaz de actuar en mi nombre, Yo autorizo a la siguiente persona para asi hacerlo:

NOMBRE:     TELEFONO:       

DIRECCION:       RELACION

Yo entiendo perfectamente que este documento permitira a la persona arriba identificada a apoyar, evitar o retirar consentimiento del tratamiento propuesto y de hacerlo en mi nombre. Este individuo puede tambien aplicar para beneficios publicos para deferir los costos de atencion desalud y autorizar mi transferencia hacia o desde una facilidad de atencion de salud.

Yo reafirmo mas aun que este designacion no se ha tomado como condicion de una facilidad de atencion medica para recibir tratamiento o ser admitido. Entiendo que si mi capacidad de juicio o de incompetencia se reversa seré considerado inmediatamente competente para tomar mis propias decisiones, estas decisiones seran otra vez mis.

Yo entiendo que puedo cancelar esta declaracion en cualquier momento en que se determine que soy competente y capaz de discernir por mi mismo.

INSTRUCCIONES ADICIONALES: _________________________________________________________________________________

___________________________________________________________________________________________________________

¿TIENE USTED UNA DECLARACION DE TESTAMENTO EN VIDA?   ___SI     ___NO

SIGNATURE:     DATE:       

WITNESS #1:       DATE:       

WITNESS #2:       DATE:       

NOTE: One witness should not be a spouse, blood relative, heir to the Estate of the designee or responsible for paying health care costs for that individual.
Thank you for contacting Prestige Health Choice. All appeals must be submitted in writing to the Prestige Health Choice "appeals department". This form will help ensure that your appeal is processed as efficiently and effectively as possible. Please fill out the form completely.

MEMBER INFORMATION

LAST NAME: FIRST NAME:

MEMBER ID/MEDICAID#: ADDRESS:

CITY: STATE: ZIP:

PROVIDER INFORMATION

LAST NAME: FIRST NAME:

PROVIDER#: TIN# NPI#:

ADDRESS:

CITY: STATE: ZIP:

CLAIM IF APPLICABLE

CLAIM#: AUTHORIZATION#:

DATE(S) OF SERVICE: __________________________________________

Please provide an explanation of the appeal reason with supporting documentation:

Please place a check mark next to the items being submitted with the appeal

__ Copy of original claim __ Medical records __ EOB

__ Evidence of Eligibility Verification __ Contract rate sheet as evidence

__ Approved referral and authorization form

Appeals should be addressed to:

Prestige Health Choice
Grievance and Appeal Department
P.O. Box 19709
Charlotte, NC 28219-9709

Or by Toll-free Telephone to: 888-611-0786
Or by Toll-free Fax to: 800-338-4195

Prestige Health Choice
LAST NAME: FIRST NAME: MIDDLE INITIAL:

HOME ADDRESS: APT#: 

CITY: STATE: ZIP: 

DATE(S) PROBLEM OCCURRED: 

LOCATION WHERE PROBLEM OCCURRED: 

Please describe the problem you have encountered (be as specific as possible: include time, date, sequence of events, and subsequent events etc.

Action requested as follow-up to problem:

MEMBER SIGNATURE: ___________________________ DATE: __________________________

I understand that Prestige Health Choice will contact me within five (5) working days of the receipt of this form to acknowledge receipt of this grievance and to notify me of its initial findings to course of action regarding this complaint.

RECEIVED BY: ___________________________ DATE/TIME: __________________________

__ BY MAIL __ TELEPHONE __ IN PERSON __ OTHER

Grievances should be addressed to:
Prestige Health Choice
Grievance and Appeal Department
P.O. Box 19709
Charlotte, NC 28219-9709

Or by Toll-free Telephone to: 888-611-0786
Or by Toll-free Fax to: 800-338-4195
PCP SPECIALIST REFERRAL FORM

Member Information

Member #: ____________________
Name: __________________________
Gender: _____________________
Birth Date: ___________________
Phone: ________________
Fax: ____________________

PCP Information

Primary Care Physician
PCP #:_________________________
County: ________________________
PCP Name: _____________________
Phone: _______________________
Fax: _________________________

