

# Provider Manual

## Welcome

Welcome to the Elkhart Medical Organization (EMO) network of participating providers! As a participating provider, you have an important role in delivering quality health care services to our members. To assist you in your efforts, we have prepared this reference guide. This guide contains the procedures that are applicable to our self-funded direct employer contracts. The purpose of this manual is to provide a brief, yet detailed and useful description of services offered to providers of the Elkhart Medical Organization.

Elkhart Medical Organization is not an insurance company, but rather a network of providers accessed by employer's insurance companies and other claim payors. Since we are not an insurance company or a payor, there are some administrative differences we feel are very important which you and your billing and registration staff should be aware. This manual was designed to illustrate those differences and minimize any possible confusion.

We hope you find this information helpful. The EMO Provider Relations personnel are dedicated to serving you. Our team is available to discuss network and participation matters, resolve systemic issues, and provide assistance and training to you and your staff. You can expect courteous and responsive service from EMO.

We truly value every provider that participates in our network and look forward to continuing a strong and positive relationship.

EMO contracts do not require the selection of a primary care physician, nor do they require written referrals. If a provider is in network benefits are payable at a higher percentage than out of network benefits. That benefit differential is at least 20% actuarially determined.

# Provider Manual Overview

## Table of Contents

|                                  | Page |
|----------------------------------|------|
| Vision, Mission, History         | 1    |
| Governance & Administration      | 1    |
| Contacts                         | 4    |
| Definition of terms              | 4    |
| The Network                      | 5    |
| Participating Providers          | 5    |
| Contracts                        | 6    |
| Credentialing Process            | 7    |
| Roles and Responsibilities       |      |
| EMO                              | 8    |
| Members                          | 9    |
| Providers                        | 9    |
| Payors                           | 10   |
| Member identification & Referral | 11   |
| Insurance cards                  | 11   |
| Employer Group Information       | 11   |
| Reimbursement                    | 12   |
| FAQ                              | 15   |
| Forms (print as needed)          | 18   |

P:\MC\Shared\Provider Relations\Provider Manual 2005 Final version.doc

# **Elkhart Medical Organization**

## **Mission Statement**

Elkhart Medical Organization provides customers with access to comprehensive medical care through effective management of an integrated regional delivery system.

## **Vision Statement**

Elkhart Medical Organization will build, manage and market a high quality network of regional health care providers to patients, employers and other quality-oriented managed care plans through effective customer service, medical management and aligned financial incentives.

## **History**

Elkhart Medical Organization, a physician hospital organization, was created to furnish area businesses with a single, user-friendly entity for contracting purposes. EMO began late in 1995. As of December 2004, EMO served over 100,000 members throughout northern Indiana and southwest Michigan.

## **Governance**

### **Board of Directors**

The nine member EMO Board of Directors sets strategic direction for EMO. It is comprised of seven physicians, at least four of which are primary care, and two hospital representatives.

### **Committees**

#### **Credentialing**

This committee sets criteria for provider participation, reviews and approves or rejects potential providers for the network, and re-credentials current providers following National Committee for Quality Assurance (NCQA) guidelines.

#### **Finance**

This committee recommends reimbursement schedules for direct employer contracts, reviews financial operations, and decides other financial matters.

#### **Utilization Management & Quality Assurance**

This committee reviews quality issues as they arise.

## Administration

### Executive Director

- Conducts the affairs and pursues opportunities responsive to strategic mandates of Board of Directors
- Maintains good relations with carriers, brokers, and other PHOs
- Manages day-to-day operations of EMO
- Serves as non-voting secretary for the Board of Directors and attends all committee meetings

### Administrative Assistant

- Manages system for retention of contract documentation
- Participates in multiple data file management activities
- Provides organization support to Executive Director

### Credentialing Coordinator

- Prepares and maintains all documentation and credentialing verification for applicants and re-credentialing
- Performs site surveys
- Serves as non-voting support for the Credentialing Committee

### Contract Coordinator

- Performs EMO financial record keeping and contract research analysis
- Maintains data files on employer contracts
- Determines general customer satisfaction as expressed by Members bi-annually
- Serves as non-voting support for the Finance Committee

### Provider Relations Coordinator

- Coordinates activities of Provider Relations personnel for consistency in representing EMO
- Provides orientation and in-services for practitioner offices in Indiana
- Supports practitioner billing offices
- Responds to concerns and questions brought forward by practitioners
- Determines general practitioner satisfaction bi-annually

