Provider Training Tool

&

Quick Reference Guide

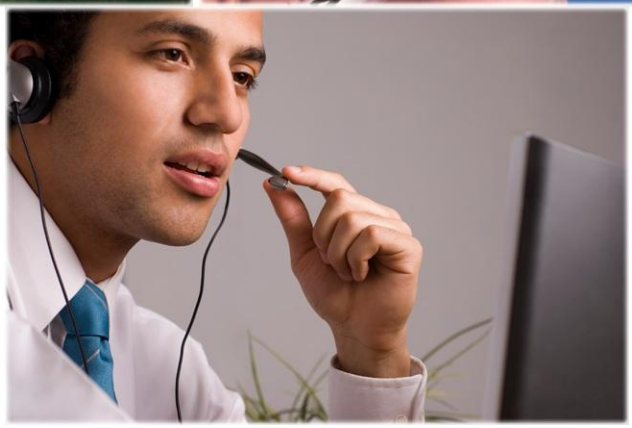

Table of Contents

I. EMP History

EMP, established in 1999 and which currently has over one-hundred employees and multiple office locations. EMP is a leader in designing managed care solutions that deliver Home Care Services to Commercial, Medicare and Medicaid insured throughout the State of Florida. EMP brings together the delivery of Durable Medical Equipment, Home Health (skilled nursing, OP, PT and Speech therapies), Home IV, and Diabetic Supplies via our statewide network of reputable community based providers.

Central Medical Equipment Rental, Inc. (Central) a sister company of EMP is a JCAHO Accredited FL DME Company serving Miami-Dade, Broward, Palm Beach, Monroe, St. Lucie, Indian River, Okeechobee and Martin counties.

EMP and Central are both dedicated to meeting medical, respiratory, pharmacy, nursing, equipment and social service needs of our patients. Our mission is a strong commitment to restoring & rehabilitating the health or our patients by promoting quality home health practices. EMP has developed a collaborative model of care that support our health plan partners provide a viable solution that simplify access to ancillary services through “Single Point of Entry”.

II. Services

New order request(s) for Durable Medical Equipment, Medical Supplies, Home Health Care, Home Infusion and Diabetic Supplies are the responsibility of EMP Medical Services, Inc. on a statewide basis as.

- Providers may contact EMP 24 hours a day/7 days a week by calling 800.225.6765 or 305.446.4421
- Physician orders may by submitted by facsimile at 800.228.1958 or 305.446.5871
- Hospital Discharge Planners may also submit request via ECIN.

III. Obtaining Authorization

The referral authorization process is an important component of EMP’s Clinical Intake Program. The referral authorization process must be used by all participating Home Health, Home Infusion, and Durable Medical Equipment providers to assure that the member receives the maximum benefit and that claim(s) are considered for benefits in a timely manner and processed correctly.

EMP will review all orders and select the most appropriate participating provider and issue authorization in order for the service(s) to be rendered to patient. All services require clinical review, assignment and prior authorization. EMP's referral authorization process confirms member eligibility, member benefits, the services are reasonable for treatment of illness or injury, and meets all applicable medical, health plan and regulatory criteria.

Once an EMP Participating Provider has accepted the patient for service, an authorization is issued and an EMP Referral Authorization Form is sent to the provider outlying the specific service/item being approved. The Referral Authorization Form is accompanied by the doctor's order and pertinent patient information including any member financial responsibility.

The Referral Authorization Form contains: Patient Information, Ordering Provider Information, Clinical Information, Special Comments along with Date Ranges and CPT4/HCPC Codes for the precise services being authorized. The authorization number remains in effect until the patient is discharged. **See attached sample Referral Authorization Form.**

Participating Providers must notify EMP immediately if services are unable to be provided for any reason. For example, a patient may not be home or medications may not have arrived and care cannot start as requested.

The authorization process and the claim processing are closely linked. Claims are considered for benefits based on CPT4 and HCPC Codes and units authorized. Submission of accurate claims information in a timely manner is an essential part of Participating Provider's role. Appropriate authorization number must be submitted on all claims. A claim submitted without an authorization number may be rejected and/or denied.

EMP Intake Flow

Order Received via Fax

Fax is Logged
Plan Eligibility Verified and Prescription is reviewed for Completeness
EMP Data Management System Reviewed
Patient File Created

Patient Active?