Specialist Information

County : __________________________
Type (Specialty) : ________________
(Specialist) Provider: ____________________________
Provider Phone number : ___________________________
Provider Address: ____________________________________________________________________________
Diagnosis - ICD-9: _______________________________

Evaluation Only  □
Evaluation Plus Visits : # ____
Time Frame:   □ 30 days  □ 60 days  □ 90 days  □ 1 year

Background Description:
_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________

Service Requested & Reason for Referral:
_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________
DATE: __________________________________________________

MEMBER’S NAME: __________________________________________________________________________________________

MEMBERS ID/MEDICAID #: _____________________________________________________________________________________

PCP’S NAME: ________________________________________________________________________________________________

SPECIALIST NAME: ______________________ PROVIDER # _______________________________

SPECIALTY: _____________________________

MEMBER’S DIAGNOSIS: _____________________________________________

Describe the medical justification for selecting a specialist as PCP for this member:

The signatures below indicate agreement by specialist, Prestige Health Choice and the member for whom the specialist will function as this member’s PCP including providing to the member access 24 hours a day, 7 days a week.

Specialists Signature: __________________________________________ Date: __________________________

Medical Directors Signature: _________________________________ Date: __________________________

Members Signature: _______________________________________ Date: __________________________
PCP REQUEST FOR TRANSFER OF MEMBER

Med Rec #_____________________

Physician: ___________________________________________ Member: ________________________________

ID#: ___________________________________ ID#: ______________________________

Telephone: ___________________________ Telephone: ___________________________

Fax: _______________________________ Commercial ___ Medicare ___ Medicaid ___

Please include detailed reason for request:

__ Disruptive Behavior __ Non-compliance with treatment

Missed appointment: Date: ____________ Date: ____________ Date: ____________

Other: ____________________________________________________________________________________________________

Description:
__________________________________________________________________________________________________________
__________________________________________________________________________________________________________
__________________________________________________________________________________________________________
__________________________________________________________________________________________________________
__________________________________________________________________________________________________________

Please submit a copy of the progress notes from the member’s medical record that documents your concern.

Physician signature: ________________________________ Date: ________________________________

Instructions:

Complete this request in its entirety and attach all supporting documentation, including pertinent medical records and office notes. Requests to transfer a member from your care should not be discussed with the member until approval is received from the Plan.

Submit request to:
Member Services
Prestige Health Choice
P. O. Box 19709
Charlotte, NC 28219-9709

Or fax to Member Services at: 800-338-4195

Section to be completed by the Plan

Medical Director: ___________________________________________________________________________________________

Date: _______________________________ Date: _______________________________ New PCP __________________________

Received: ____________________ Closed: ____________________ Assignment: ____________________

CSCL # ____________________________

Prestige Health Choice
Instruction for Completing Form DPA 2189

To facilitate the processing of a claim to which the attachment of Form DPA 2189, Consent Form, is required, all sections must be completed.

Additionally, the following information is to be provided:

**PHYSICIAN’S STATEMENT SECTION**

Recipient Number – Enter the nine-digit number assigned to the individual, as shown on the corresponding claims form, either in the line listing the “name of the individual to be sterilized” or, if space is not adequate, enter the number beneath the line.

Practitioner Number – Enter the appropriate Practitioner’s Number following the “physician” name, using the following guidelines: If the practitioner is a physician (MD), enter the American Medical Association (AMA) number. If the practitioner is a physician (DO), enter either the AMA number or Social Security (SSN).

**PHYSICIAN’S STATEMENT**

Shortly before I performed a sterilization operation upon ___________________________________________________________

On _________________, I explained to him/her the nature of the sterilization operation __________________________________, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I formed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by federal funds.

To the best of my knowledge and belief, the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below, except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual’s signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual’s signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days, but more than 72 hours after the date of the individual’s signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

___ Premature Delivery
___ Individual’s expected date of delivery
___ Emergency abdominal surgery (describe circumstances)

___________________________________________________________________________________________________________

Physician Date

___________________________________________________________________________________________________________

Signature Date
INTERPRETER’S STATEMENT
If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _______________________ language and explained its contents to him/her. To the best of my knowledge and belief, he/she understood this explanation.

