WASATCH BEHAVIORAL HEALTH
SPECIAL SERVICE DISTRICT

INTAKE, TREATMENT/RECOVERY PLANNING & DISCHARGE SERVICES FOR MEDICAID CLIENTS BY OUTSIDE CONTRACTED PROVIDERS– C – 4.31

Purpose:

To ensure Wasatch Behavioral Health's (WBH) outside contracted providers provide its Medicaid Enrollees quality services, including (1) timely access to intake and treatment (2) an individualized treatment/recovery plan designed to provide a proper diagnosis, age-appropriate growth and development (3) the ability to attain, maintain, or regain the client's functional capacity, and (4) to ensure that, when possible, clients are discharged appropriately from services.

Definitions:

Medically Necessary (Medicaid Manual): Medical Necessity: A service is "medically necessary" if it is (1) reasonably calculated to prevent, diagnose, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, or threaten to cause a disability; and (2) there is no other equally effective course of treatment available or suitable for the client requesting the service which is more conservative or substantially less costly. (R414-1-2 (18))

Contract Manager: WBH's Associate Director is responsible for oversight of all outside contractor operations. These duties include obtaining contracts, contractor provider certification and recertification, contractor contract application reviews, and ABDs and Appeals processes

Outside Provider Program Manager (Manager): WBH's Outside Provider Manager or his or her designee shall be responsible for all service authorization requests including prior and continuing authorizations for Enrollee treatment, contractor contract compliance reviews, records auditing, and certification of claims for payment. The Outside Provider Program Manager or designee in this policy is personified in the terms program manager or manager.

Service Authorization: The request for services from an outside contracted provider when WBH is unable to supply an Enrollee with a qualified in-house clinician to provide the medically necessary service(s). The Manager shall be responsible for all service authorization requests.

Policy:

A. Wasatch Behavioral Health (WBH) shall provide timely access (See Policy 3.06 – Access Performance Standards) and mental health and substance use evaluation services to all Pre-paid Mental Health Plan (PMHP) Medicaid Enrollees who request treatment services to an outside contracted provider. Enrollees requiring medically

necessary, services with an outside contracted provider shall be offered appropriate, individualized mental health and/or substance use treatment. Medicaid Enrollees shall not be refused treatment services for any reason other than failure to meet medical necessity criteria or due to the requested service not being a service covered by the PMHP contract.

B. When WBH is unable to supply the Enrollee with a qualified in-house clinician to provide the medically necessary service(s) it shall refer the client to a contracted, qualified, outside provider. WBH may elect to allow an Enrollee to be treated by an outside contracted provider under other circumstances, but is not required to do so by the PMHP Medicaid contract between Medicaid and WBH when it has a qualified in-house provider.

C. An Enrollee, who requests and is refused an outside contracted provider as a result of WBH having a qualified in-house provider, may grieve WBH's decision orally or in writing. (See Policy C – 3.08, Medicaid Enrollee ABDs and Grievance System).

D. An Enrollee requesting an outside contracted provider shall be screened by an in-house intake clinician through a face-to-face evaluation to determine any special circumstances of medical necessity, or required clinical expertise that would preclude the use of an in-house provider prior to being referred to an outside contracted provider. Should an outside contracted provider be necessary, the manager shall make all necessary arrangements, including an attempt to contract an Enrollee requested non-contracted provider, and shall provide initial and continuing authorizations for treatment as needed.

E. It is a violation of this policy for WBH to refuse to allow an Enrollee access to an available, qualified, outside contracted provider when WBH has no in-house provider with the required expertise and when the Enrollee qualifies for treatment services. The refusal constitutes a denial of services and is defined as an ABD by the PMHP Medicaid Contract. WBH shall upon initiating an ABD immediately notify the Enrollee and all affected parties, in writing, of its decision and provide the parties with all necessary information regarding their appeal rights. (See Policy C - 3.08, Medicaid Enrollee ABDs and Grievance System).

F. The WBH approved outside contracted provider and his/her Medicaid Enrollee client, staying within WBH's prior-authorization of services parameters, shall collaboratively develop a mutually agreed upon Individualized treatment/recovery plan designed to address treatment, discharge planning, and the Enrollee's cultural competency issues. The treatment/recovery plan shall be considered a living document, and as such shall be updated as needed. All prescribed services shall be included in the plan and prescribed prior to implementation.

G. The outside contract provider's treatment services shall be provided as promptly and continuously as is consistent with generally accepted standards of medical/mental health/substance use services practice and contract requirements. All treatment/recovery plans and clinical treatment shall be documented in the client's medical record. Treatment notes of all services provided shall be written and placed in the clinical record.

H. All authorized medically necessary services in terms of amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished shall be provided. Covered services shall be provided by qualified staff in accordance with the scope of services identified in the WBH's Provider Agreement (see attached Agreement), Utah Medicaid Mental Health Centers Providers Manual, and the Utah State Division of Substance Abuse and Mental Health's Preferred Practice Guidelines

where guidelines have been identified and approved. (See WBH Policy C - 5.01 Preferred Practice Guidelines and its website www.wasatch.org for the guidelines).

I. WBH shall ensure that utilization management activities are not structured in such a way as to provide incentives to any individual or entity to deny, limit, or discontinue medically necessary mental health and/or substance use services to any Enrollee.

J. Should WBH deny payment to an outside contracted provider, and/or reduce, suspend or terminate a Medicaid client's previously authorized services it shall notify the provider and client in writing, and provide them information regarding the Enrollee's appeal rights to WBH's ABD. The notification shall contain all the necessary information required regarding the appeal process, including the right to receive assistance if needed**.** (The Enrollee's rights and a brief description of the process are contained in the Enrollee's Medicaid Handbook. The full particulars are contained in WBH's Policy C – 3.08, Medicaid Enrollee ABDs and Grievance System).

K. Clients shall be discharged from services with mutual agreement between WBH, the outside contracted provider, and the client whenever possible. When a client drops out without mutual agreement, the outside contracted provider shall attempt to contact the client, and when appropriate, encourage him/her to continue treatment to mutual termination.

L. WBH shall provide technical assistance training on WBH's Provider Agreement (See attachment Agreement) to the outside contracted provider when requested. It is expected that the provider shall be knowledgeable of all agreement obligations and shall faithfully act in accordance with them. Failure of the provider to do so could result in denial of payment for services rendered.

M. WBH Outside Providers shall not be prohibited from advising or advocating on behalf of the client for the following:

   i. The client's health status, medical care, or treatment options—including any alternative treatments that may be self-administered.

   ii. Any information the client needs in order to decide among all relevant treatment options.

   iii. The risks, benefits, and consequences of treatment or non-treatment.

   iv. The client's right to participate in decisions regarding his or her health care, including the right to refuse treatment and to express preferences about future treatment decisions.

Procedure:

Service Authorization Procedures:

1. Each client, WBH intake clinician, outside contracted provider, and family member(s), where appropriate, shall collaboratively develop a mutually agreed upon Individualized treatment/recovery plan designed to address treatment, discharge planning, and their cultural competency issues. The treatment/recovery plan shall be considered a living document, and as such shall be updated as clients' needs indicate, the outside provider is responsible to conduct reassessments/treatment plan reviews with the client as clinically indicated to ensure the client's treatment plan is current and accurately reflects the client's rehabilitative goals and needed behavioral health services. All prescribed

services shall be included in the treatment/recovery plan and prescribed prior to implementation.

