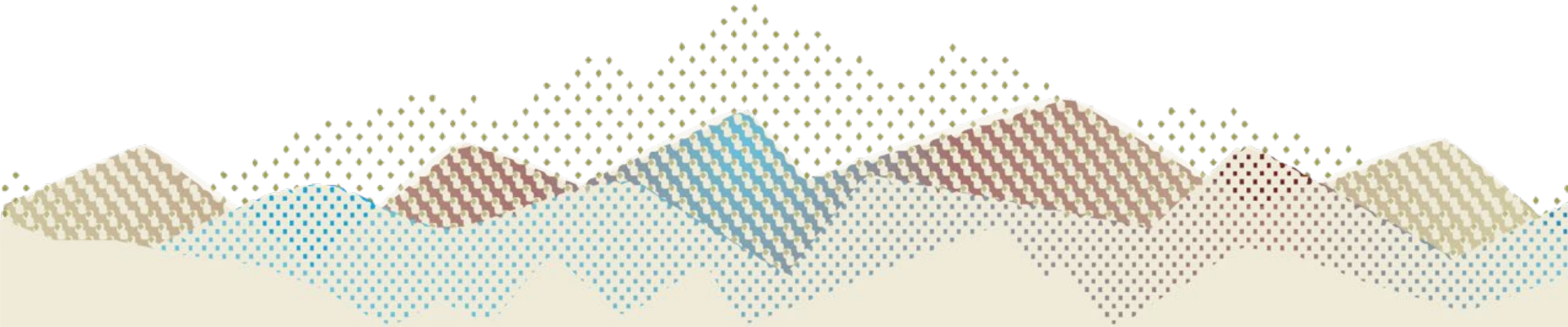


New Provider Orientation

Provider Relations



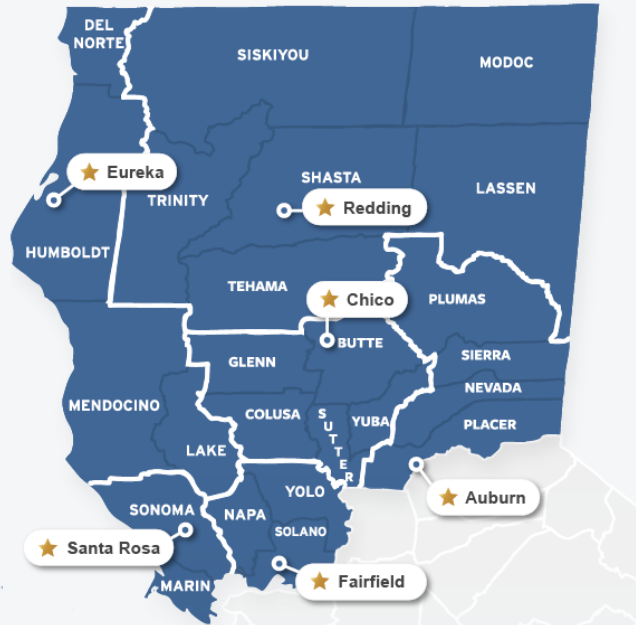
Agenda

- Background
- Organizational Goals
- Departments and Responsibilities
 - Member Services
 - Health Services
 - Enhanced Health Services
 - Claims
 - Network Services
 - Provider Relations
- Additional Benefits and Information



About Us

Regional Offices



Mission:

To help our members, and the communities we serve, be healthy.

Vision:

To be the most highly regarded managed care plan in California.

How we are organized

Partnership is a County Organized Health System (COHS) Plan

Non-Profit Public Plan

- Low administrative rate (less than four percent) allows for Partnership to have a higher provider reimbursement rate and support community initiatives.

Local Control and Autonomy

- A local governance that is sensitive and responsive to the area's healthcare needs.

Community Involvement

- Advisory boards that participate in collective decision making regarding the direction of the plan.

