



# **Douglas County Community Provider Outreach January 2018**

# Douglas County Gold Rx Plan Changes



Description	2017 In-Network / Out-of-Network	2018 In-Network / Out-of-Network
<b>Gold Rx – Premium</b>	<b>\$180</b>	<b>\$189</b>
• Ambulance	\$100	\$150
• Emergency	\$65	\$100
• Dialysis	15% / 20%	20% / 30%
• Outpatient Surgery – Hospital	\$200 / \$325	\$225 / \$325
• Maximum Out of Pocket Limit	\$2,500 / \$3,500	\$3,000 / \$3,500
<b>Gold Rx Prescription Drugs</b>		
• Stage 2 Limit (Initial Coverage Period)	\$3,700	\$3,750
• Stage 3 Discounts (Coverage Gap)	Generics 49% / Brands 60% True Out of Pocket - \$4,950	Generics-56% / Brands 65% True Out of Pocket - \$5,000
• Stage 4 Copays (Catastrophic Coverage)	Generics \$3.30 / Brands \$8.25	Generics \$3.35 / Brands \$8.35

# Douglas County Silver & Silver Rx Plan Changes



Description	2017 In-Network / Out-of-Network	2018 In-Network / Out-of-Network
<b>Silver &amp; Silver Rx – Premiums</b>	<b>\$59 / \$113</b>	<b>\$65 / \$122</b>
• Ambulance – Silver	Silver - \$200	Silver - \$150
• Emergency	\$65	\$100
• Durable Medical Equipment	15% / 30%	20% / 30%
• Dialysis	15% / 30%	20% / 30%
• Outpatient Surgery – Hospital	Silver - \$200 / \$325 Silver Rx - \$225 / \$325	20% / 30%
• Outpatient Surgery – ASC	20% / 30%	\$225 / \$325
<b>Silver Rx Prescription Drugs</b>		
• Deductible (Tiers 3, 4, 5 only)	\$0	\$75
• Stage 2 Limit (Initial Coverage Period)	\$3,700	\$3,750
• Stage 3 Discounts (Coverage Gap)	Generics 49% / Brands 60%	Generics-56% / Brands 65%
• Stage 4 Copays (Catastrophic Coverage)	Generics \$3.30 / Brands \$8.25	Generics \$3.35 / Brands \$8.35



# Douglas County Bronze & Bronze Rx Plan Changes

Description	2017 In-Network / Out-of-Network	2018 In-Network / Out-of-Network
<b>Bronze &amp; Bronze Rx – Premiums</b>	<b>Bronze - \$0 Bronze Rx - \$0</b>	<b>Bronze - \$0 Bronze Rx - \$0</b>
• Specialist Visit	Bronze Rx - \$15 / \$50	Bronze Rx - \$25 / \$50
• Emergency	\$65	\$100
• Outpatient Surgery – ASC	Bronze Rx - 20% / 30%	Bronze Rx - \$225 / \$325
<b>Bronze Rx Prescription Drugs</b>		
• Deductible (Tiers 3, 4, 5 only)	\$0	\$100
• Specialty Medications (Tier 5)	33%	31%

# Douglas County



## 2018 Plans - Extra Covered Services

(In-network/Out-of-network)

Benefit	Silver & Silver Rx	Gold Rx
Routine Eye Exam (every calendar year)	\$15 / \$40	\$15 / \$30
Vision Hardware (every two years)	Silver - \$150 Silver Rx - \$100	\$200
Preventive Dental (every calendar year)	n/a	\$15 / \$15 \$500 maximum
Health Club Reimbursement	\$500	\$500
Routine Chiropractic	n/a	\$15 / \$15 \$500 maximum
Routine Podiatry	n/a	\$15 / \$25 \$500 maximum
Routine Hearing	n/a	\$15 / \$25 \$300 maximum

# Douglas County SNP Plan Changes



Description	2017	2018
• Plan Deductible	\$0	\$125
• Inpatient Hospital	\$0	5% of Cost
• Skilled Nursing Facility	\$0	\$0- Days 1-20, 10% of Cost- Days 21-100
• Most all other outpatient services	\$0	5% of Cost
• DME, Prosthetics & Diabetic Supplies	\$0	10% of Cost
• End-Stage Renal Disease	\$0	10% of Cost
• Ambulance	\$0	10% of Cost
• Comprehensive Dental	Covered/\$1000 max benefit (excludes crowns & prosthodontics)	Not Covered

# Commercial Plan Changes



ATRIO Health Plans is leaving the commercial (individual and small group) market at the end of the 2017. Those plans will remain active through December 31, 2017. **In 2018, ATRIO will no longer offer commercial plans.** Current ATRIO commercial members have been notified of this change.