2. Treatment services shall be provided as promptly and continuously as is consistent with generally accepted standards of medical/mental health/substance use services practice and PMHP Medicaid contract requirements. All treatment/recovery plans and clinical treatment shall be documented in the client's clinical record including any family or significant others involvement. Treatment notes shall be written and placed in the clinical record immediately following services whenever possible.
4. All appropriate medically necessary contract covered services in terms of amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished shall be provided.
3. When an Enrollee requests at intake to see a non-contracted outside provider or an outside contracted provider, the intake staff person shall notify the manager of the request and inform the Enrollee that the manager shall review the Enrollee's request with the Enrollee. When the selected provider is contracted with WBH, the manager shall follow the Service Authorization Request Review procedures. When a selected provider is not contracted with WBH, the manager shall follow the Outside Provider Contract Process in this policy. The manager shall notify the Enrollee of the decision within 14 calendar days of their request. The manager may under certain circumstances, described below, request up to an additional 14-day extension. (See flow chart page 1 Standard Service Authorization Request ABD #1: Denial or Limited Authorization Requested Service and related policy C-3.08 Medicaid Enrollee ABDs and Grievance System).
5. When an Enrollee's selected provider initiates a request for the Enrollee to be treated by the selected provider, the program manager shall make a decision and provide notice to the selected provider and Enrollee as expeditiously as the Enrollee's health condition requires, but no later than 14 calendar days from receipt of the outside providers request for a service authorization. The manager shall also consult, as appropriate, with the requesting provider.
6. WBH shall inform the Enrollee that they will need to complete WBH's intake process. When the selected provider is contracted with WBH, the manager shall follow Service Authorization Request Review procedures pg. 5. When a selected provider is not contracted with WBH, the manager shall follow the Outside Provider Contract Process in this policy.
7. When an Enrollee/ or the Enrollee's selected provider indicates that adhering to the 14-day standard time frame could seriously jeopardize the Enrollee's life, or health, or ability to attain, maintain, or regain maximum function, the manager shall make an expedited authorization decision and provide notice as expeditiously as the Enrollee's health condition requires. The program manager must make an expedited decision no later than 72 hours after receipt of the request for Service Authorization. (See flow chart page 2 Expedited Service Authorization Request ABD #1: Denial or Limited Authorization Requested Service and related policy C-3.08 Medicaid Enrollee Grievance, ABD, and Appeal).
8. When the manager denies a service authorization request from an outside contracted provider, or authorizes a service in an amount, duration, or scope that is less than requested by the outside contracted provider, including the type or level of service, this constitutes an ABD unless the Enrollee agrees with the services offered. When an ABD

is constituted, the manager shall notify the Associate Director. The Associate Director shall:

a. Notify the requesting provider verbally or in writing, and give the Enrollee written notice of ABD that includes his /her right to Appeal, and the right to receive reasonable assistance with the appeal process (See form 7.59b-N2a Notice of ABD and Appeal Rights.

b. Notify the Manager who shall monitor service authorization requests and report any ABDs to the Associate Director.

c. Forward verbal and/or written notice information to the Associate Director designee who shall log the ABD information, as per PMHP Medicaid Contract requirements, in the Enrollee Grievance/ABD/Appeal database.

9. Should the Enrollee or other affected parties, decide to appeal an ABD, WBH's Associate Director shall follow the policy and procedures in Policy C-3.08 Medicaid Enrollee Grievance, ABD, and Appeal.

   NOTE: While it is highly unlikely WBH would ever refuse to continue authorizations to an Enrollee's current provider, WBH's Medicaid contract specifies in Article X, B.,1., b. that this decision does not constitute an ABD.

10. When the manager fails to reach a decision on a standard or expedited service authorization request within the required time frames, this constitutes an ABD. The manager shall notify the Associate Director. The Associate Director shall:

    a. Notify the requesting outside contracting provider verbally or in writing, and give the Enrollee written notice of ABD, that includes his /her right to Appeal, and the right to receive reasonable assistance with the appeal process (See form 7.59b-N2a Notice of ABD and Appeal Rights, by or on the date the applicable time frame for making the decision expires.

    b. Forward verbal and/or written notice information to the designee who shall log the ABD information, as per PMHP Medicaid Contract requirements, in the Enrollee Grievance/ABD/Appeal database.

Extensions for EXPEDITED Service Authorization Requests:

1. The manager may extend the 72 hour time period by up to a total of 14 calendar days if:
   a) The Enrollee requests an extension; or
   b) The manager needs an extension for additional information, the extension is in the Enrollee's interest, and the manager can justify his/her reason to the Utah State Department of Health upon their request.
2. Should the manager extend the time frame to make an expedited service authorization decision, the manager shall, within the allocated time period, make a decision and provide notice to the Enrollee and all affected parties. Notice shall include the Enrollees right to file a grievance if the Enrollee disagrees with the decision to extend the time frame.

The designee shall log information, as per PMHP Medicaid Contract requirements, in the Enrollee Grievance/ABD/Appeal database and maintain documentation of Request for Extension.

Extensions for STANDARD Service Authorization Requests:

1. When the manager extends the time frame for making a standard service authorization decision, the manager shall:
   a) Give the Enrollee/provider written notice of the reason for the decision to extend the time frame (See form 7.59a-N1a Notice of Extension for Service Authorization Request).
   b) Inform the Enrollee of his/her right to file a Grievance, and how to do so, if the Enrollee disagrees with the decision to extend the time frame (See Policy C-3.08 Medicaid Enrollee ABDs and Grievance System).
   c) Provide the member with written notice of the reason for the delay that includes notification of the member's rights to file a grievance if the member disagrees with the decision to extend the time frame.
   d) Issue and carry out the determination as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires.

11. When an Enrollee seeks services from an outside contracted provider, and WBH authorizes the request, the date and time of 30-minute follow-up screenings for emergencies shall not be documented.

Service Authorization Request Review:

1. When the manager establishes medical necessity for treatment and the Enrollee's needs can be met in house, the Enrollee shall be offered appropriate service within WBH.
2. When there is medical necessity and the Enrollees needs cannot be met within WBH, the manager shall contact an appropriate outside contracted provider to meet the clinical needs of the Enrollee.
3. When the Enrollee becomes eligible for Medicaid and has an established relationship with a provider outside WBH and is involved in treatment, the manager shall attempt to contract with the treating outside provider if they meet the Medicaid guidelines (See Outside Provider Contracting Process).
4. The manager shall make a decision and provide notice to the Enrollee/provider as expeditiously as the Enrollee's health condition requires, but no later than 14 calendar days from receipt of the request for service authorization.
5. The manager shall monitor service authorization requests and report to the Associate Director.
6. The Associate Director or designee shall log information, as per PMHP Medicaid Contract requirements, in the Enrollee Grievance/ABD/Appeal database and maintain documentation of notice or decision.
7. When the request is in favor of the Enrollee, the manager shall submit the Service Authorization request to WBH's Contracted Provider Records Coordinator (CPRC). The CPRC shall develop and send a treatment authorization to the Enrollee/provider.
8. Should the manager deny the Enrollee's request to see an outside contracted provider when WBH has no in-house qualified provider for the needed services and/or refuses continuation of services when WBH has no qualified provider, the manager notify the Associate Director who shall follow Notice of ABD procedures in policy C-3.08 Medicaid Enrollee ABDs and Grievance System.

9. Should the client be refused a requested outside contracted provider and WBH has a qualified in-house provider who can provide the service the Enrollee may grieve the decision by asking orally or in writing that it be reviewed. WBH's decision, following a review by the Grievance Review Committee, is final.
10. Should the Enrollee or other affected parties, decide to appeal an ABD, WBH's Associate Director shall follow the policy and procedures in Policy C-3.08 Medicaid Enrollee ABDs and Grievance System, Appeal Process.