Organizational Goals

Improve patient access to care

Focus on primary and preventive care

Increase availability of specialty services

Decrease avoidable emergency room services

Provide timely reimbursement

Be a locally-responsive organization

Our Program



Welcome to Partnership HealthPlan of California. Partnership providers must promptly notify Partnership of any changes in their practice location, hours of operation, or if they plan to terminate their relationship with their medical group or Partnership. It is especially important for a primary care provider (PCP) to provide at least 90 calendar days' notice of termination to Partnership, as Partnership is required by law to re-assign patients to another PCP and to provide a 30-day advance notification to members of this transition.



Member Services

Member Services

Member Services assists with:

- Providing information about health benefits
- Selecting or changing primary care provider
- Ordering a new Partnership ID card
- Requesting a member handbook, provider directory, or other Partnership materials
- Assisting with problems getting appointments

Available Monday – Friday
8 a.m. to 5 p.m.
(800) 863-4155

Member Services

Available Monday – Friday
8 a.m. to 5 p.m.
(800) 863-4155

- Addressing vision services
- Coordinating interpreting services
- Supplying auxiliary aids and alternative formats
- Resolving billing problems
- Handling complaints and appeals
- Accessing the member portal
- Capturing and reporting demographic changes (such as name, phone, and address) to the county offices

Please review our [Policy MC305](#) on the Distribution of Member Rights & Responsibilities.

Member Complaints and Grievances

Time frames for filing & resolving complaints	
<u>Time frame for filing (from date of denial, service, incident or bill)</u>	
Type of complaint	Timeframe
Grievance	No time limit
<u>Time frame for processing</u>	
Type	Grievance and appeals process
Standard	30 calendar days
Expedited	72 hours

A Medi-Cal member must first exhaust a Medi-Cal managed care plan's appeals process prior to proceeding with a state hearing. Requests for state hearings must be submitted within 120 calendar days of an action with which the member is dissatisfied. For standard state hearings, the state will make a decision within 90 days of the request.

Membership

Direct members are:

- Members who are not assigned to a PCP
- Members with a share of cost
- First month eligibility, if they haven't selected a PCP
- Long term care (LTC) residents
- Foster care children, if known to Partnership

Partnership members are Medi-Cal recipients.



Primary Care Provider Assignment



Members who are assigned to a unique PCP site are called “case managed” members.



Members select their PCP from a list of practices that are open.



Members who do not select a PCP will be assigned based on home zip code to a practice open to new members.



The PCP is responsible for the management of patient’s care. The PCP office issues referral authorization form (RAF) for specialty care.



Newborns are covered for eligible services under their mother’s membership during the month of birth and the month following. Newborns must then be enrolled via the county eligibility office to continue coverage as a Medi-Cal member.



Accessibility

- **Preventive care** – within 10 business days of request
- **Routine care** – within 10 business days of request
- **Prenatal care** – within 10 business days of request
- **Newborn care** – newborns discharged from hospital should be seen within 48 hours of discharge
- **Emergent visit** – immediate treatment or referral to an appropriate emergency services provider
- **Same-day appointments** – open access appointments available same day or advanced access appointment scheduling if patient prefers
- **Specialty care** – within 15 business days
- **Urgent care** – within 48 hours



Interpretive Services AMN Healthcare

Telephone language services: (844) 333-3095

Providers will be asked to provide the following at the start of the call:

- Partnership number, provider site name and city, member ID (if applicable)
- If you do not have the member's ID, bypass the prompt by stating you do not have that information but will still require interpreting services.

There is no cost for each provider license. Partnership will pay the cost of interpreting services.

Resources:

AMN Healthcare Training Video: [click here](#)

Where to find your Partnership number: [click here](#)


VRI Guidelines: [click here](#)

VRI Setup Form: [click here](#)



Interpretive Services AMN Healthcare

Video language services:

- 
- Determine if the device meets the technical requirements for the app (linked below).
 - Request a license from AMN by completing the VRI setup form link and submitting.
 - AMN will contact provider within three business days to confirm approval status.
 - Please note that each individual device will require a separate license and login.

There is no cost for each provider license. Partnership will pay the cost of interpreting services.