### Provider Relations Representative

- Provides orientation and in-services for practitioner offices in Michigan
- Supports practitioner billing offices
- Responds to concerns and questions brought forward by practitioners

- Determines general practitioner satisfaction bi-annually

#### Process Analyst

- Maintains data file of network provider demographics
- Assists in tracking unpaid claim issues

#### Customer Service Representative

- Provides telephonic support for Member inquiries

## Contact Information

|                                   |                |
|-----------------------------------|----------------|
| Executive Director                | (574) 523-7914 |
| Administrative Assistant          | (574) 523-3133 |
| Contract Coordinator              | (574) 523-7989 |
| Credentialing Coordinator         | (574) 523-7990 |
| Provider Relations Coordinator    | (574) 523-7931 |
| Provider Relations Representative | (574) 523-7969 |
| Customer Service                  | (574) 523-3436 |
| Out of Elkhart Area               | (800) 543-3195 |
| General fax                       | (574) 523-7940 |
| Credentialing fax                 | (574) 523-7962 |

## Definition of Terms

**EMO:** Elkhart Medical Organization is a network of practitioners, hospitals, surgery centers, and ancillary facilities such as home medical care, home infusion and durable medical equipment.

**Explanation of Benefits:** The EOB is sent by a TPA or insurance company to the provider of service. It shows what services are covered at the negotiated rate, what the amount of patient responsibility is, and amount paid.

**Member:** A Member is an employee or other covered person accessing EMO through a contractual relationship.

**Participating Provider:** This relates to whether the practitioner or facility is a credentialed provider within EMO.

**Payor:** The third party administrator or insurance company that administers the plan document. The payor is responsible for providing explanations of benefits and/or remittance advice to the appropriate parties along with appropriate funds.

**Remittance Advice (RA):** The RA is sent by the TPA or insurance company to the provider. Some payors use a RA in lieu of an EOB.

**Repricer:** The primary function of repricing is to verify network participation status as well as apply the allowable reimbursement for services billed.

**Third Party Administrator:** A TPA serves to adjudicate and pay claims with funds provided by the contracted employer or benefit plan. A TPA works for self-funded clients.

## The Network

### Participating Providers

#### Specialty Concentration

The composition of the EMO network is to serve the employers and their employees in Northern Indiana and Southern Michigan. Because the basic nature of a PPO plan is characterized by the element of choice for its members, it is essential that a sufficient number and variety of providers be contracted to respond to member preference.

#### Additional Providers

The customary course of securing an EMO provider application is for multiple patients of that provider to request the inclusion of the particular provider. Once demand for a potential applicant has been established, a needs assessment is performed. During this latter process, a review is conducted to assure that the network has not previously contracted a sufficient number of representatives in the geographical area for the kind of service in question. If a potential applicant has passed the “need” screening process, the EMO application process is initiated.

Generally, a practitioner joining an existing group, wherein members are currently EMO, will be given an application. One of the primary intents of EMO contracting is to assure adequate treatment accessibility, which can be demonstrated by flexible scheduling of partners within a group.

#### Current Specialties

One of the guiding principles for EMO is to make available those services, practitioners and facilities for which customers have potential medical need. As a consequence of this intent, the entities contracted ideally represent a solid continuum of care. Currently EMO credentials and contracts with physicians, outpatient surgical centers, hospitals, CRNAs, clinical social workers, optometrists, psychologists, nursing homes, and certified surgical assistants as well as several other specialties.

Secondary to the guidance of the Board of Directors, the network is responsive to the rapidly changing nature of the provision of health care. As new treatment methods and protocols evolve, discussions occur regarding the relative merit of extending the network to additional classifications of providers.

EMO does contract with insurance companies, network consolidators, and directly with ERISA exempt self-funded employers. The receptivity of each of these contracted parties to the array of providers that have been credentialed by EMO will vary. Typically, the existing policies of those entities will define the acceptability of any particular specialty or service. One of the elements identified during contract negotiations is payor recognition of the various professions and entities. Acceptance is not automatic.