Outside Provider Contracting Process:

1. When an outside provider is not contracted with WBH, the manager shall submit a request for contracted (outside) provider to the Associate Director. The Associate Director or his/her designee shall send the outside provider a Contracted Provider Application (See attachments 1-10). The outside provider must complete the application and submit back to the Associate Director. The Associate Director shall complete a Contracted Provider Contract (See attachment Agreement). The contract shall be submitted to WBH's Executive Committee and WBH's attorney for review. The contract shall be approved or rejected by WBH's Authority Board.
2. For Termination of a Contracted Provider see policy C – 3.14.
3. Should WBH decline to include an outside provider applicant see policy A – 1.10 Selection and Retention.

WBH Intake Staff Responsibilities:

All intake/crisis staff shall:

1. Provide supportive intake services designed to encourage client follow through from telephone contact to treatment. Intake staff shall be responsive to barriers to accessing treatment such as cultural competency issues, and transportation problems.
2. Respond as quickly as possible to minimize the length of time between screening, intake, and first appointment with the outside contracted provider.
3. Allow Enrollees to choose their mental health and/or substance use services provider to the extent possible and appropriate.
4. Ensure Enrollees are aware of how to access outpatient emergency crisis services if needed prior to their intake, and/or emergency hospitalization services if needed.

Outside Contract Provider Responsibilities:

Outside contracted providers shall be knowledgeable of WBH's Contracted Provider Agreement provisions including:

1. All laws, regulations, or ABDs applicable to the services provided therein.
2. All terms and conditions applicable to licensed mental health and substance use services providers contained in "Mental Health Center Provider Manual" – Utah State Division of Health Care Financing.
3. The Enrollee grievance system and client rights contained in WBH's Medicaid Member Handbook.

4. "Best Practice Guidelines" found on WBH's website (www.wasatch.org)Providers agreement to abide by and cooperate with WBH's Quality Utilization and Performance Improvement (QAPI) policies and procedures as they apply to private providers located on the www.wasatch.org website. Conduct a monthly review of its agency staff through the Inspector General (HHS - OIG) list of excluded individuals and entities (LEIE) and the System for Award Management (SAM) databases http://exclusions.oig.hhs.gov/ and https://www.sam.gov/sam/
5. Obtain a National Provider Identifier number (NPI). https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.npistart
6. See Access to Treatment Performance Standards "Policy C – 3.06"

Identifying Members of the "Treatment/Recovery" Plan:

At the time of the client's first treatment session, clients who shall be receiving their mental health treatment or substance use services from an outside contracted provider shall conjointly develop a treatment/recovery plan with their outside contracted provider and identify any treatment/recovery team members necessary. The outside contracted provider shall, in conjunction with the client, be responsible for initiating, maintaining, and updating the client's treatment/recovery plan as required in the outside contracted provider agreement with WBH.

Sharing of Protected Health Information for Treatment Among Treatment Team Members:

The outside contracted provider shall abide by and follow The Health Insurance Portability and Accountability Act (HIPAA) and all local, state, and federal regulations pertaining to Protected Health Information (PHI).

Establishment and Continuation of the Treatment/Recovery Plan:

A. The treatment/recovery plan shall be written within ten (10) working days of the initial appointment and include a DSM, five axis diagnosis. Individualized plan, which contains measurable treatment goals related to problems identified through diagnostic intake interview(s) that include addressing any cultural competency issues. The treatment/recovery plan shall be designed to improve and/or stabilize the client's condition.

B. Per the Utah Medicaid Mental Health Centers Providers Manual, the treatment/recovery plan shall include the following:

    1. Measurable treatment/recovery goals.

        If the treatment plan contains individual skills training and development or psychosocial rehabilitative services as treatment methods, there must be measurable goals specific to all skills issues being addressed with these treatment methods. Actual treatment goals may be developed by qualified providers identified in the 'Who' section in Chapter 2 -10, Individuals Skills Training and Development, and Chapter 2-11, Psychosocial Rehabilitative Services, and they may be documented in an addendum to the treatment plan;

2. The treatment/recovery regimen – The specific treatment/recovery methods that shall be used to meet the measurable treatment goals
3. A projected schedule for service delivery, including the expected frequency and duration of each treatment/recovery method.
4. The licensure or credentials of individuals who shall furnish the prescribed services.

C. The outside contracted provider shall request continuing treatment authorizations in writing at least 10 business days prior to the expiration of the current authorization.

D. The outside contracted provider shall collect continuing outcome and client satisfaction data using instruments provided by WBH. Measures must be collected monthly unless alternative arrangements have been made.

E. The outside contracted provider shall be responsible for verifying the Enrollee's continuing Medicaid eligibility each month.

Documentation of Therapy:

Outside Contracted Provider shall:

1. Maintain sufficient written documentation for each medical or remedial therapy, service, or session for which billing is made using the documentation requirements associated with each service as identified in Utah Medicaid Provider Manual, Chapter 2, Scope of Services.
2. The clinical record shall be kept on file for the GRAMA legally required time, and made available for State and Federal review, upon request. An adult record may be destroyed, with the exception of the last discharge summary, 10 years following the client's last discharge from service. A youth record may be destroyed, with the exception of the last discharge summary, 10 years following the client's 25th birthday, or 10 years following the Enrollee's last treatment episode whichever is later.

Termination From Services:

1. Should WBH decide to reduce, suspend or terminate a Medicaid client's previously authorized services WBH shall notify the client, and inform him/her of their right to appeal the Center's ABD. The notification shall contain all the necessary information required regarding the appeal process, including the right to receive assistance if needed. (See Policy C – 3.08b, Medicaid ABDs and Appeals, ABD 2 Reducing, Suspending, or Terminating Previously Authorized Services).
2. Clients shall be terminated with mutual agreement between WBH, contracted outside provider, and client. A Discharge Summary shall be completed by the outside contracted provider and placed in the client's record.
4. When a client drops out of treatment without mutual consent, the outside contracted provider shall, when appropriate, initiate a follow-up contact to encourage the client to return to treatment.

Provider Selection, Credentialing and Re-credentialing:

Outside contracted provider shall follow the procedures outlined in WBH policy A – 1.10 Provider Selection and Retention.

Outside Provider Auditing:

All WBH clients' currently in services with contracted outside providers shall have their clinical record and billing documentation audited by the Outside Provider Contract Program Manager or his/her designee annually. (See policy C-3.12 Peer and Electronic Record Review).

