CareFirst Community Health Plan
District of Columbia

Provider Quick Reference Guide

Our Vendor Partners and Provider Services	
Member Transportation Services MTM	**mtm-inc.net** 855-824-5693
Behavorial Health— Beacon Health Options	**beaconhealthoptions.com** 888-204-5581
24 Hours Nurse Line—Envolve	**EnvolvePeopleCare.com** 855-872-1852
National Image Associates (NIA)	**RadMd.com** 888-899-7804
Dental and Vision—Avesis	**avesis.com** 833-554-1013
Lab Services—LabCorp	**labcorp.com**
Prescription—Abarca	**abarcahealth.com** 866-287-6156
Translation Services— AT&T Language Line	**languageline.com** 866-874-3972
Enrollee and Provider Services	202-821-1100

Eligibility

- Providers can check eligibility through our provider portal: **carefirstchpdc.com/provider-login.html**.
- Providers may call the District Eligibility Verification System at 202-906-8319.

Provider portal functionalities

- View patient's eligibility status and benefit Information
- Verify patients claims
- Download forms
- Request prior authorization
- Check referrals
- Check authorization status
- Update provider demographics
- Credentialing update
- Provider manual

Electronic payments

- CareFirst CHPDC will accept claims electronically through **Change Health Care** (formerly Emdeon)—**Payor ID L0230**.
- Change Health Care also has electronic remittance/direct deposit capability.
- All clean claims submitted in a timely manner will be paid within 30 days.

Claims submission & appeals

Paper claims can be mailed to:

All claims for services rendered must be submitted within 365 days from the date of service, or date of discharge for inpatient admissions. Claims submitted by practitioners must be billed on CMS-1500 forms

CareFirst CHPDC
DC. Healthy Families Program (Medicaid)
P.O. Box 830786
Birmingham AL, 35283-0786

CareFirst CHPDC
DC Alliance Program
P.O. Box 830210
Birmingham,AL 35283-0210

CareFirst CHPDC will accept both paper and electronically submitted claims.

- Provider's appeal must be received by CareFirst CHPDC within 90 calendars days from denial date.
- Standard appeal resolution must be rendered no later than 30 calendar days of receipt appeal.
- Expedited appeal resolution must be rendered within 72 hours of receipt appeal.
- All denied claims can be submitted for reconsideration through the provider appeals/reconsideration process. Formal medical necessity and formal administrative claim appeal letter forms can be submitted in our Provider Portal.

Referrals

- Primary care physicians (PCP) must send the referral request via letter, prescription or phone call with the specialist rendering the services.
- If a specialty provider is out of network and the service cannot be provided in-network, a prior authorization must be obtained.
- Referral requests for non-participating practitioners are reviewed on a case-by-case basis by the Utilization Management Department.
- Key referrals information:
  - Patient/member name
  - Member ID
  - DOB
  - Address
  - Referring provider
  - Referred services
  - Limitations
  - Diagnosis/procedure codes

Health services

Case/disease management referral

CareFirst CHPDC has a robust case/disease management program to coordinate the care of enrollees with high risk or chronic conditions. Please use referral for chronic conditions. Please use the form located on our website to refer enrollees to the following programs: childhood asthma, renal diabetes, cardiovascular, respiratory (asthma and COPD), social services, high risk pregnancy, etc.

Diabetes disease management program

All CareFirst CHPDC enrollees aged 18+ with a primary or secondary diagnosis of diabetes or pre-diabetes (except for gestational diabetes) are eligible to receive benefits from this program. All eligible enrollees will undergo a diabetes health risk assessment and receive education and services customized to the severity of illness.

Childhood asthma disease management program

All CareFirst CHPDC enrollees aged 2–20 with a primary or secondary diagnosis of asthma are eligible to receive benefits. All eligible enrollees will undergo asthma assessment and receive education and services customized to their severity of their illness.

Case management services, PCP outreach and care coordination are also available to high-risk enrollees. If you know an enrollee that would benefit from these services, please contact CareFirst CHPDC at 202-821-1132, or complete the referral form on **carefirstchpdc.com**.

Prior authorizations process

An authorization is not a guarantee of payment.

Requests for pre-authorization should be submitted to:

- Utilization management authorization: 202-821-1100
- Utilization management fax number: (202)821-1098
- Urgent concurrent authorization decisions made within 24 hours of receipt of request for services. Oral notification will be made within 24 hours of the decision.
- Urgent expedited pre-service authorization decisions made within 72 hours of receipt of request for services with a possible extension of up 14 calendar days. Oral notification will be made within 24 hours of decision.
- Standard, non-urgent pre-service authorization decisions made no later 14 days of receipt of request for services, with a possible extension of up to 14 calendar days. Oral notification will be made within 24 hours of the decision.
- Post-service authorization decisions, as expeditiously as the member's health condition requires and no later than than 14 calendar days of receipt of the request for services with a possible extension of up to 14 days. Oral notification will be made within 24 hours of the decision.
- Pre-service authorization requests for behavioral health services are handled by Beacon Health Options at 855-481-7041.
- Pre-service authorization requests for certain non-emergent imaging services are handled by National Imaging Associates (NIA). **RadMd.com** or 1-888-899-7804.
- Wellness care and diagnostic services (such as screening and labs) require no prior plan notification.

Services that do require prior authorization are consistent with other plans. These services include, but aren't limited to: outpatient and inpatient services, rehabilitative services, nursing home/ skilled nursing/hospice care, major surgery and general anesthesia, out-of-network providers and non-formulary pharmaceutical.

Emergency services notification

- Emergency services and transportation do not require prior authorization, but plan notification is encouraged as soon as possible.

Medical authorizations

- It is important to complete all relevant information on the prior authorization form. Prior to sending requests, please be sure that eligibility is checked. Requests will not be processed if they are missing the member number, clinical information, CPT, ICD-10 codes and/or physician signatures.

Pharmaceutical authorizations

- If an enrollee requires medication not on the formulary, practitioners may request a medication exception form located on our website **carefirstchpdc.com**.
- Completed form and copy of prescription should be faxed to the pharmacy department at 202-821-1098.

Obstetrical notifications

- Pregnancy care does not require pre-authorization. However, plan notification of OB services is required. OB care and services will be coordinated by a CareFirst CHPDC OB case manager. You may fax this OB Authorization form to UM at 202-821-1098.