- Discontinuing all **Standard Plans (PPO)** (3)
- Discontinuing all **Pioneer Plans (EPO)** (non-standard) (3)
- Discontinuing all **Enhanced Plans (PPO)** (non-standard) (5)

# Provider Networks



Our Medicare Advantage plans utilize the following provider network for accessing In-Network benefits:

- ATRIO Provider Network (direct contracts and Umpqua Health network)

With Commercial Plans no longer being available, the following networks **will not** be utilized in 2018:

- First Choice Health Network (AK, ID, MT, OR, WA, WY, ND and SD)
- First Health Network- Nationwide (excluding States listed above)



# Provider Directories




All payers are under Medicare mandates for directory accuracy. This includes:

- Quarterly outreach and verification
- Data elements:
  - Phone, Address, Name, Specialty, open/closed status, Medicaid acceptance, etc.
- Penalties for inaccuracies
- Contact Preferences

Please contact the provider directory team at [Providerdirectory@atriohp.com](mailto:Providerdirectory@atriohp.com) with any changes to directory information.

# Member ID Card



  
RxBin: 003585  
RxPCN: ASPROD1  
RxGrp: ATR01  
Issuer: ATRIO Health Plans  
Administrator: MedImpact  
Part B RX only

NAME: XXXXX NAME XXXXXXXXXXXXXXXXXXXXXXXXXXXX  
MEMBER ID: XXXXXX  
PLAN: **ATRIO Silver Rogue** (PPO)  
EFFECTIVE DATE: XXXXXX

X2013113934900001



Medicare Limiting Charges Apply  
CMS# H6743 013

**PROVIDER INFORMATION**  
Provider Services: (855) 204-2964 M-F 8am to 5pm

*Send Claims to:*  
ATRIO Health Plans  
PO Box 5490  
Salem, OR 97304

*Rx Emergency Services:*  
Evenings, Weekends & Holiday.  
(800) 681-9571  
atriohp.com

**MEMBERS ONLY:**  
Customer Service: (877) 672-8620 Daily 8am to 8pm  
TTY/TDD: (800) 735-2900

*Possession of this card does not in itself guarantee plan benefits*



# Secure Member Portal

ATRIO members have access to a secure member portal through our website <http://www.atriohp.com/Members.aspx>. In addition to our mobile phone application available for all Androids and iPhones.

Portal and App features:

- Member can view eligibility, benefits, medical claims, deductible and out-of-pocket amounts.
- View or order a temporary membership card
- Contact our customer service team

# Medicare Advantage Appeals, Grievances & Reconsiderations



- **Appeals:**
  - Submit within 60 calendar days.
  - 60 day turnaround for Part C Payment (Claim) Appeals.
  - 30 day turnaround for Part C standard Pre-Service Appeals or 72 hours for expedited
  - 7 day turnaround for Part D standard Appeals or 72 hours turnaround for expedited
  - Member, Authorized Rep. (AOR CMS 1696 required), or Physician may appeal Pre-Service.
  - Member, Authorized Rep. (AOR CMS 1696 required), or Provider with a signed Waiver of Liability (WOL) for Payment (claim) appeals.
- **Grievances:**
  - A grievance is any complaint, other than one that involves a request for a coverage determination or an appeal. Examples of a grievance include a complaint about quality of care, waiting times, or the customer service received.
  - Submit within 60 days of the event or incident.
  - 30 days turnaround from receipt.
  - Member, or Authorized Rep (AOR 1696 required).
- **Reconsiderations:**
  - When a Participating Provider wants a plan determination on adverse claim decision or payment.
  - Contracted providers can request a reconsideration within 60 days of post service denial notification date and we will respond within 60 days. Other timelines may be based on contract. This is not a CMS requirement.