No

Ordering Physician or Health Plan Notification Provided

Yes

Order Provided to Department Case Coordinator

Home Medical Equipment

Home Health Care

Infused and Non-Infused Therapies

Diabetic and Other Supplies

Coordinator Will Review Benefits And Medical Necessity and Refer Any Questions/ Issues Accordingly (Health Plan, Case Manager, Director). Coordinator Will Contact Network Providers To Coordinate Services, Coordinate Faxing of Information and Confirm Receipt of Fax by Network Provider and Staffing of Service. Case Coordinator Will Also Contact Discharging Facilities to Confirm Staffing and Patient to Advise Them of EMP's Role and Provider That Will Directly Provide the Services.

Services Are Provided By Network Providers and Claims forwarded to EMP for Processing

Coordinators Conduct Surveys to Ensure Satisfaction

Case Managers Utilize Interdisciplinary Process to Manage Patient Care and Review and Coordinate Requests for Additional Services based on physicians orders.

Weekly Rounds Conducted With Agencies and Health Plans to Address The Clinical Challenges and Progress of Patients With Certain Chronic Conditions or Participating in Health Plan's Case Management Program

Documentation Filed Accordingly

Our Case Management Monitoring Promotes The Delivery of Health Care and Services in an Effective Cost Efficient Manner. This is a Process Whereby We Evaluate the Adequacy and Appropriateness of The Delivery of Home Care Services.

2850 Douglas Road 3rd Floor

P#6706
Coral Gables, FL 33134
Phone: (800)225-6755

REFERRAL AUTHORIZATION FORM

Authorization #: (1) **Referral Status:** (2)

PATIENT INFORMATION

Patient Name: (3) **DOB:** (4) **SSN:** (5)

Patient ID: (6)

Address: (7) **Home Phone:** (8)

Payer ID: (9) **Plan ID:** (10) **Benefit Contract:** (11)

PCP Name: (12) **PCP ID:** (13) **PCP Phone:** (14)

Facility ID: (15) **Contact Name and Phone:** (16)

Referral Type: (17)

ORDERING PROVIDER

Name: (18) **Phone:** (19) **Fax:** (20)

CLINICAL DATA

Primary Diagnosis: (21)

Secondary Diagnosis: (22)

Special Instructions:
(23)

Service Requested: (24)

Requested Dates of Service: (26) **to:** (27)

Eff From	Eff Thru	Approved Procedures	Approved # of Visits
(28)		(29)	(30)

EMP Coordinator/Manager: (31) **Urgency:** (32)

REFERRED TO PROVIDER

(33)

Name: **Specialty:**

Address: **Phone:** **Fax:**

This Referral Authorization Form is NOT a guarantee of payment. Reimbursement is subject to patient's eligibility with the Health Plan at the time the service is rendered.

Printed By: Printed On: Page: 1 of 1 Standard Report Last Modified:

Referral Authorization Form – field definition

1. EMP Authorization Number (applicable authorization number must be submitted on all claims)
2. Referral Status (i.e.: approval amended, approved, denied, entered, information) requested, non Admit, Under Review
3. Name of Patient (Last, Middle, First)
4. Date of Birth
5. Social Security No.
6. Patient ID - Health Plan assigned identification number
7. Patient Address
8. Patient Home Phone No.
9. Name of Insurance Plan
10. Insurance Plan Name
11. Insurance Plan Benefit Specification (i.e.: Commercial, Medicare and Medicaid)
12. Patient's Primary Care Physician Name
13. Primary Care Physician ID
14. Primary Care Physician Phone No.
15. Hospital/Facility Name
16. Contact name and Phone No. (of ordering provider/facility)
17. Type of Service/Equipment
18. Name of Doctor Requesting Services or Equipment
19. Doctor's Phone No.
20. Doctor's Fax No.
21. Primary Diagnosis
22. Secondary diagnosis
23. Notes or Special Instructions for Service or Equipment Provider (i.e.: Member Co-payment/responsibility, Reference Number & etc.)
24. Service Discharged (Discharged or blank)
25. Authorized Date of Service Start Date (One Month Time Span)
26. Authorized Date of Service End Date (One Month Time Span)
27. Authorized Start Date for Service or Equipment to be Executed or Delivered
28. Authorized End Date for Service or Equipment to be Executed or Delivered
29. CPT4 Code and/or HCPC Code of authorized Service or Equipment with Description
30. Approved No. of Visits for precise CPT4 Cade, HCPC Code or No. of Equipment
31. EMP Intake Coordinator
32. Delivery Instruction - Route, Within 24 hours; Stat, Within 4 Hours; Urgent, Same Day
33. Company Providing Services/Equipment

IV. Request for Additional Services

Home Health/Infusion

The referral re-authorization process is an important component of EMP's Clinical Intake Program. The Clinical Recommendation & Status Report Form must be used by all participating Home Health and Home Infusion providers to assure that the member receives on-going services beyond EMP's initial referral authorization.