Fraud and Abuse Prevention and Reporting

Outside contracted providers who furnish WBH authorized Medicaid mental health and/or substance use services, and who perform billing and/or coding functions for services provided for WBH clients shall adopt WBH's fraud and abuse prevention policies and procedures or develop similar policies and procedures as required by law. (see policy C - 3.13 Fraud and Abuse Prevention and Reporting)

Related Policies:

C-3.05 Client Rights

C-3.06 Access Performance Standards

C-3.07 Quality Assessment and Performance Improvement Program (QAPI)

C-3.08 Medicaid Enrollee Grievance

C-3.08B Medicaid ABD and Appeal

A-1.10 Provider Selection and Retention

C – 3.12 Peer and Electronic Record Review

C-3.13 WBH Fraud and Abuse Deficit Reduction Act

C-5.01 Preferred Practice Guidelines

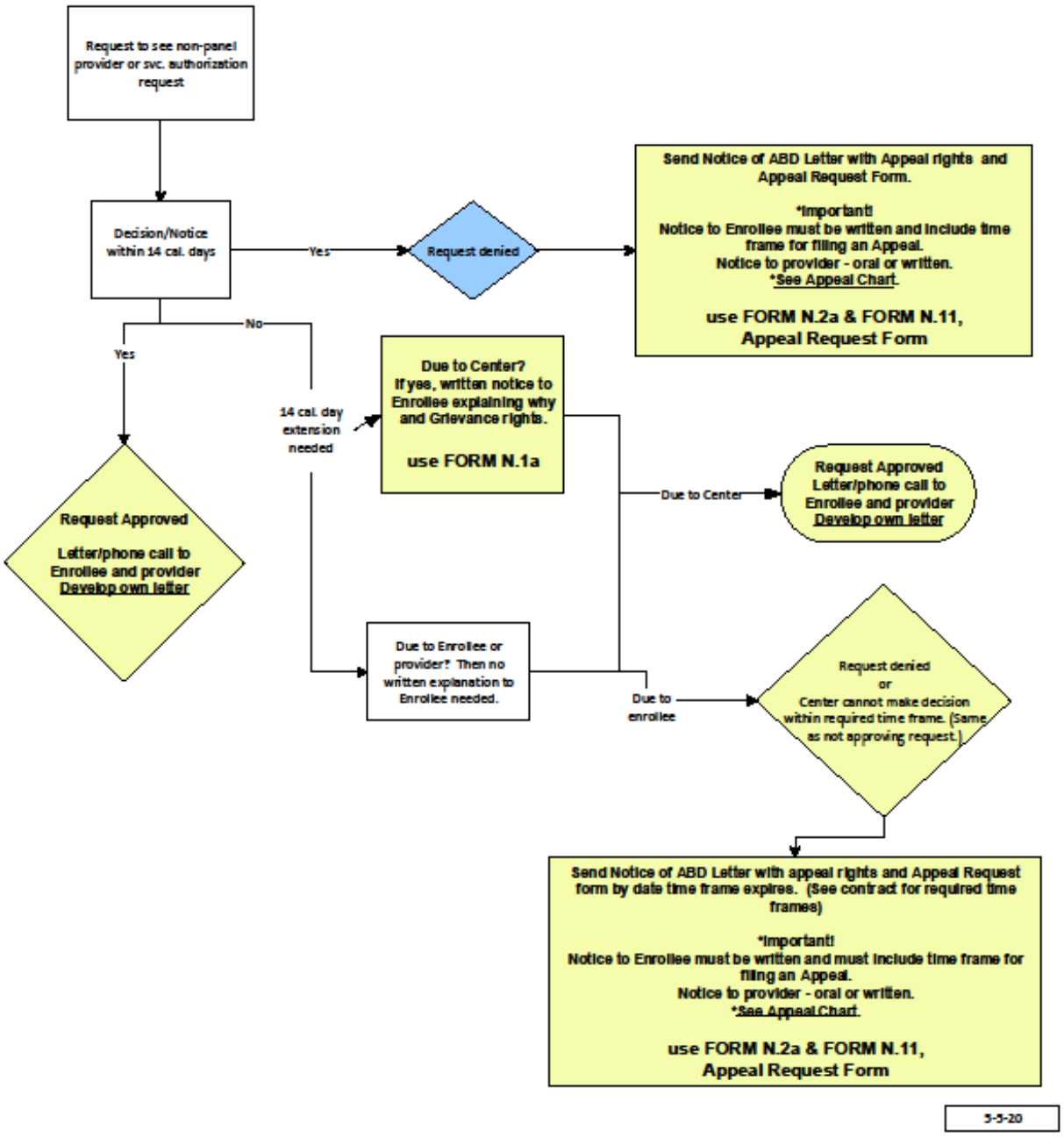
C-5.06 Advance Directives

F-1.07 ABD to Deny Claim Payment

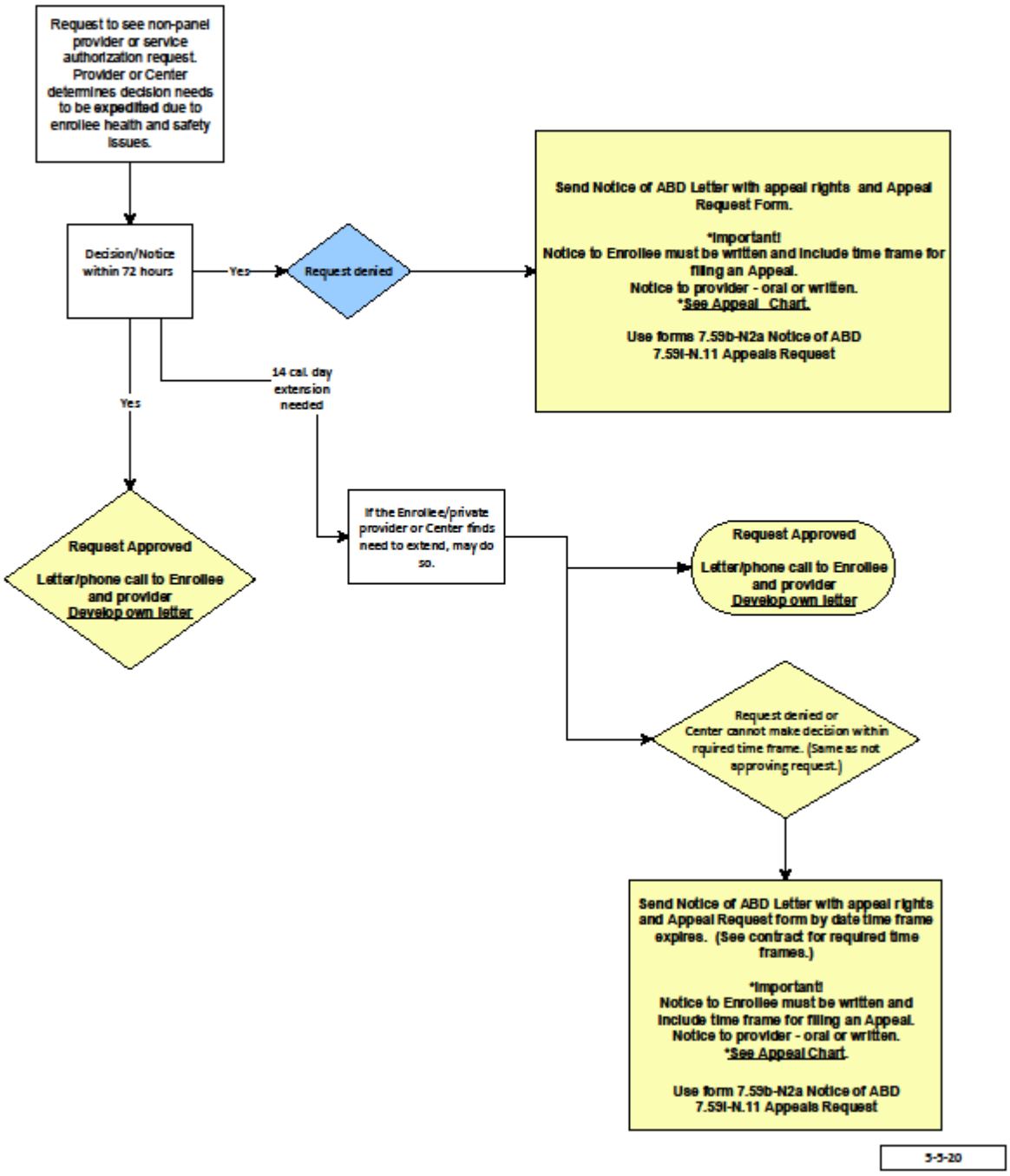
Right to Change and/or Terminate Policy:

Reasonable efforts shall be made to keep employees informed of any changes in the policy; however, WBH reserves the right, in its sole discretion, to amend, replace, and/or terminate this policy at any time.