# Appeals, Grievance & Reconsiderations Contacts

- Appeals and Grievance Phone: 877-672-8620 opt 3
- Appeals and Grievance Fax: 866-339-8751
- Appeals and Grievance Email: [Appeals@atriohp.com](mailto:Appeals@atriohp.com)
- Appeals and Grievance Mailing:
  - ATRIO Appeals
  - 2270 NW Aviation Dr. Suite 3
  - Roseburg, OR 97470
- Reconsideration Email: [ProviderRelations@atriohp.com](mailto:ProviderRelations@atriohp.com)
- Reconsideration Fax: 1-866-256-9002
- Reconsideration Mailing:
  - ATRIO Provider Reconsiderations
  - 2965 Ryan Drive SE
  - Salem, OR 97301

# Medicare Star Ratings Program



CMS established the Star Ratings Program to measure and help improve the quality of care provided to Medicare Advantage beneficiaries. Plans receive a Star score based on plan performance across dozens of measures. Star Measures are the same across all Medicare Advantage health plans.

## (30%) **HEDIS – Clinical Prevention and Disease Management**

- Percentage of patients receiving colorectal cancer screening
- Percentage of diabetic patients keeping their blood sugar controlled
- Percentage of all-cause hospital readmission within 30 days of discharge

## (30%) **CAHPS/HOS – Patient Perception of Health Care Received**

- Patient perception of access to care, office wait times, care coordination
- Patient perception of physical and mental health
- Patient perception of quality of life

## (20%) **Pharmacy – Medication Adherence and Safety**

- Percentage of patients taking High Risk Medications
- Adherence rates for hypertensive medication, diabetic medication or cholesterol

## (20%) **Administration of Health Plan Services**

- Appeal timeliness
- Call Center and Customer Service Experience

# CAHPS



## Consumer Assessment of Healthcare Providers and Systems

### Types of questions asked on surveys

- How often did your personal doctor explain things in a way that was easy to understand?
- In the last 6 months, how often did your personal doctor listen carefully to you?
- In the last 6 months, how often did you and your personal doctor talk about all the prescription medicines you were taking?
- In the last 6 months, did you get the help you needed from your personal doctor's office to manage your care among these different providers and services?

### Ways to improve

- Make a positive patient experience part of your culture
- Educate patients in terms they can easily understand
- Use tools or props to improve communication
- Make each patient feel like the only patient
- Remind patients that if they receive a survey to please fill them out and return!

# Combining Risk and Quality



- In 2017 ATRIO combined Risk and Quality
  - Take advantage of a single visit with the provider
  - Making visit more patient centric
  
- Medicare is moving to Quality over Quantity



# New P4P-Selective Program Comprehensive Annual Visits (CAV)



- Identifying members and using the correct intervention
- List of qualifying members will come from our SAC partners (verified for correct PCP attribution)
- Accommodating established workflows
- 2 different forms, Q&A and coding documentation provided for training and education purposes (99381-99387, 99391-99397)
- Receive within 10 business days of DOS
- 60 day look back to make CAV payment (in addition to the billed claim)

# Workflow of CAV Process



**1 Who?**

Call each patient on the "hotlist" provided to your office

**2 What?**

Schedule a wellness or preventative visit with PCP

**3 When?**

Visit type should not cause the patient to incur a co-pay and must be completed prior to the end of the current year

**4 Why?**

Patients identified have not met the ATRIO clinical documentation requirements needed to maximize risk scores and close care gaps.

To meet requirements, follow the documentation descriptions included in the accompanying guidelines.

**5 How?**

Complete the visit and bill for it using the diagnostic guidelines found in the Documentation and Coding Guide found in the packet.

The Documentation Tips sheet included in the packet offers helpful guidance for this specific visit type.

**6 Final Steps**

Provider completes "CAV EMR Form" or "CAV Form" depending on whether or not your office uses an EMR.

Once the form is completed and signed, follow the submission instructions at the bottom and send to ATRIO.

ATRIO QA will review the CAV Form and provide feedback. After feedback issues are addressed, your office will qualify for the Incentive Payment.

After claim is billed and provider has submitted the appropriate CAV Form, the Incentive Payment will be processed

Please email questions to:  
[QI@atriohp.com](mailto:QI@atriohp.com)

# Comprehensive Annual Visit links



- <http://www.atriohp.com/documents/Providers/ATRIO-CAV-Documentation-Coding-Guide.pdf>
- <http://www.atriohp.com/documents/Providers/ATRIO-CAV-EMR-Checklist.pdf>
- <http://www.atriohp.com/documents/Providers/ATRIO-CAV-Form.pdf>
- <http://www.atriohp.com/documents/Providers/ATRIO-CAV-Incentive-Program-Q-A.pdf>
- <http://www.atriohp.com/documents/Providers/CAV-Process-Flowchart.pdf>

# Provider Resources



ATRIO Health Plans' website ([www.atriohp.com](http://www.atriohp.com)) contains helpful information for both providers and members. We will often outreach to providers via phone, email, mail, and will post helpful plan information in the Provider Information center found at <http://www.atriohp.com/Providers.aspx>.