After the member has been treated by a participating provider, their findings, diagnosis and recommendations should be sent to EMP Intake Department using the attached Clinical Recommendation & Status Report Form.

After the member has been seen by a participating provider and the provider desires to request additional covered medical services, the Clinical Recommendation & Status Report Form will be used to evaluate and process requests for on-going treatment/services. Failure to provide the Clinical Recommendation & Status Report Form could result in your patient's requested covered medical services being delayed and/or claims payment denied.

EMP's Intake Department will review the Clinical Recommendation & Status Report Form for medically necessity and/or benefits coverage and extend existing Referral Authorization. The extension of medically necessary treatment/services will be authorized according to specific CPT4 Code(s), HCPC code(s), units and date ranges. The initial referral authorization number will remain in effect until the patient is discharged.

Home Medical Equipment & Supplies

All participating Durable Medical Equipment and Medical Supply providers are required to request re-authorization by the 5th day of each month of existing authorization to assure that the member receives on-going services beyond EMP's initial referral authorization and ensure continuity of care and reimbursement.

Initial Home Medical Equipment authorizations for rental equipment are usually provided with a time frame of thirty (30) days. Participating Providers must track the rental cap timeframe as payment will not be made once reached. EMP authorization will indicate if the equipment is a purchase or rental. Small ticket items (canes, walkers, commodes & Nebulizers) are usually handled as a purchase unless otherwise determined and indicated.

Home Medical Equipment authorizations will be accompanied by the ordering physician's orders and must meet medical necessity & criteria. Brand specific items or supplies are not considered covered by most insurers however they may be reimbursed at the appropriate allowable amount for the HCPCS Code. Reimbursement will not be brand specific.

Network Providers may request renewal of the authorization with their system's active patient list which must include: 1) patient name; 2) health plan Id#; 3) current authorization #; 4) description of equipment; 5) HCPC Code and 6) Start of Care.

Failure to obtain timely re-authorizations could result in your patient's requested covered medical services being delayed and/or claims payment denied.

EMP MEDICAL SERVICES, INC. beyond patient care.

CLINICAL RECOMMENDATION & STATUS REPORT

Please return attn: Xenia to 1-800-228-1958.
Any questions, contact 1-800-225-6755 ext. 857

Agency: ① **Date:** ② **S.O.C:** ③

Patient's Last Name: ④

First Name: ⑤

D.O.B: ⑥ SSN#: ⑦ Tel #: ⑧

Primary Diagnosis: ⑨		
Secondary Diagnosis: ⑩		

History of Present Illnes: ⑪

Vital Signs: Temp: AP (Reg/Irr) ⑫ RP (Reg/ Irr) ⑬ Resp: ⑭ BP: ⑮

Homebound, Describe Reason: ⑯

Teaching and training of patient/caregiver/ friend/ family: ☐ Possible ☐ Not Possible ⑰

Home Environment: ☐ Lives Alone ☐ Debilitated ☐Frail Elderly Caregiver ☐ Other: ⑱

Wound Care:

Type	Location	Dimensions	Drainage	Stage	Improving
⑲	⑳	L_____cm x W_____㉑ cm x D _____cm	㉒	㉓	㉔
		L_____cm x W_____cm x D _____cm			
		L_____cm x W_____cm x D _____cm			

(Agencies must submit a status report on all wound care cases on a weekly basis)

Has a physician been notified of Plan of Care: ☐ Yes ☐ No ㉕ Next Physician Appt: ㉖

Medications being administered by Nurse: ☐ Yes ☐ No ㉗ Indicate Medication: ㉘

AGENCY RECOMMENDATIONS/ REQUEST				EMP OFFICE USE ONLY			
Discipline	**# Visits**	**From**	**To**	**Discipline**	**# Visits**	**From**	**To**
㉙	㉚	㉛	㉜	㉝	㉞	㉟	㊱

