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.
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 2014 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
Attn: Quality Partners Incentive Program

Fax number: 412-454-5664

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.
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: ______/_____/_____

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)
    - Date: ______/_____/_____ (email/mail/telephone/other)
    - Date: ______/_____/_____ (email/mail/telephone/other)
    - Date: ______/_____/_____ (email/mail/telephone/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: __________________________