- Provider Login (link to CIM)
- Provider Manual
- Provider Support Help Desk (provider customer service)
- Resources and Support (plan forms)
- Prior Authorizations (plan grids/forms/notifications)
- Provider Education (plan notifications/documents)
- Compliance (reporting compliance concerns)
- Quality of Care Concerns (reporting quality of care concerns)

# Provider Service Contacts



ATRIO Health Plans' purpose is to deliver improved health outcomes to the communities we serve. ATRIO teams are located in Oregon and offer individualized support to providers and members.

- **Provider Customer Service**
  - Phone: 1-877-672-8620
- **Provider Relations Department**
  - Email: [ProviderRelations@atriohp.com](mailto:ProviderRelations@atriohp.com)
  - Fax: 1-866-256-9002
- **Provider Directory Department**
  - Email: [Providerdirectory@atriohp.com](mailto:Providerdirectory@atriohp.com)

# ATRIO Health Plans Local Office



## Douglas County

Address:

ATRIO Health Plans

2270 NW Aviation Drive, Suite 3  
Roseburg, OR 97470

Office Hours:

8 a.m. to 5 p.m. (M-F) (Pacific)

Customer Service Hours:

8 a.m. to 8 p.m. Daily (Pacific)

Toll Free: (877) 672-8620

TTY/TDD: (800) 735-2900

# Medical Management



There are no changes to any Prior Authorization requirements for 2018.  
Links to ATRIO's lists of services requiring Prior Authorization or Referral:

2018 Medicare Prior Authorization Grid:

<http://www.atriohp.com/documents/Prior-Authorization/2018-Medicare-Prior-Authorization-Grid.pdf>

2018 Medicare Part D Coverage Determination Request Form:

<http://www.atriohp.com/documents/Prior-Authorization/Medicare-Part-D-Coverage-Determination-Request-Form.pdf>

## Douglas County

- Medical Prior Authorization Electronic: CIM portal
- Medical Prior Authorizations Fax: 541-672-4318
- Medical Prior Authorizations Email: [atriodcipa@dcipa.com](mailto:atriodcipa@dcipa.com)
- Pharmacy Prior Authorization Requests Fax (MedImpact): 858-790-7100
- Pharmacy Prior Authorization Request Online (MedImpact):  
<https://mp.medimpact.com/partdcoveragedetermination>

# Drug Formulary



ATRIO Health Plans drug formulary links:

Medicare Advantage

<http://www.atriohp.com/Medicare/Member-Tools-Resources.aspx>

The ATRIO list of covered drugs may change periodically. Changes are posted to our website.

- Pharmacy Authorization Requests Fax (MedImpact): 858-790-7100
- Pharmacy Customer Service: 541-492-5131
- Pharmacy Benefit Manager (PBM): [www.medimpactdirect.com](http://www.medimpactdirect.com)



# Claims Billing & Contact Information



- **Paper Claims Submission Address**
  - ATRIO Health Plans  
Claims Administration  
PO Box 5490  
Salem, OR 97304
- **Electronic Claim Payor ID's**

EDI Payer ID List					
Clearinghouse	Payor Name	Payor ID	ENR	ERA/835 Notification	Administered By/Notes
AVAILITY	Atrio Health Plans	ATRIO	N	Y - PaySpan	PH Tech
CORTEX EDI	ATRIO	CX031	N	Y - PaySpan	PH Tech
GATEWAY EDI	Atrio	ATRIO	N	Y - PaySpan	PH Tech
OFFICE ALLY	ATRIO Health Plans	ATRIO	N	Y - PaySpan	PH Tech
RELAYHEALTH PCS	ATRIO (Professional)	CPID 4799	N	Y - PaySpan	PH Tech
	ATRIO (Institutional)	CPID 5934	N	Y - PaySpan	PH Tech

## Legend

- ENR = Pre Enrollment Required
- Payor Name = The name of the payor
- Payor ID = Payor ID associated with the payor
- ERA/ Notification = Identifies if programmed to process Electronic Remittance Advice (ERA)(835)for this payor.