Resources:

AMN Healthcare Training Video: [click here](#)
Where to find your Partnership number: [click here](#)

VRI Guidelines: [click here](#)
VRI Setup Form: [click here](#)



Health Education

- Partnership members must be provided with health education services at no cost. Health education services include but are not limited to primary and obstetrical care, clinical preventive services, education and counseling, and patient education and clinical counseling.
- Visit Partnership's website at www.partnershiphp.org to access Partnership's Health Education Library. Health Education resources are available in Partnership's threshold languages. If you would like more information about Health Education, please contact Partnership at CLHE@partnershiphp.org.

Community Resources

COMMUNITY RESOURCES

PARTNERSHIP SERVICE AREA

We provide quality care to members in 24 Northern California counties.



Select your county below to find resources for your area.

Butte	Colusa	Del Norte	Glenn
Humboldt	Lake	Lassen	Marin
Mendocino	Modoc	Napa	Nevada
Placer	Plumas	Shasta	Sierra
Siskiyou	Solano	Sonoma	Sutter
Tehama	Trinity	Yolo	Yuba

Members can access health education materials and community resources online at <https://www.partnershiphp.org/Community/Pages/Community-Resources.aspx>

- Utilities
- Dental
- Emergency response
- Disabilities
- Vision services
- Clothing and personal care
- Support groups
- COVID-19
- Veteran services
- Transportation
- Children and families



Health Services

Health Services

Utilization Management

- Referrals (RAF – Referral Authorization Form)
- Authorizations (TAR – Treatment Authorization Request)
- (707) 863-4133

Care Coordination

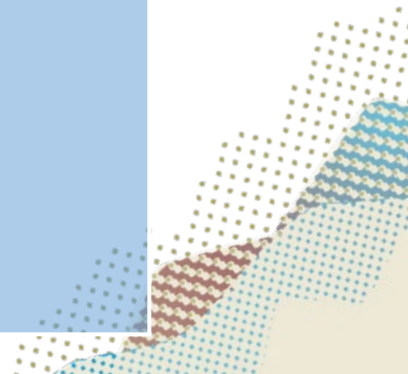
- Complex case management
- Transitional care services
- Access to care
- (800) 809-1350

Quality Improvement

- Healthcare Effectiveness Data and Information Set (HEDIS)
- Quality Improvement Program (QIP)
- (707) 863-4213

Population Health

- Health education
- Community outreach
- (855) 798-8764



Referral Authorization Form

- **What is a RAF?**
 - A RAF is a permission slip from PCP to a specialist
- **What does a RAF cover?**
 - RAFs only cover office visits, consultations, evaluations, and follow-ups
- **When do I need a RAF?**
 - A RAF is required anytime a member has an assigned PCP. If a member switches PCPs during eligibility, a new RAF is needed from the new PCP
- **How long does it take Partnership to review a RAF?**
 - RAF request can take up to five business days, 80% will auto adjudicate. “urgent” RAFs will be reviewed within 72 hours
- **Who submits the RAF?**
 - PCP submits a RAF on the provider portal:
<https://provider.partnershiphp.org/UI/Login.aspx>



Treatment Authorization Request Requirements

- TARs are submitted by the rendering provider of the service prior to the provision of services unless emergent.
- TARs can be submitted through the provider portal: <https://provider.partnershiphp.org/UI/Login.aspx>
- TAR requirements can be found on our website: <http://www.partnershiphp.org/Providers/HealthServices/Pages/Utilization-Management.aspx>

Appeal of Utilization Management (UM) Decisions


- Providers appealing UM decisions must follow [MCUP3037](#) in the provider manual. Please see form [MCUP3037-A](#) to submit a request for appeal.

UTILIZATION MANAGEMENT

Partnership HealthPlan of California's Utilization Management (UM) program team serves to implement a comprehensive integrated process that actively evaluates and manages utilization of health care resources delivered to all members, and to actively pursue identified opportunities for improvement. The UM program serves our members by assuring that:

- Members receive the appropriate quantity and quality of healthcare services
- Service is delivered at the appropriate time
- The setting the service is delivered in is consistent with the medical care needs of our members


Submitting Referrals and Authorizations



Please use our online system to submit Referral Authorization Forms (RAF) and Treatment Authorization Forms (TAR).