__________________________________________________________
Signature                      Date

STATEMENT OF PERSON OBTAINING CONSENT

Before ______________ , ____________________________ signed the consent form, ___________________________

(name)

I ____________________________ explained to him/her the nature of the sterilization operation, ____________________________

(name)

The fact that it is intended to be a final and irreversible procedure, and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

Signature of person obtaining consent ____________________________  Date ____________________________

Facility ____________________________  Address ____________________________
Consent Form – DPA 2189

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS

Consent to Sterilization

I have asked for and received information about sterilization from ________________________________ (doctor or clinic).

When first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving federal funds, such as AFDC or Medicaid that I am now getting or for which I may become eligible.

I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not want to become pregnant, bear children or father children.

I was told about the temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as ________________________________.

The discomforts, risks and benefits associated with the operations have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on _____________________________________________.

(Month/day/year)

I, ____________________________________________, hereby consent of my own free will to be sterilized by ________________________________

(Patient’s name)

(Doctor’s name)

by a method called ________________________________________________.

My consent expires 180 days from the date of my signature below.

I also consent to the release of his form and other medical records about the operation to representatives of the Department of Health, Education, and Welfare or employees of programs or programs or projects funded by that Department, but only for determining if federal laws were observed.

I have received a copy of this form ________________________________________________

(Signature) (Date)

You are requested to supply the following information, but it is not required:

Race and Ethnical designation (please check)

__ American Indian or Alaska Native    __ Black (not of Hispanic origin)    __ Hispanic

__ Asian or Pacific Islander    __ white (not of Hispanic origin)
To: Prestige Care Management Department  
Fax: (800) 338-4195  
Phone: (888) 611-0784

From:

Name of PCP/OB: ________________________________________________________________

Center Name: _______________________________________________________________

Phone #: _________________________________________________________________

Member Name: ______________________________________________________________

Member ID#: ______________________________________________________________

Member Due Date: ___________________________________________________________

We have identified the above mentioned member as being pregnant.
FAX AUTHORIZATION REQUEST FORM

Date of Request: __________________
Member Name: _________________________________________________________
Member ID#: ___________________________________________________________
Medicaid #: _____________________________________________________________
Date of Birth: ___________________________________________________________

Requesting Provider Name: _______________________________________________
Provider ID#: ___________________________________________________________
Location: ______________________________________________________________
Caller: _________________________________________________________________
Phone#: ____________________________ Fax #:

REQUEST FOR PRE-AUTHORIZATION

Authorization #: __________________
(For Office Use Only)

Location of Service: __________________
Diagnoses: _______________________
Dx Codes: _______________________

TYPE OF REQUEST (please check box and specify)

DIAGNOSTIC / INVASIVE STUDIES
☐ Sonogram __________________ Code: _____________
☐ Nuclear ___________________ Code: _____________
☐ Stress Test _______________ Code: _____________
☐ MRI ______________________ Code: _____________
☐ CT ________________________ Code: _____________
☐ Other _____________________ Code: _____________
Additional Procedure Codes: _________________________

OUTPATIENT SERVICES
☐ Therapy PT OT ST
   Frequency: __________________
☐ Chemo ___________________
☐ Radio ____________________
☐ __________________________
☐ __________________________
☐ __________________________

SPECIALTY REFERRAL: Requesting less than 2 visits in 180 days
# of Visits Requested: __________________
Start Date: ________________ End Date: ______________
Reason: ______________________
Referral to: _____________________
Phone: _________________________

AMBULATORY SURGERY
Procedure: _______________________
Proc Codes: ______________________
Date of Surgery: __________________
Medical Necessity: __________________

INPATIENT: ☐ Elective Admission ☐ Emergency Admission Notification
Scheduled Date: _______ Admission Date: _______
Procedures for Elective Admission: _______________________
Procedure Codes: _______________________

STATEMENT OF MEDICAL NECESSITY Pre-authorization cannot be provided without the following
(Please provide any pertinent medical records to support the request)
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

• Call 1-888-611-0784 for any questions regarding Pre-authorization  • Use this form for standard requests  • 72 hours advance notice is preferred

Prestige Health Choice