**\*Your specific clearinghouse may already be forwarding claims to one of these known entities. If you do not see that entity as an option, please contact your clearinghouse to have the claims forwarded. Please contact EDI Support at 503.584.2169 Opt. 1 and speak to an EDI specialist about testing for this payer.**

# Claims Billing & Contact Information



- **Electronic Claim Support** (EDI Support: Transmission and Clearing house questions)
  - Email: [EDI.Support@phtech.com](mailto:EDI.Support@phtech.com)
  - Phone: 503-584-2169 Opt. 1
- **CIM Access and Support** (Claims System)
  - Email: [Support@phtech.com](mailto:Support@phtech.com)
  - Phone: 503-584-2169 Opt. 2
- **Electronic Fund Transfer (EFT)**
  - Payspan Provider Payment Services is available Monday through Friday 6:00AM to 3:00PM Pacific (9:00AM to 6:00PM Eastern)
  - Email: [ProviderSupport@payspanhealth.com](mailto:ProviderSupport@payspanhealth.com)
  - Phone: 1-877-331-7154 Opt. 1

# CIM Applications



Once you have access to CIM, you will be able to check member eligibility, claims status, see plan message board, run claim history reports, enter Prior Authorization request, etc.

- Claims Search (check claims status, pull claims reports)
- Code Search (search CPT and ICD-9 or ICD-10 codes/descriptions)
- Member Search (check member eligibility/demographics/enter Prior Authorizations)
- Provider Services (Quick Links: CIM user manual/Pioneer Plan Preferred Prioritized List)
- Referral Manager (Review/email/update Prior Authorizations)

# Claim Search



CIM - Claim Search x

← → ↻ <https://cim1.phitech.com/cim/claim/Search> ★

← [BACK TO MAIN MENU](#) **Claim Search** Claim Search ▾

Search **Advanced**

Patient Last: <input type="text"/>	Patient First: <input type="text"/>	Patient ID: <input type="text"/>	All Statuses ADJUST CAPITATE ADJUST REVIEW ADJUSTMENT APPROVED APPROVED PAYMNT ▾	<input type="button" value="Search"/>
Provider Last: <input type="text"/>	Provider First: <input type="text"/>	Claim Number: <input type="text"/>		<input type="button" value="To File"/>
Service From: <input type="text" value="12/30/2016"/>	Service To: <input type="text" value="12/30/2016"/>	Invoice Number: <input type="text"/>		<input type="button" value="Reset"/>
Diagnosis Code: <input type="text"/>	Procedure Code: <input type="text"/>	Benefit Types: <input type="text" value="All Benefit Types"/>		

# Code Search

A screenshot of a web browser window displaying the "Code Search" application. The browser's address bar shows the URL "https://cim1.phtech.com/cim/reference/codesearch/". The application header includes a "BACK TO MAIN MENU" link, the title "Code Search", and a dropdown menu currently set to "Code Search". The main search area contains four input fields: "Code" (empty), "Description" (empty), "Code Type" (set to "Diagnosis"), and "Code Set" (set to "All"). A blue "Search" button is positioned to the right of these fields.

CIM - Code Search

← → ↻ <https://cim1.phtech.com/cim/reference/codesearch/> ☆ ⋮

◀ [BACK TO MAIN MENU](#) **Code Search** Code Search ▼

Code  Description

Code Type:  Code Set:

# Member Search



The screenshot shows a web browser window with the title "CIM - Member Search" and the URL "https://cim1.phitech.com/cim/Member/Search". The page has a dark blue header with a "BACK TO MAIN MENU" link on the left, the "Member Search" title in the center, and a "Member Search" dropdown menu on the right. Below the header is a search form with the following fields: "Last Name:" (text input), "SSN:" (text input), "Insurance Carrier:" (dropdown menu with "All Carriers" selected), "First Name:" (text input), "DOB:" (text input with "mm/dd/yyyy" placeholder), "Member ID:" (text input), and "Eligibility Date:" (text input with "mm/dd/yyyy" placeholder). There are "Search" and "Reset" buttons to the right of the form. Below the form is a section titled "Search Criteria" with the following text: "When searching for members, the following fields are required: **Member ID Number ('Member ID')** - or - **Two (2) of the following elements:** - Member First and Last *full* names (exact matches only); - Member Date of Birth ('DOB'); - Member Social Security Number ('SSN');".