Specify Reason for Follow-up Visit/Plan of Care/ Frequency (Please be Specific) ㊲

Comments: ㊳

Provider Signature: _____
Date: _____

Case Manager Signature: _____
Date: _____

**Authorizations are usually provided to cover 2 weeks of care at which time a Recommendation and Status Report Form must be submitted for review if recommendation is for services to be continued.*

Clinical Recommendation & Status Report – field definition

1. Agency providing home care services
2. Date requested
3. Start of care date
4. Patient last name
5. Patient first name
6. Patient Date of Birth
7. Patient Social Security Number
8. Patient Telephone Number
9. Primary diagnosis and ICD9 code
10. Secondary diagnosis and ICD9 code
11. History of present illness
12. Apical Pulse
13. Radial Pulse
14. Respiratory Rate
15. Blood Pressure
16. Homebound Description (Reason and way the patient is homebound)
17. Can the family or friends be trained?
18. Home Environment (Description of how the patient lives)
19. Type of wound
20. Location of wound on body
21. Size of wound
22. Does the patient have drainage?
23. Stage of wound
24. Is the wound improving?
25. Has physician been notified of Plan of Care?
26. Date of next physician appointment
27. Are medications being administered by Nurse?
28. Type of medication(s)
29. Type of discipline requested by agency
30. Number of visits requested by agency
31. Date from requested by agency
32. Date to requested by agency
33. Type of discipline approved by EMP (i.e.: High Tech Nursing, RN, LPN, OT, PT, SP & etc.)
34. Number of visits approved by EMP
35. Date from approved by EMP
36. Date to approved by EMP
37. Description for on-going services/Plan of Care
38. Comments from EMP

Note: Sections 33, 34, 35, 36 and 38 are reserved for EMP Intake Staff use only

V. Claim Submission

The Agreement between EMP and participating providers indicate that all claims should be submitted on a CMS/HCFA 1500 Health Insurance Claim Form. For fee-for-service medical services, a CMA/HCFA 1500 Clams Form is to be submitted either by a paper claim or electronic claims submission.

EMP has the following guidelines:

- An original form is required with any submission
- Home Health Providers must submit all Clinical notes with each members claim
- For timely filing, claims must be received no later than one hundred and eighty (180) days after the date of services were rendered per your Agreement. Claims received thereafter will be denied for late submission.
- Provider can collect only applicable co-payment(s), co-insurance and deductible(s) from members at the time medical services are rendered.
- Provider agrees to accept contractual reimbursement from EMP as payment in full and will not bill member for any covered medical services.
- EMP will pay based on your contractual agreement.
- Complete all applicable boxes on the claim form and each covered service must be itemized on a separate line to expedite payment of your claims.
- For payment to made directly to the provider, the following items are required
- Patient's original signature, or "Signature on File" or "Assignment on File" stamped or typed and dated.
- Provider must maintain on file a valid written Assignment of Benefits from the member. This will serve as evidence that the provider is entitled to all payments for billed covered services.
- All documentation or information related to COB, Third Party Liability, etc. should be attached to the CMS/HCFA 1500 Claim Form for prompt adjudication of claim.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name. First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)

1. ____ . ____ 3. ____ . ____

2. ____ . ____ 4. ____ . ____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH. # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS

For claims to be paid promptly, a properly completed claim must be submitted by paper or electronically. Providers must use a CMS/HCFA 1500 Claims Form. Providers should reframe from submitting hand-written CMS/HCFA 1500 Claim Forms. The following mandatory information is required on the CMS/HCFA 1500 Claim Form:

