UPMC HEALTH PLAN

Fax-Back Forms

The Health Plan has several forms designed to assist providers with requests. Please be sure to submit the form that best meets your needs. Descriptions are provided below:

Service reconciliation: For closing gaps in care; must be accompanied by relevant clinical documentation. As a reminder, your practice has the ability to access and monitor all of your UPMC Health Plan patients' care through ProHEDIS, a Web-based clinical application. This is easily accessible through the Partners Program Gaps in Care navigation link in Provider OnLine.

Verify patient affiliation: For situations where documented outreach attempts have been unsuccessful, a patient has transferred care to another PCP, or a patient is deceased.

Patient dismissal: For occasional and unfortunate circumstances where the doctor-patient relationship has been compromised; must be accompanied by the letter sent to patient. The Health Plan will connect the member with a new PCP when possible.

QP QualityPartners

FAX BACK FORM - SERVICE RECONCILIATION

Attn: **Quality Partners Incentive Program**

Person completing form: ______________________

Fax number: **412-454-5664**

Date: __________________

Office information

Site ID: ______________________________

Office name: __________________________

Phone number: ______________________

Location: _____________________________

Fax number: _______________________

Member information

Member/patient name: _________________________________ Product/line of business: ____________________

Member ID: ____ DOB: ______/______/________

A copy of the medical record documentation from the patient chart must be attached and must include: member/patient name and DOB, date of service, and exam/test results.

- ☐ Adolescent well visit, ages 12-21
- ☐ Cholesterol screening (LDL-C)
- ■ Comprehensive diabetes:
  - ☐ HbA1c test
  - ☐ Monitor nephropathy (result of microalbumin test)
  - ☐ Eye exam (performed by optometrist or ophthalmologist)
- ☐ Breast cancer screening (once every 2 years)
- ☐ Cervical cancer screening (once every 3 years)
- ☐ Blood pressure (UPMC *for You*)

The following measures will not count toward your 2016 Quality Partners Incentive Program, but they can still be updated by returning this form with clinical documentation.

- ☐ Spirometry testing in assessment and diagnosis of COPD (once every 3 years)
- ☐ Glaucoma screening (performed by optometrist or ophthalmologist; once every 2 years)
- ☐ Colorectal cancer screening (colonoscopy once every 10 years, flex sigmoidoscopy once every 5 years, FOBT yearly)
- ☐ Lead screening in children

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Person completing form: ______________________

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Office information

Site ID: ______________________________

Office name: __________________________

Location: _____________________________

Phone number: ______________________

Fax number: _______________________

Member information

Member/patient name: ________________________________ Product/line of business: __________________

Member ID: ____ DOB: ______/______/______

Request will not be processed unless one of the following is satisfied:

■ Practice was unable to reach patient.

☐ Outreach attempts (please circle mode of communication):

Date: ____/____/____ (email/mail/telephone/other) If other: ________________________________

Date: ____/____/____ (email/mail/telephone/other) If other: ________________________________

Patient was unreachable (non-working phone #, incorrect address); explain: ____________________

☐ This patient sees a primary care physician at a different office. (Please provide new PCP information.)

PCP name: ____

Practice name: ____

Practice location: ____

☐ Patient expired.

Date of death: ____/____/____

Members must consent to be reassigned.

QualityPartners

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Fax number: **412-454-5664**

Date: ________________

Office information

Site ID: ____________________________

Office name: ________________________

Phone number: ____________________

Location: ___________________________

Fax number: _____________________

Member information

Member/patient name: ______________________________ Product/line of business: _________________

Member ID: ____ DOB:_____/_____/______

Please include a copy of the letter mailed to the patient and communication to UPMC Health Plan, in accordance with Health Plan Policy.
Please note: Physicians must continue to treat patient for 30 days following dismissal.

Request will not be processed unless one of the following is satisfied:

■ Failure to keep appointments or persistent cancellations (please list four missed/cancelled appointments within past 12 months with corresponding follow up/outreach)

☐ Dates of missed/cancelled appointments:

Date: ____/____/____ Date: ____/____/____ Date: ____/____/____ Date: ____/____/____

☐ Outreach attempts (please circle mode of communication):

Date: ____/____/____ (email/mail/telephone/other) If other: ____________________

Date: ____/____/____ (email/mail/telephone/other) If other: ____________________

Date: ____/____/____ (email/mail/telephone/other) If other: ____________________

Date: ____/____/____ (email/mail/telephone/other) If other: ____________________

Patient was unreachable (non-working phone #, incorrect address); explain: ____________________

☐ Inappropriate or disruptive behavior on the part of the patient.

Please explain: ____

☐ Documented failure to comply with the Narcotic Agreement (please provide documentation).

☐ Other extenuating circumstances:

Please explain: ____

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