## Contracts

Currently three distinct variations of contracts are written on the providers' behalf. First, the network is made available to ERISA exempt self-insured employers. Those employers define and develop the benefit plan made available to their employees. In the process, the following parties are brought together: a repricer, a claims payor, a re-insurer, a utilization management company, and a network of providers. Sometimes a contracted entity will perform multiple roles for this employer.

Second, EMO contracts with network consolidators. Network consolidators typically will contract with an array of PHOs or regional PPOs in order to serve regional and/or national clients. The weaving together of these separate networks can be conducted as broadly as the consolidator chooses to function. An example of a consolidator is Private Health Care Systems (PHCS).

Finally, EMO contracts directly with insurance companies. These carriers may have multiple insurance products. Among the selection will be PPO plans. Consequently, they will identify PHOs or regional PPOs that function in areas common to their PPO marketing and service targets. For these agreements, insurance companies contracted with EMO are obligated to act only as PPO providers. There is no contractual duty through the EMO commitment to recognize the patients who have signed on for any of the other products sold by the insurance company.

Through the regular mailings from EMO, offices will know at any time which contracts are effective.

Various criteria determine the consideration of contracts with the consolidators and the insurance companies. Customer service standards, the number of local covered lives, and effective reimbursement policies and practices are among elements reviewed closely.

EMO has other agreements such as reciprocity agreements beneficial to its providers. A reciprocity agreement is one with another PHO whereby each party to the agreement accepts the providers of the other. That is, upon reviewing each other's credentialing process, each agrees to accept the other's providers. Additionally, each shares new contracts for potential participation as well.

These reciprocity agreements with PHOs in contiguous regions serve multiple purposes. First, reciprocity effectively expands the provider selection opportunities for covered employees and their family members of the contracted employers. Employees do not always reside where they work. It is therefore possible to bring them participating providers from a wider geographical region. Second, each provider's opportunity for service is expanded because of the additional working agreements in place.

## Credentialing Process

Once an EMO application is received, it is reviewed for its completeness. All applications are subject to credentialing verification by tools such as the National Practitioner Data Bank, professional licensing agencies and/or accrediting entities, state insurance departments, and/or medical associations. Once the data has been assimilated, materials are gathered for review by the EMO Credentialing Committee. This committee determines acceptance into the network. The Credentialing Coordinator will notify the provider of his/her status.

Providers or their delegate can assist in the credentialing process by:

- Completing credentialing and re-credentialing forms promptly
- Providing all of the requested supplementary documents
- Routinely faxing all license and insurance renewals
- Accepting that the credentialing verification process takes time (i.e., a minimum of forty-five days for practitioners)
- Routinely notifying the Credentialing Coordinator of TIN and demographic changes by using the EMO Change Form

The Credentialing Committee credentials all providers. Re-credentialing occurs every three (3) years thereafter.

### Effective Date

When the credentialing process is complete, an effective date is assigned for participation in the network. An approval letter documenting the effective date is sent to the provider. Simultaneously, the provider data is forwarded for inclusion in the next update to the TPAs and insurance companies. This database is updated monthly.

## Roles and Responsibilities

### EMO will:

- Follow policies and procedures as approved by the EMO Board of Directors
- Support standing EMO committees
- Negotiate managed care contracts
- Promote the network to self-funded entities through the broker/agent community
- Disseminate accurate provider information in a timely manner to payors
- Distribute accurate reimbursement schedules in a timely manner to payors and providers.
- Respond to any reimbursement schedule requests from providers' offices
- Serve as liaison between payors and providers to resolve systemic claims and/or participation issues
- Maintain current and accurate provider participation information available on the web site of [www.EMOnetwork.org](http://www.EMOnetwork.org) (monthly)
- Offer education for provider offices with orientation programs, supplemental in-services, and periodic newsletters
- Manage the members' and providers' grievance processes
- Provide customer service line responsive to member inquiry
- Provide a direct contact for participating providers
- Provide access to EMO leadership

### Members

- May go to any provider in the network for a lower amount of 'out-of-pocket' expense
- May go to any out-of-network provider, but must accept an increased level of 'out-of-pocket' expense as defined in their benefit package
- Hold no responsibility for claim submission if current insurance card is presented at time of service
- May access the web site [www.Emonetwork.org](http://www.Emonetwork.org) or request information from their employer
- Must present current insurance card(s) at time of service
- Should understand their insurance plan and how it works
- Must determine if the provider of their choice is in the network at the time of service
- Must pay co-payments at time of service
- Are liable for deductibles, co-insurance, and non-covered benefit amounts (as determined by the plan description) after the explanation of benefits is issued