Flowchart 1
Adverse Benefit Determination (ABD) 1
Standard Service Authorization
Denial or Limited Authorization of Requested Service



Flowchart 2
Adverse Benefit Determination (ABD) 1
Expedited Service Authorization Request
Denial or Limited Authorization of Requested Service



7.59a-N1a Notice of Extension for Service Authorization Request

If you need this letter in Spanish, call the Wasatch Behavioral Health customer service representative at 801- 373-4760.
Si usted necesita esta carta en español, llame a un representante de Wasatch Behavioral Health al 801- 373-4760.

Delete all information in Red before sending letter to client… Use 12 pt font
"[Click here and type date]"

"[Click here and type recipient's name]"
"[Click here and type recipient's address]"

Dear "[Click here and type recipient's name]" ,

*On"[Click here and type date]" you asked for approval to get **(name of service)** from **(name of therapist)** or **(name of therapist)** asked for approval to provide **(name of service)** to you. We are supposed to make a **decision in 14 days. If we cannot make a decision in that time, we can take up to 14 more days.** We are letting you know that we need more time to make a decision.

We need more time because **(explain reason for the delay *and why it'll help them in the long run, including type of information needed and from whom, if applicable)**

*If you are unhappy that we need more time, you may file a grievance with us.

You, your authorized representative or your provider may file your Grievance. If you need help filing your Grievance, call the Wasatch Behavioral Health customer services representative at 801- 373-4760.
Interpreters are free of charge and are available in all languages, including sign language. If you need an interpreter to help you file your Grievance, call Wasatch Behavioral Health customer services representative at 801- 373-4760. Outside of Utah County call 866-366-7987.
You or your authorized representative will be provided, upon request and free of charge reasonable access to, and copies of, all documents, records and other information relevant to the ABD.

To file a grievance:

You may file your grievance by calling us, talking to a center staff member in person or by giving it to us in writing. If you want to mail it, please mail it to:

Wasatch Behavioral Health
c/o Care Management Department
750 North 200 West, Suite 300
Provo, UT 84601

Once we get the grievance, we will give you a decision within 90 **calendar days**. We will either talk to you about our decision, or we will send you a letter.
Sincerely,

[Click **here** and type your name]

Cc: Private provider (if applicable)
Affected Parties (if applicable)

Form # 7.59b-N2a Adverse Benefit Determination (ABD)
If you need this letter in Spanish, call the Wasatch Behavioral Health customer service representative
at 801- 373-4760.
Si usted necesita esta carta en español, llame a un representante de Wasatch Behavioral Health al 801- 373-4760.

Delete all information in Red before sending letter to client…Use 12 pt font

(The ABD shall clearly indicate the ABD that has been taken and provide a clear statement of the basis for the ABD. The notice must be individualized to the Enrollee's case and medical and legal terms must be explained if the terms cannot be simplified. The notice shall also be written in easily understood language and format. See policy C-3.10 Readability of Documents for testing procedures)**Use form 7.59c-N3a for ABD to either decrease, suspend or end services, individualized to the Enrollee.**

"[Click here and type date]"

"[Click here and type recipient's name]"
"[Click here and type recipient's address]"

Dear "[Click here and type recipient's name]" ,

On "[Click here and type date]" Wasatch Behavioral Health took the following Adverse Benefit Determination (ABD);

☐ We denied or limited approval of your requested service/provider.

(Explain why services were limited or denied. If limited, explain the details of the request and the limited approval. Limited approvals may include: a. provider asked for certain number of sessions, you approve less with no chance for approval of the remaining sessions requested; or b). provider asks for certain number of sessions and services are approved in segments and you do not end up approving the original amount requested.)

☐ We denied payment for a service you received that you may have to pay for.

(Explain what led to the ABD, individualized to the Enrollee. Refer to your handbook section on payment liability and provide information to the Enrollee as to which reason fits their situation.)

☐ We did not offer your first appointment within the required amount of time, and you were unhappy with this.

(Explain what led to the ABD, individualized to the Enrollee)

☐ We did not make a decision about your request service within the required amount of time (14 days for a standard request or 3 days for an expedited (quick) request).

(Summarize request and explain why you were not able to make a decision within the required time frame and when you plan to make decision by- may reduce likelihood they'll appeal.)

☐ We did not make a decision about your Grievance within the required amount of time

(90 days.)

(Explain why you were not able to make a decision within the required time frame and when you plan to make decision by- may reduce likelihood they'll appeal.)

If you are unhappy with this ABD, you have the right to appeal. The rest of this letter explains how to file an Appeal.

You must file your Appeal within 60 calendar days from the date on this letter.

You, your authorized representative or your provider may file your Grievance. If you need help filing your Grievance, call the Wasatch Behavioral Health customer services representative at 801- 373-4760.
Interpreters are free of charge and are available in all languages, including sign language. If you need an interpreter to help you file your Grievance, call Wasatch Behavioral Health customer services representative at 801- 373-4760. Outside of Utah County call 866-366-7987.
You or your authorized representative will be provided, upon request and free of charge reasonable access to, and copies of, all documents, records and other information relevant to the ABD.

To file an Appeal:

1. You may file your appear orally or in writing. You may file your appeal by calling us at 801- 373-4760 and asking for the Wasatch Behavioral Health customer service representative. The Customer Service Representative will fill out the Appeal Request form for you.

3. If you do not want to call first, you must complete the enclosed Appeal Request form and send to us within 60 calendar days of the date on this notice.

4. If your authorized representative or your provider sends us your Appeal Request form, the Appeal Request form must include your written permission. You may give your written permission by completing and signing the bottom of the enclosed Appeal Request form or by sending us a separate note. <u>This is important</u>. If we do not receive your written permission, your provider may not appeal the ABD.

5. Send the complete Appeal Request form to:

Wasatch Behavioral Health
c/o Care Management Department
750 North Freedom Blvd., Suite 300
Provo, UT 84601

If you call us first to file your Appeal, we plan to make a decision within 30 **calendar days** from the date **you called.** If you send us your Appeal Request Form, **we plan to make a decision within 30 calendar days from the date we get your Appeal Request form.**

Sometimes we will need more time to make a decision, or you may ask us to take more time. If so, we may take an additional 14 calendar days to make our decision. If we need to take extra time, we will send you a letter telling you that.

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EXPEDITED (QUICK) APPEALS)

If you or your provider or authorized representative believes taking this amount of time could place your life or health in danger, or that you might have a permanent setback, you may ask for an expedited (quick) Appeal.

To file an expedited appeal:

1. You may ask for an expedited appeal by calling the Wasatch Behavioral Health customer services representative at 801- 373-4760. You do not also have to send your Appeal in writing.

2. If you do not want to call first, check the "expedited Appeal" box on the enclosed Appeal form and send it to us.

3. If your authorized representative or your provider sends us your Appeal Request form, the Appeal Request form must include your written permission. You may give your written permission by completing and signing the bottom of the enclosed Appeal Request form or by sending us a separate note. This is important. If we do not receive your written permission, your provider may not appeal the ABD.

If we agree the decision needs to be made quickly, we will make a decision in **72 hours after we receive your expedited Appeal request**. If you or we need more time to make the decision, we can take up to another **14 calendar days**. If we need more time, we will send you a letter telling you why.

If your Appeal is denied, we will send you a letter explaining the reason why it was denied and tell you how to ask for a State Fair Hearing.