Box 1	Coverage Category
Box 1a	Insured's I.D. Number
Box 2	Patient name (Last Name, First Name, Middle Initial)
Box 3	Patient's birth date and sex
Box 4	Insured's name (Last Name, First Name, Middle Initial)
Box 5	Patient's address
Box 10	Is patient's condition related to
Box 12	Patient's or authorized person's signature or signature on file and date
Box 13	Insured's or authorized person's signature or signature on file
Box 14	Date of current illness, injury or pregnancy
Box 17	Name of referring physician
Box 17A	I.D. number of referring physician
Box 21	Diagnosis or nature of illness or injury, ICD-9 diagnosis codes at the highest level of specialty. Multiple codes should be used submitted as necessary to identify all components of complex diagnosis as well as co-existing conditions.
Box 23	EMP referral authorization numbers (The authorization process and claim processing are closely linked. Please use correct referral authorization number when submitting a claim)
Box 24A	Date(s) of service
Box 24B	Place of service
Box 24C	Type of service
Box 24D	CPT/HCPCS and modifier (please provide nursing visit notes when services have been authorized)
Box 24E	Diagnosis code (designate as 1, 2, 3 and/or 4 from Box 21)
Box 24F	Charges
Box 24G	Days or units
Box 24k	UPIN of the rendering provider
Box 25	Provider's Federal Tax ID (Social Security number or EIN)
Box 26	Patient's Account No.
Box 27	Accept assignment
Box 28	Total billed charges
Box 29	Amount Paid
Box 30	Balance Due
Box 31	Signature of the rendering provider or supplier
Box 32	State and Zip code of where services were rendered
Box 33	Provider or supplier's billing name and address

Acknowledging Claims Received

EMP will provide acknowledgement of receipt of claims within 15 days after receipt of the claim via EMP's Claims Inventory Report. The Claims Inventory Report will be sent to each participating provider from whom claims have been received two (2) weeks prior. The Claims Inventory Report will be printed by participating provider and include the following fields:

- Date claims was received
- Patient's insurance group
- Insured's name
- Patient I.D. number
- Dependant information (if applicable)
- Incurred Date
- Claim Number
- Charged/Billed amount

<u>Participating Providers are encouraged to review the Claims Inventory Report carefully.</u>
Please see below sample Claims Inventory Report

EMP MEDICAL SERVICES, INC.
beyond patient care.

CLAIM INVENTORY REPORT RECEIVED 02/08/10 THRU 02/12/10

Provider	Claim#	Patient name	Member Id	Received	First DOS	Last DOS	Charges	Invoice #

Remittance Advice

The EMP claims processing policies, procedures and guidelines are set in accordance with applicable Florida & Medicare/Medicaid statutory requirement for timely payment of claims. All fee-for-services reimbursement will be sent to participating provider with a remittance advice.

Prompt Payment

EMP claims processing policies, procedures and guidelines follow the current applicable Florida & Medicare/Medicaid requirements. A clean claim is processed promptly within statutory guidelines.

Claim Mailing Address

Participating Providers should mail CMS/HCFA 1500 Claim Forms to:

EMP Medical Services, Inc.
2850 Douglas Road, 3rd Floor
Coral Gable, FL 33134
Attn: Claims Department

Electronic Claim Submission

In addition to submitting paper claim(s), participating providers may also submit claims electronically to EMP. To submit claims electronically, please take the following steps:

- Register with ZirMed (EMP's clearing house)
- To register, please phone 877.494.7633
- Select sales when prompted
- Once registered, ZirMed will provide support on submitting claims electronically

Reminders:

- Home Health Providers must submit all Clinical notes with each member claim
- For timely filing, claims must be received no later than one hundred and eighty (180) days after the date of services were rendered per your Agreement. Claims received thereafter will be denied for late submission.
- Provider can collect only applicable co-payment(s), co-insurance and deductible(s) from members at the time medical services are rendered.
- Provider agrees to accept contractual reimbursement from EMP as payment in full and will not bill member for any covered medical services.
- EMP will pay based on your contractual agreement.
- For payment to made directly to the provider, the following items are required

- Patient's original signature, or "Signature on File" or "Assignment on File" stamped or typed and dated.
- Provider must maintain on file a valid written Assignment of Benefits from the member. This will serve as evidence that the provider is entitled to all payments for billed covered services.
- All documentation or information related to COB, Third Party Liability, etc. should be attached to the CMS/HCFA 1500 Claim Form for prompt adjudication of claim.

VI. Transition *(when applicable)*

EMP's contract effective date:

New DME orders beginning:

New Home Health & Home Infusion orders beginning

Health Plan Name is holding weekly conference calls with EMP to identify and coordinate those member and provider concerns

VII. EMP Contact Information

EMP Medical Services, Inc
2850 Douglas Road, 3rd Floor
Coral Gables, FL 33134
800.225.6765 or 305.446.4421 (main number)
800.228.1958 or 305.446.5871 (facsimile)