Members have the right to:

- Available and accessible services, which can be secured as promptly as appropriate for the symptoms presented, and the right to have emergency services available 24 hours a day, 7 days a week.
- Be treated with respect, recognition of their dignity, and need for privacy.
- Receive information regarding the health problems, treatment alternatives, and associated risk sufficient to assure an informed choice
- Participate in decision-making regarding their health care

Providers will:

- Maintain licenses, certificates, etc. required to perform duties of their specialty
- Maintain privileges with EMO participating hospital or designated facility (if a physician)
- Provide EMO office with copies of licenses, and information on changes in TIN, addresses, telephone numbers, contact parties, etc.
- Participate in tri-annual re-credentialing process
- Permit, with appropriate notice, on-site survey of facility
- Allow EMO to negotiate managed care contracts on your behalf according to policy guidelines
- Accept lesser of reimbursement schedule or standard charge as payment in full for covered services (subject to deductibles, coinsurance)
- Maintain complete medical records as required by state law
- Secure appropriate releases of information as required by HIPAA and state law
- Protect patient rights
- Cooperate with utilization management, quality improvement and grievance processes
- Clinically treat patients of EMO contracts in nondiscriminatory manner as they do all their patients regardless of source of payment
- Handle medically or financially non-compliant EMO patients (recognizing any contractual constraints) as provider policy defines for all patients
- Copy and maintain both sides of the patients' insurance cards for future reference as per provider policy
- Verbally verify coverage with patient at each visit
- Promptly bill for services rendered on appropriate bill form to the address on the member's ID card
- Collect any office co-pay at time of visit and not require further payment regarding that visit until receiving an explanation of benefits

Payors and Carriers will:

- Pay clean claims within the parameters of the contract between EMO and the employer group.
- Identify to interested parties any filing limits
- Provide a sample explanation of benefits (EOB)
- Place network name clearly on EOB
- Distribute in timely manner member identification cards with:
  - Patient name
  - Member number
  - Patient group number
  - Network identification
  - Claim mailing address
- Identify internal points of contact for claim inquiry and resolution
- Provide timely claim payment information in the manner requested

## Member Identification and Referral

### Insurance Cards

The member's ID card is an essential component of the delivery process of healthcare services, and a copy of the card should be obtained each time a patient presents for services. It is the "key" to receiving the quality healthcare services arranged by the employer for their employees. Important phone numbers to verify benefits and coverage eligibility, along with co-payment obligations, precertification requirements, and claim filing instructions are all identified on the member card.

- Insured persons and enrolled family members should check-in at the provider's office with the current identification card upon each visit.
- Offices should maintain a copy of both sides of the current card for reference.
- The card is to be reviewed for network identification, co-payment amounts, and billing/claim information.
- The eligibility of the patient presenting the insurance card is not guaranteed because of possession of the card.
- If current information is desired, the office representative should call the number on the card identified for eligibility and benefits.
- Co-payment should be collected when the patient checks in rather than when they check out. Collecting co-payment up front makes check-out and re-scheduling faster for the patient.
- If the provider wants to refer to another provider either in or out of the network, **THERE ARE NO FORMS TO BE COMPLETED**. Schedule the patient with the other provider's office.
- If EMO contracts to be a point of service (POS) product, the PCP will be compensated for those required referrals either through improved evaluation and management code reimbursement or a per member per month fee.

### Employer Group Information (EGI) Sheets

EMO creates EGI sheets and distributes as requested. These EGI sheets define the summary of the benefit plan for the members of various locally contracted employers.

Not every locally contracted employer will have a sheet. Network consolidators and national insurance companies do not supply EMO with this information.

EGI Sheets are as current as the information EMO has on file. Employers and/or brokers do not always provide EMO with changes in information, e.g., benefit modifications. EMO continues, however, to affirm the relevance of this information on an annual basis.

A list of contracted entities and employers will be forwarded to you in the monthly mailing of the EMO Office Manager's newsletter.

## Reimbursement

### Claim Filing

- Submit charges and file claims as soon as possible after the services have been rendered. A healthy cash flow for the practice is dependent on timely filing.
- The member ID card should always be referenced for claims mailing instructions.
- Electronic claims transmissions need to be monitored to ensure all claims transmitted were received by the clearing house.