If you have any questions, please contact the Wasatch Behavioral Health customer services representative at 801- 373-4760.

Sincerely,

[Click **here** and type your name]

Cc: Private provider (if applicable)
Affected Parties (if applicable)

Enclosure: Appeal Request Form

Wasatch Behavioral Health
APPEAL REQUEST FORM

1. Is the client or a provider requesting this ***Appeal***? Client? Or Provider? (Circle)

2. Name of Client:_____

   Client's Address:_____

3. Name of Provider Involved:_____ _____

   Provider's Address:_____

4. The reason you are requesting the Appeal:_____

   _____

5. You may ask for an expedited (quick) decision on your Appeal if you believe taking the regular amount of time could place your life or health in danger, or that you might have a permanent setback.

   ___ Check here if you want an expedited Appeal.

6. If the Appeal is about decreasing or ending services, do you want these services continued during the Appeal process? Please remember if the Appeal decision is not in your favor, you may have to pay for these services. use form Form # 7.59c-N3a ABD for Decreasing or Ending Services

   ___ Check here if you want these services continued.

7. If you need help filling out this form, an interpreter, or have any questions about the Appeal process please call (name or title) at (phone number).

8. **REMINDER**!! You may ask for an expedited appeal by calling the Wasatch Behavioral Health customer services representative at 801- 373-4760. You do not also have to send your Appeal in writing. If you do not want to call first, you must complete the enclosed Appeal Request form and send to us within 60 calendar days of the date on this notice.

9. If you have evidence or additional documentation to submit. Please attached to this form or attach a statement explaining what you intend to submit and when you intend to submit it. You may also submit additional evidence or documentation at a later time.

Provider Permission Statement

If your provider is filing the Appeal for you, you must give your written permission.

I _____ (your name) give my permission for

_____ (provider's name) to file this Appeal for me.

_____ _____
Client's Signature Date

Form # 7.59l-N11

Attachment 1

Cover Letter (print on letterhead)

Date

Name
Company
Address
CSZ

Sample Form

Dear ,

Thank you for your interest in becoming a Contracted Provider with Wasatch Behavioral Health Special Service District. NAME OF CONTRACT MANAGER has requested that I send you our Credentialing Application packet. I will be in charge of getting your application and contract processed and completed. Because so many entities are involved, this process can take anywhere from 5 to 12 weeks to complete.

- Please complete the application and attach any necessary documentation required (see page 3). Also enclosed is a W-9 IRS form and a BCI form that will need to be filled out. The application, BCI and W-9 forms will need to be returned by mail to the attention of . A Reimbursement Rate Sheet has also been enclosed.

- When I have received the application along with copies of all the required documents, I will review it for completeness then submit it to the Contract Program Manager for review. If approved, two contracts will be generated and submitted to the Executive Committee for approval.

- Upon approval from the Executive Committee, the contracts are then given to the County Attorney for review and then to the Authority Board for a final approval and signatures. When approved, the two signed contracts will be sent to you, one of which is to be signed by you and sent back to me. The other contract is to be kept for your records.

- As you can see, this process does take quite a bit of time to complete. Therefore, if you can fill out the Credentialing Application and the other required forms and return them as soon as possible, I can get the contracts on their way through this lengthy process.

If, at any time, you have any questions, please do not hesitate to call me at NUMBER. Thank you again for your interest in working with Wasatch Behavioral Health Special Services District.

Sincerely,

NAME OF STAFF
Outside Provider Records/Contract Coordinator

Enclosures: Contracted Provider Application
BCI Application / W-9 Form / Rate Sheet

Cover Letter - Supervisee
(print on letterhead)

Date

Name
Company
Address
CSZ

Sample Form

Dear ,

Thank you for expressing interest in your colleague becoming a Contracted Provider for Wasatch Behavioral Health Special Service District. NAME OF CONTRACT PROGRAM MANAGER has requested that I send you our Credentialing Application packet. I will be in charge of getting your application and contract processed and completed. Because so many entities are involved, this process can take anywhere from 5 to 12 weeks to complete.

- Please have this application filled out and attach all required documentation (see page 3). Also enclosed is a W-9 IRS form and a BCI form that will need to be filled out. The application, BCI and W-9 forms will need to be returned by mail to the Attention of NAME OF STAFF. A Reimbursement Rate Sheet has also been enclosed.

- When I have received the application along with copies of all the required documents, I will review it for completeness then submit it to the Associate Director for review. If approved, two contracts will be generated and submitted to the Executive Committee for approval.

- Upon approval from the Executive Committee, the contracts are then given to the County Attorney for review and then to the Authority Board for a final approval and signatures. When approved, two signed contracts will be sent to you, one of which is to be signed by you and sent back to me. The other contract is to be kept for your records.

- As you can see, this process does take quite a bit of time to complete. Therefore, if you can fill out the Credentialing Application and the other required forms and return them as soon as possible, I can get the contracts on their way through this lengthy process.

If, at any time, you have any questions, please do not hesitate to call me at NUMBER. Thank you again for your interest in working with Wasatch Behavioral Health Special Services District.

Sincerely,

Staff Name
Outside Provider Records/Contract Coordinator

Enclosures: Contracted Provider Application
BCI Application / I-9 Form

Attachment 2

CONTRACTED PROVIDER APPLICATION
MEDICAID PREPAID CAPITATED PLAN
WASATCH BEHAVIORAL HEALTH

Application Profile

Last Name | First Name | MI

Degree | SS#

Office Address

Street | Suite

City | State | ZIP

Office Telephone Number

Office Manager or Contact Person

Practice Information

Type of Practice (Solo, Group, Other)

Corporate or Group Name (if applicable)

Billing Tax ID Number (if different from SS#)

After Business Hours Availability

How do you handle 7 day/week, 24-hour backup and crisis Coverage?

Licensing Information

Type of Utah License | Utah License Number

Date of First Issue | Expiration Date

Other Licensure or Certification | NPI #

Psychiatrists/Physicians

Board Certified ☐ Yes ☐ No Date: _____

Board Eligible ☐ Yes ☐ No Date: _____

DBA # | Medicaid # | Medicare#

Clinical Expertise and Practice

Please summarize the major characteristics of your current practice (age, gender, diagnosis, etc).

Identify areas of clinical expertise and summarize your style of practice and clinical orientation.

Identify any specialized skills you use in your practice (languages, cultural competency, etc.).

Professional Liability Information

Carrier

Expiration Date

Per incident amount

Per aggregated amount

Please respond to each of the following questions. If you answer YES to any of these questions, please explain on a separate sheet.

1. Has your clinical license been revoked, suspended, limited or is any ABD pending?	Yes	No
2. Within the past five years, have you been denied hospital privileges?	Yes	No
3. Has your narcotics license ever been revoked, suspended or limited?	Yes	No
4. Have you had liability insurance denied or canceled?	Yes	No
5. Have you been party to malpractice suits, which resulted in payment to the plaintiff?	Yes	No
6. Do you presently have any malpractice suits pending against you?	Yes	No
7. Have you resigned from a professional group because of problems with credentials?	Yes	No
8. Within the past five years, have you been convicted of or pleaded guilty to a felony?	Yes	No
9. Do you suffer from any physical or mental condition, which impairs you ability to practice?	Yes	No
10. Has Medicaid or Medicare ever denied you provider status?	Yes	No

Instructions

Please attach the following documentation to this application:

1. Photocopy of State Professional License and DEA certificate (if applicable) with expiration date visible.
2. Photocopy of current city/county business license.
3. Proof of professional liability coverage indicating coverage limits and expiration date.
4. Proof of general liability insurance covering accident or other mishap at your office.
5. Background Criminal Investigation Clearance required by State of Utah. (Application Form Enclosed)
6. A curriculum vitae (resume) which includes education, post graduate training, professional experience, credential, professional memberships and three references.