# Member Search



CIM - Member Search

https://cim1.phitech.com/cim/Member/Search

Member Search

Last Name: medicare    SSN:    Insurance Carrier: All Carriers    Search

First Name: myrtle    DOB: mm/dd/yyyy    Member ID: 123456    Eligibility Date: mm/dd/yyyy    Reset

**MEDICARE, MYRTLE - TEST MEMBER**

[<< Back](#) | [Add Notes](#) | [View Notes](#) | [Auth History](#) | [Current Auths](#) | [Claims](#) | [Copay Info](#) | [Disclosure](#) | [Add'l Info](#) | [Flags](#)

<b>Address 1:</b> PO BOX 9999 <b>Address 2:</b> <b>City/State:</b> DALLAS, OR 97339 <b>Phone:</b> (503) 999-0505 <b>Alt Phone:</b> <b>SSN:</b> 999-99-9999 <b>DOB:</b> 07/01/1900 <b>Language:</b> ENGLISH <b>Gender:</b> F <b>Condition:</b> <b>Contact:</b> <b>Preg. Due Date:</b>	<b>Plan:</b> ATRIO Comm Douglas <b>Phone:</b> (855) 204-2964 <b>Fax:</b> null <b>Email:</b> <a href="mailto:atrio.cs@phitech.com">atrio.cs@phitech.com</a> <b>For Mental Health Information:</b> <b>Phone:</b> (503) 584-2151 <b>Fax:</b> (503) 566-9801 <b>Benefit Plan:</b> Silver_H6743-002 <b>Member ID:</b> 203733 <b>Effective:</b> 01/01/2016 <b>Termination:</b> 10/31/2016 <b>Coverage Code:</b> <b>Flags:</b> Open_Card
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[print](#)

**Member's PCP:** Baker, Rola P - Family Medicine (effective: 12/07/2016 )

- **Primary Care Physician**
- Rola P Baker MD (Office Phone: (541) 440-9128)
- No primary contact defined for this office

[\(PCP History\)](#)

**Other Coverages:**

- [COB Record Exists](#)

Submit Referral    or    Submit Pre-Auth

# Provider Services



CIM - Quick Links x

Secure | <https://cim1.phitech.com/cim/reference/resources/>

[BACK TO MAIN MENU](#) **Quick Links** Provider Services ▾

Filter:

<a href="#">CIM Provider Manual</a>	<b>CIM Provider Manual</b>
<a href="#">Quick References</a>	<b>Quick References</b>
<a href="#">ATRIO Exchange Preferred List</a>	<b>Search the Atrio Pioneer Plan preferred list for covered benefits.</b>
<a href="#">Health Systems Division Line Search</a>	<b>Search the Health Systems Division (formerly DMAP) priority line for covered benefits.</b>
<a href="#">Health Systems Division Prioritized Line</a>	<b>Health Systems Division (formerly DMAP) Prioritized Line, Health Services Commission (EXTERNAL).</b>
<a href="#">Federal Register</a>	<b>Federal Register Search (provided by PH Tech)</b>
<a href="#">HIPAA Manual</a>	<b>MVIPA HIPAA Privacy Kit</b>
<a href="#">OHP - OMAP Link</a>	<b>Oregon Health Plan - Oregon Medical Assistance Program</b>
<a href="#">ATRIO Pioneer Preferred List</a>	<b>ATRIO Pioneer Preferred List PDF</b>



# Referral Manager



The screenshot shows a web browser window titled "CDM - Referral Manager" with the URL "https://cim1.phitech.com/cim/referral/manage". The page header includes a "BACK TO MAIN MENU" link, the title "Referral Manager", and a dropdown menu set to "Referral Manager".

The search interface is divided into four tabs: "Search", "Office", "Advanced", and "Sorting". The "Search" tab is active, displaying the following search criteria:

Patient Last Name:	<input type="text"/>	Patient First Name:	<input type="text"/>	Patient ID:	<input type="text"/>	- All Statuses - Additional info requested Approved Approved - As Amended Approved - Claim Review Pending Approved - Closed Approved - Payment Review	Search
Referring Provider:	<input type="text"/>	Delivering Provider:	<input type="text"/>	Auth #:	<input type="text"/>		
Submitted From:	12/30/2016	Submitted To:	12/30/2016	Ref #:	<input type="text"/>		
				Episode:	<input type="text"/>		

Below the search criteria, a large blue area contains the text: "To search, enter a reference number or search criteria above."



Questions?



**Thank you!**