### Payment

- Most direct employer self-funded contracts signed by EMO specify thirty calendar days from bill date for turn around of clean claims.
- Offices should challenge claim non-payment or discounted payment as a result of Payor inquiries of persons other than provider office staff, e.g., regarding issues of coordination of benefits or subrogation.

### Billing Patients

- The actual level of payment by the Payor is defined by the benefit plan
- Benefit information is available at the customer service number on the insurance identification card.
- Patients can not be billed for any medically unnecessary services unless a waiver is signed prior to rendering the service.
- Patients may be billed for co-payments, coinsurance, deductibles, and non-covered medically necessary services or patient elective services.
- Providers may request the payment of deductibles and coinsurance amounts at time of service, but can not require their payment until after the EOB is received.

### Patient Responsibility

- With the exception of “pre-certification” duties performed by the provider’s representative, the patient is ultimately responsible for determining if a service or supply is covered.
- Patients must pay office co-payments at time of service. Providers should never have to bill for this amount.
- A patient who abuses the payment of co-payments may be terminated from the practice if that is the provider’s policy for all patients.
- EMO will assist in recovering payments for covered services due from payors (either unpaid or paid incorrectly) after the provider’s office has made the first effort by speaking with the payor. In some instances, a payor’s automated voice response may resolve the problem.
- EMO will not assist in collecting balances due from patients for co-payments, deductibles, or non-covered services.

## Billing Practices

- The appropriate definition of a particular medical service will be the procedure code as presented by the American Medical Association for those services billed on a CMS 1500 or a UB revenue code for those services properly billed on a CMS 1450 (UB-92).
- Submission of a code does not guarantee reimbursement. Although EMO will assist provider offices with appeals that challenge the payor's interpretation of an adjudicated claim, final determination by the payor on reimbursement issues will prevail. The CPT code does not mean that the claim will be paid.
- The insurance carrier and/or employer determines plan benefits.
- If a service is medically necessary, but non-covered, the patient may be billed at the usual charge.

## Aged Claims Inquiry Process

- Follow-up on aged claims 30 days and older should be done on a regular basis. The provider office staff must first contact the payor to determine that the claim was received and the current status of the claim.
- Electronic claims not received by the payor within 30 days should be dropped to paper and resubmitted by the provider.
- If no action, submit a CLAIMS ISSUE FAX COVER SHEET to EMO, along with a copy of the claim. The issue will be researched and you will be contacted with resolution information within 2 business days. Please complete the requested information on the fax cover sheet. Claims that have not been worked initially by the provider office will be returned with a request to provide payor status information.

## Reimbursement Schedule Issues

- Initial follow-up on all claims issues should take place between the provider office and the payor.
- Any claim not paid in accordance with the appropriate reimbursement schedule should be reprocessed in its entirety for correct payment.
- The CPT reimbursement schedule and facility discount rates used for direct contracts with employers is recommended by Administration, reviewed by the EMO Finance Committee and approved by its Board of Directors.
- This reimbursement is developed from the relative value units released through the Federal Register of the previous calendar year. (Note: e.g., the 2005 schedule is based on values defined in 2003 for 2004 use.) They are developed and compiled by Ingenix, the largest health data warehouse in the United States.
- The EMO schedule is approved annually in September for October distribution. Payors have over sixty days to load in preparation for a January 1 effective date.

- Provider offices may request reimbursement disks, or common code listings for reimbursement schedule information.
- Unspecified codes or unlisted codes are paid at 90% of charge, unless there are contractual exceptions.
- Psychologists are paid at 90% of the physician fee schedule; all other allied health professionals are paid at 80% of the physician reimbursement schedule.

### Referrals

- EMO functions as a PPO plan.
- PPO plans typically do not require referrals.
- Eligible providers are identified on the website [www.EMOnetwork.org](http://www.EMOnetwork.org) or by accessing the information by calling the number provided on the insurance card.
- In-network referrals benefit the patients because they have to pay less money out of pocket for medical services.
- Out-of-network referrals may be made; however, the patient must be made aware of the consequences if an in-network provider is available.