Please return this information to:

Credentialing Office
c/o NAME OF CONTRACT MANAGER
Wasatch Behavioral Health
750 North Freedom Blvd. (200 West), Suite 300
Provo, UT 84601

Certification

I certify that the information contained herein and attached to this application is correct and complete to the best of my knowledge and belief. I understand that misrepresentations or omissions from the application constitute cause for denial or dismissal from provider status in the Wasatch Behavioral Health Medicaid Prepaid Capitated Plan.

By applying to be a provider in the Wasatch Behavioral Health Medicaid Prepaid Capitated Plan, I hereby authorize WBH and its representatives to consult with individual, institutions, and professional organizations with which 1 have been associated, who may have information bearing on my professional competence.

_____ _____

Signature of Applicant Date

Sample Form

Attachment 3

BCI Cover Letter

Date

Sample Form

Dear Applicant:

Attached is a Background Criminal Investigation (BCI) application form. This is a document Wasatch Mental Health is required by the State to have completed for all clinical employees, both in-house and outside contracted providers, in order to provide treatment for adolescents and children.

In order to expedite this process as quickly as possible with the State, please follow the steps outlined below:

1) Complete and sign the attached BCI Background Screening Application form.
We will need the *original* form with your *original* signature - *NOT A COPY)*

2) Attach to the BCI Application form *a very clear* copy of your driver's license with the expiration date clearly visible**.** Your license must have a current expiration date/not expired. *If your license has been renewed and the expiration date is on the back, please make a copy of both the front and back of your driver's license.*
(ENLARGING THE PICTURE & LIGHTENING IT, MAKES IT CLEARER)

2) DO NOT FAX THIS PAPERWORK. Please mail the BCI and the copy of your ID to:
Wasatch Behavioral Health
Attn: Outside Provider Coordinator
750 North Freedom Blvd. (200 West), Suite 300
Provo, UT 84601

Please return the BCI as soon as possible. Wasatch Behavioral Health cannot authorize children or adolescents to be seen by anyone not having a BCI clearance from the State. If you have any questions, please feel free to contact me at NUMBER.

Sincerely,

Staff Name
Contract Coordinator

Enclosure: BCI Application

Attachment 4
Background Screening (BCI) Application

DHS OL
September 2019

☐ Live Scan completed

TCN:_____

UTAH DEPARTMENT OF HUMAN SERVICES, OFFICE OF LICENSING
195 North 1950 West, Salt Lake City, Utah 84116

BACKGROUND SCREENING APPLICATION for All Program Employees and all individuals NOT living in foster, proctor, or adoptive homes This includes Adoption Agency Staff and SAS & DSPD Certified Providers

CBS USE ONLY

☐ New applicant
☐ Renewal – has a current approved screening
☐ Transfer of or concurrent use of approved Rap Back screening from:

1. APPLICANT INFORMATION, AUTHORIZATION AND RELEASE

This section must be completed by the Applicant. Missing information or unreadable applications will be returned unprocessed.

Legal First Name:	Given Middle Name: (Indicate if middle name is an initial only. Use N/A if no middle name)	Current Legal Last Name:
List ALL Maiden, Alias & Previous Married Names:		
Date of Birth: ___/___/___ MM DD YYYY	Social Security Number:	Email address:
Permanent / Physical Address:	City:	State: / Zip Code:

2. Have you ever been arrested or charged with a crime by any law enforcement authority (local, state, federal or international)? Disclose ALL CRIMINAL OFFENSES even if they were later dismissed, you completed a plea in abeyance or diversion program, whether you pled guilty or not guilty to an offense, or if you are waiting to enter a plea to the court.

☐ Yes ☐ No — If yes to 2, please attach a certified court docket or other certified record (available from the court that handled your case) indicating the disposition of each charge or offense, or the status of each plea in abeyance or diversion agreement.

3. Have you ever been investigated for child or adult abuse, neglect or exploitation by Child Protective or Adult Protective Services?

☐ Yes ☐ No — If yes to 3, please attach complete case report showing final outcome. If previously submitted, provide a detailed explanation of the investigation including the names, dates, location and the case number if known.

4. Are you applying to work in a youth residential program? ☐ Yes ☐ No 4a. If yes to 4, Have you lived outside the State of Utah in the last 5 years? ☐ Yes ☐ No

4b. If YES to 4a, please submit out of state registry records for each state resided in. Instructions are located at https://hslc.utah.gov/Out-of-state-registries

☐ I certify out-of-state registry records are in process and I will be ineligible for renewal if this process is not completed.

4c. If YES to 4a, please list city and state within the last 5 years:

5. I authorize the Utah Department of Human Services Office of Licensing to investigate and continually monitor my past and present child and adult abuse, neglect and exploitation records, law enforcement, driver license, and any information which may be pertinent to my application according to Utah Code 62A-2-120, 121, 122, and Administrative Rule 501-14.I authorize the release of all information and I release and hold harmless the Department of Human Services from any damages resulting from the Department of Human Services furnishing such information to authorized agencies. I certify my answers contain no misrepresentations or falsifications, and the information is true and complete. I understand that providing false or inaccurate information or failing to provide information may result in my background screening being denied. I have read and understand the Consent and Privacy Statement on page 2. DHS may contact me to complete, fill out or correct technical omissions such as a date or other typographical errors.

Applicant Signature: _____ Date: _____

TO BE COMPLETED BY PROGRAM REPRESENTATIVE BASED ON APPLICANT'S OFFICIAL IDENTIFICATION DOCUMENTION

Please visit our website for full information and instructions prior to signing. www.hslc.utah.gov

Print Applicant Legal Full Name: _____ Is this a Youth Residential Program? ☐ Yes ☐ No
If yes: please verify that the applicant submits the required out of state registry checks with this application.

Valid Identification Type: (Driving Privilege Cards are not acceptable forms of I.D.) ☐Driver License ☐Passport ☐State ID ☐Military ID	State/Country Issued by: (See #4)	ID Number:	Expiration date: mm/dd/yy	Gender: ☐ Female ☐ Male

Race: ☐Asian ☐Black ☐White ☐Native American ☐Unknown	Eye Color:	Hair Color:	Height:	Weight:	Place of Birth:

6. Initial Applications and renewal applicants not on rap back: Submit two completed, properly rolled fingerprint cards along with a company check, cashier's check or money order made payable to: Department of Human Services

☐ $38.25 - Ongoing Statewide Rap Back Subscription & Fingerprint Fee

Program Name: [illegible] Street Address: [illegible] 7 N Freedom Blvd Provo, UT 84601

License Type: ☐ Out Patient Treatment ☐ Adult Day Care ☐ Adult Foster Care ☐ Child Placing Adoptive Employee ☐ Day Treatment ☐ RAS ☐ Intermediate Secure Care ☐ Outdoor Youth Treatment ☐ Recovery Residence ☐ Residential Support (Adult/Youth) ☐ DSPD Certified ☐ Residential Treatment (Adult/Youth) ☐ Social Detoxification ☐ Therapeutic School ☐ Child Placing Foster Employee

7. I certify that I have inspected and entered accordingly the applicant's social security card and passport, state driver license or state identification card issued by the Driver License Division and they do not appear to have been forged or altered. I have reviewed the entire completed application, applicant and licensed program sections, and they contain no misrepresentations or falsifications to the best of my knowledge. The licensed program releases the Department of Human Services from any damages resulting from disclosing information to authorized agencies. The licensed program shall not disclose this form or its contents except as authorized by Utah or federal law.