### Authorizations

Some plans require prior authorizations for specific events. Those may include CT, MRI, PET, elective surgery. If you do not have an authorization for the service, ask the patient to sign a waiver stating they will obtain it or be responsible for any denied payment.

## Frequently Asked Questions

### **Are physical, occupational, or speech therapists in network?**

EMO's current policy is to not credential physical, occupational, or speech therapists as they are employees of a hospital or physician group. EMO considers the provision of this type of service covered as "in network" when the following conditions are met.

If the facility is participating in EMO, then

1. The physical, occupational, or speech therapy services are provided at the same physical location(s) as the enrolled facility, and
2. The physical, occupational or speech therapist is an employee of the enrolled facility, and
3. The physical, occupational, or speech therapy service is billed under the enrolled facility's TIN.

***OR***

If the facility is *not* an EMO network enrolled facility, then the therapist may accept referrals as in network from that facility's physicians only in the same physical location as the EMO physician.

While it is correct to say that EMO does not *credential* physical, occupational, or speech therapists one must add that services provided by physical, occupational, or speech therapists meeting the above criteria are considered participating and will be reimbursed as in network.

### **What happens when the doctor I want to see is not in EMO?**

EMO is a Preferred Provider Organization (PPO) which is a type of managed care plan in which members may obtain care either from a network (in this case EMO) of physicians, hospitals, and other allied professionals *or* from any non-network providers that the member prefers. However, members should be aware that if they select participating providers, their co-payments and/or deductible are lower than if they choose a non-network provider.

### **How can I get my doctor or allied health professional to join the network?**

EMO invites members to nominate a practitioner to be considered for the EMO panel of providers. A member may nominate a practitioner by completing the Practitioner Referral Form located on the web, [www.EMOnetwork.org](http://www.EMOnetwork.org).

Once a nomination is received, the Provider Relations Coordinator/Representative will gather more information about the practitioner and screen to determine:

1. If there is sufficient need for that category of practitioner?
2. Whether there are sufficient numbers of practitioners in that category already participating within the geographical area?
3. If the practitioner has privileges at a network hospital or approved surgery center or is willing and able to become privileged?

4. Is the practitioner joining an existing EMO provider group or providing coverage for a current network practitioner?

If the nominated practitioner successfully meets the pre-application screening criteria, a letter will be sent inviting the referred applicant to complete an application. The opportunity to complete an application does not presume that the practitioner will ultimately be invited to join the EMO network. The decision to invite a specific practitioner to join the network is made by the Credentials Committee upon review of the completed application and verification of credentials.

You could also ask your doctor or allied health professional if he or she would consider joining the EMO network. This may influence his or her decision if an invitation to complete an application to join the network is forthcoming.

### **Is Elkhart Medical Organization the insurance company?**

No. EMO is the network of providers and facilities the employer has elected to use for their healthcare benefit plan. EMO is **not** associated with benefit determinations or what the covered services are on the member's plan. The employer is responsible for benefit design.

### **What is a Third Party Administrator (TPA)?**

The Third Party Administrator (TPA) is responsible for the administration of an employer's medical benefit plan and the direction of the employer. TPA's typically are responsible for printing ID cards, medical benefit plan design booklets, contracting with pre-certification companies, contracting with utilization review companies and the processing of repriced medical claims.

### **Who provides the patient's ID card?**

Identification cards are distributed to the member(s) either by the TPA or the employer's Human Resources Department. Please contact employer's Human Resources Department to ensure the most current card is being used.

### **What is the patient's co-pay amount?**

The co-pay amount may vary per plan, please check the member ID card.

### **What is covered under the patient's plan?**

Coverage is determined by the employer and administered by a TPA chosen by the employer. Generally, there is a telephone number on the back of the patient's ID card. This telephone number should be able to provide a verification of eligibility and benefits.

### **Are referrals and/or pre-certifications required?**

Perhaps. Either the TPA or the employer provides each member a medical benefit plan booklet. Please contact the TPA for assistance or call the pre-certification number indicated on the patient's ID Card. Some cards may specify procedures for pre-certification.

**What do all the letters on my card mean?**

Elkhart Medical Organization has a reciprocal agreement with Community Health Alliance and Lakeland Care Inc. (LCI). If your card shows EMO/CHA/LCI this means that providers enrolled in either network are participating providers within the network.

The same applies for those cards that say EMO/CHA/LCI/Lutheran Preferred. Providers enrolled in any of the four networks are participating providers within EMO's network.

# Elkhart Medical Organization--Change Form: New, Term or Add Practice Site

**Instructions:** Complete this form *if your status has changed and you wish to remain a member in good standing in Elkhart Medical Organization (EMO) or if you wish to disassociate from EMO.* This information is needed to update your credentialing file.

*If you have questions call, Credentialing at 574-523-7990.*

**1. Practitioner Name:**

\_\_\_\_\_

*(You must check one of the following)*

I am NOT leaving my current practice but *am adding a second practice and/or TIN.* (Please complete form.)

I am leaving my current practice or leaving the area and DO NOT WISH TO MAINTAIN MY AFFILIATION WITH EMO. Ending date with current practice: \_\_\_\_\_ (You do not need to complete the rest of this form, but please sign, date, and return to the address listed below.)

I am leaving my current practice to join/start another practice and WANT TO MAINTAIN MY AFFILIATION WITH EMO. My last work date with my old practice: \_\_\_\_\_ (Please complete form.)

I am leaving my current practice on \_\_\_\_\_, *have not yet finalized my future plans, but WANT TO MAINTAIN MY AFFILIATION WITH EMO.* (Please sign, date, and fax to number listed below. When your plans become final, complete lower portion of form and again fax back with the requested documents.)

**2. Legal Name of NEW or ADDITIONAL Practice:**

\_\_\_\_\_

**3. Location address:**

\_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

**5. Correspondence address:**

\_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

**5. Appointment Phone:** \_\_\_\_\_ **FAX:** \_\_\_\_\_

**E-mail:** \_\_\_\_\_

**6. Office Manager Contact:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Off. Mgr: Fax:** \_\_\_\_\_ **Off Mgr E-mail:** \_\_\_\_\_

**7. Are there other practice locations? Yes No (If yes, list on back)**

**8. Billing address:** \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

9. **Billing Contact:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
**Billing Fax:** \_\_\_\_\_ **Billing E-mail:** \_\_\_\_\_
10. \_\_\_\_\_ I have attached a copy of current Malpractice Insurance face sheet that covers a new practice.
11. \_\_\_\_\_ I have attached a copy of a W-9 for my new employer or practice. There must be a W-9 for EACH Tax ID Number you are/will be using or billing under.
12. Effective date with *new* practice: \_\_\_\_\_
13. I continue to have privileges with the following hospital(s) or surgery centers: **NAME ALL.**
14. I want to be listed in the next Provider Director under this specialty: \_\_\_\_\_

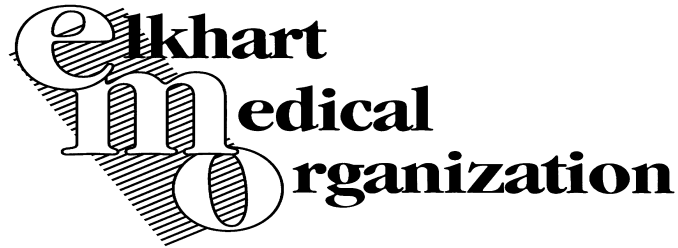
---

Print Provider Name

Date

*Please fax to (574) 523-7962 or mail to:*

**EMO, 600 East Boulevard, Elkhart, IN 46514**



## CLAIMS ISSUE FAX COVER SHEET

Please complete form and fax a copy of the claim & EOB (if claim paid) to

EMO @ (574) 523-7940

Is EMO on the ID card?       YES       NO

Have you received any payment?       YES       NO

Is the claim issue related to reimbursement schedule?       YES       NO

Is the claim issue related to provider network participation?       YES       NO

State in which services were rendered       Indiana       Michigan

Please use the lines below to list what actions you have already taken to resolve the issue including the payor contact name, phone number, and dates of your call(s), and a summary of what you were told.

Payor name & phone #

Number of pages faxed

\_\_\_\_\_

\_\_\_\_\_

Person(s) you spoke with & date(s):

---

Summary of discussion(s) with payor: Attach another page if necessary:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Your Name, (First, Last) Phone Number and E-mail address: \_\_\_\_\_

\_\_\_\_\_

**A Representative of EMO will contact you within 2 business days to relay action taken.**

|                            |
|----------------------------|
| EMO Only    Record # _____ |
|----------------------------|