Signature of verifying representative: _____ Date: _____

For Office of Licensing Use Only

FBI Date:_____ DHS/Office of Licensing Screening Approval Date:_____

1:2

Attachment 5

Expired BCI Application Cover Letter

Sample Form

Date

Name
Company
Address
City, State Zip

Dear Name,

Your Background Criminal Investigation (BCI) application has expired and needs to be updated in order to be in compliance with your Wasatch Behavioral Health Contract Agreement. Therefore, in order to expedite this process as quickly as possible with the State, please follow the steps outlined below:

1) Complete and sign the attached BCI Application request and Release form and return it to my attention. We need the original form with your original signature – (NOT A COPY).

2) Attach to the BCI Application a very clear copy of your driver's license with the expiration date clearly visible. Your license must be current/not expired. ; *If your license has been renewed and the expiration date is on the back, please make a copy of both the front and back of your driver's license.* (***ENLARGING THE PICTURE & LIGHTENING IT, MAKES IT CLEARER***).

3) DO NOT FAX THIS PAPERWORK. Please mail the BCI and copy of your ID to:

Wasatch Behavioral
750 North Freedom Blvd. (200 West), Suite 300
Provo, Utah 84601
Attn: Name, Coordinator

Please return the BCI as soon as possible. Wasatch Behavioral Health cannot authorize clients to be seen by anyone not having a BCI clearance from the State of Utah. If you have any questions please contact Name at NUMBER.

Sincerely,

Name
Title

Enclosure: BCI Application

Attachment 6
Expired Document Notice

Date

Sample Form

Name
Company
Address
City, State Zip

Dear Name,

Our records show that one or more of the documents listed below has or will expire shortly. In order to keep your Contract Agreement current through the end of the contract period, Please fax or mail to my attention a copy of the indicated item(s) as soon as possible.

Document	*Expiration Date*
___Professional License	_____
___*DEA Controlled Substance Cert*	_____
___Business License	_____
___General Liability	_____
___Professional Liability)	_____
___BCI Clearance	_____

(BCI information must be mailed – PLEASE DO NOT FAX)

Some of the above mentioned documents may not be due yet. Therefore, please mail or fax a copy of these documents as soon as they are received. My fax number is NUMBER.

If you have any question, please feel free to contact me at NUMBER. Thank you for your willingness to work with us and your prompt attention to this matter.

Sincerely,

Name
Title

Credentialing Expired Document 2nd Notice

Date

2nd Notice

Name
Company
Address
City, State Zip

Sample Form

Dear Name,

Our records show that one or more of the documents listed below has or will expire shortly.
In order to keep your Contract Agreement current through the end of the contract period, please fax or mail to my attention a copy of the indicated item(s) as soon as possible.

Document	*Expiration Date*
___Professional License	_____
___*DEA Controlled Substance Cert*	_____
___Business License	_____
___General Liability	_____
___Professional Liability)	_____
___BCI Clearance	_____

(BCI information must be mailed – PLEASE DO NOT FAX)

Some of the above mentioned documents may not be due yet. Therefore, please mail or fax a copy of those documents as soon as they are received. My fax number is NUMBER. If you have any questions, please feel free to call me at NUMBER.

Thank you for your help and willingness to work with us.

Sincerely,

Name
Title

Attachment 8
Expired Document Notice FINAL

Sample Form

Date

Final Notice

Name
Company
Address
City, State Zip

Dear Name,

In order to keep your Contract Agreement with Wasatch Behavioral Health current, the enclosed expired document form was previously sent to you asking that a current copy of the indicated Document(s) be sent as soon as possible.

To keep your contract active and any current Treatment Authorization in effect, your expired or expiring documents must be received within ten (10) days from the date of this letter unless other arrangements have been made. You can contact me at NUMBER if other arrangements are necessary.

Sincerely,

Name
Title

Enclosure

Attachment 9

GROUP PROVIDER ATTESTATIONS

Copies of current **Professional Licensure** and **Controlled Substance Certificate** *(if applicable)* for all contractors, sub-contractors and/or employees of the CONTRACTOR providing services under this agreement shall be held by CONTRACTOR – in lieu of being attached – during the term of this agreement and are subject to audit by Wasatch Behavioral Health at its discretion.

_____ _____
Signature Date

_____
Title

Copies of current, state required, **Background Criminal Investigation (BCI)** clearances for all contractors, sub-contractors and/or employees of the CONTRACTOR providing services under this agreement shall be held by CONTRACTOR – in lieu of being attached – during the term of this agreement and are subject to audit by Wasatch Behavioral Health at it's discretion.

_____ _____
Signature Date

_____
Title

Sample Form

Attachment 10

Application Deficit Letter

date

name
company
address
csz

Dear

Your Credentialing Contract Application Packet was received in my office on _____. However, in going thru the packet, I found there are some pertinent documents that are missing or are expired, making the packet incomplete. I have indicated in the list below what documents are still needed to complete your Application.

_____ Copy of current Professional License

_____ Copy of current DEA Drug License *(if applicable)*

_____ Copy of current Business License

_____ Copy of current Professional Liability Insurance

_____ Copy of current Accident/Fire Insurance for Treatment Facility

_____ Completed BCI Consent and Release Form

_____ Copy of Photo ID for BCI

We can begin to process your Application as soon as these documents are received. Please mail or fax them to NUMBER as soon as possible. If you have questions or concerns regarding the above mentioned items, please feel free to call me at NUMBER or CONTRACT MANAGER at NUMBER.

Sincerely,

STAFF NAME
PP Records Coordinator

Sample Form

Wasatch Behavioral Health
Attestation of Compliance
Fraud and Abuse Prevention and Reporting

Pursuant to your organization's contract agreement with Wasatch Behavioral Health, and as required by Utah Code, Title 26, Chapter 20 False Claims Act and United States Code 3729 – 3733, your organization is required to complete a fraud, waste and abuse prevention and reporting training to ensure your organization does not engage in fraudulent and/or abusive practices, or wrongdoing in its administrative, clinical and billing procedures.

Topics that should be addressed in a fraud, waste and abuse training program include, but are not limited to the following:

- Definitions of fraud, waste and abuse,
- Overview of laws and regulations related to fraud, waste and abuse, including a brief description of main requirements and criminal and civil penalties related to Federal and State False Claims Act,
- Entities/individuals excluded from doing business with the Federal Government (LEIE and SAM exclusion lists),
- Obligations to have appropriate policies and procedures to address fraud, waste and abuse,
- Process for reporting suspected fraud, waste and abuse,
- Protections for employees who report suspected fraud, waste and abuse.

Please indicate which of the following fraud, waste and abuse training programs have been completed by your organization.

- o Wasatch Behavioral Health's Fraud and Abuse Prevention and Reporting Policies and Procedures.
- o Your Organization's Fraud, Waste and Abuse Training Program.
- o Other _____ (Name of Training Program).

I, the undersigned, attest that I am an authorized representative with signature authority for the organization listed below and that all employees that provide services for Medicaid members have
completed Fraud and Abuse Prevention and Reporting training.

Facility/Provider Name: _____ **Sample Form** _____

Authorized Representative: _____ Title: _____

My signature certifies that the information I provided is true and correct. I understand that Wasatch Behavioral Health and/or the Utah Department of Health (Medicaid) may request additional
information to substantiate our Attestation.

Signature: _____ Date: _____

CONTRACT AGREEMENT

See copy of Contract Agreement