- Click here to submit a Treatment Authorization Request (TAR) or Referral Authorization Form (RAF) online
- Treatment Authorization Request (TAR) Requirements


RAF/TAR Status



Partnership's TAR/RAF inquiry system is available online.

- Click here to check RAF and TAR status


Forms



If online services are not available, please use RAF and TAR forms.

- eRAF Request Form
- Treatment Authorization Request (TAR) Form
- Long-Term Care 20-1 TAR form
- Bed Hold & Change of Status Report
- Long-Term Care Reference Sheet
- Behavioral Health Therapy (BHT) Fax Cover Sheet
- Incontinence Supplies Medical Necessity Certification

Endocrinology Guidelines



Project Echo
Partnership Endocrinology Referral Guidelines



Transportation Services

Transportation Services

The Transportation Services Department coordinates a variety of benefits for our members, including:



Non-Emergency Medical Transportation (NEMT)

- Door-to-door service, medical supervision



Non-Medical Transportation (NMT)

- Includes cars, taxis, trains, buses or other public transportation



Gas Mileage Reimbursement

- Family or friends eligible (valid driving credentials required)



Travel-Related Expenses

- May include lodging, meals, parking, tolls, etc.

Partnership's Transportation Services Department is available

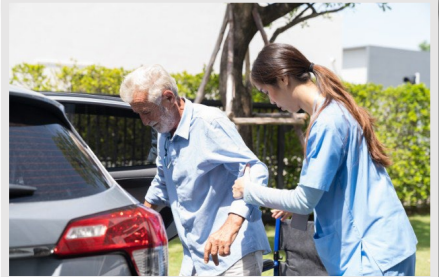
Monday – Friday, 7 a.m. to 7 p.m.

Transportation Department: **(866) 828-2303**



Note: Transportation may only be used for medically necessary, Medi-Cal covered services.

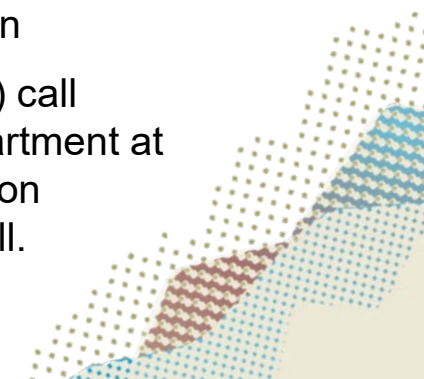
Transportation Services App



Partnership HealthPlan of California's transportation app makes it easy for members to schedule rides to Medi-Cal-covered services quickly and securely, right from your iPhone or Android device.

- Easily schedule rides to your Medi-Cal covered services
- See live trip status updates
- See your driver's current location

Have your patients (our members) call Partnership's Transportation Department at **(866) 828-2303** and a transportation representative will help them enroll.





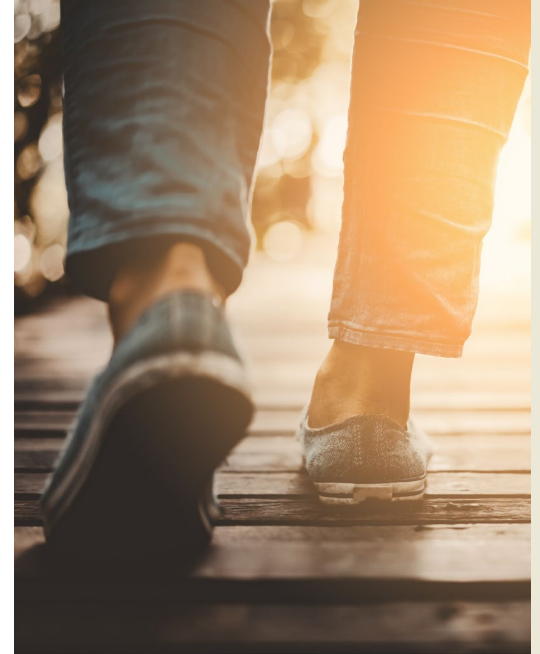
Enhanced Health Services

Enhanced Health Services

Enhanced Health Services focuses on the California Advancing and Innovating Medi-cal (CalAIM) initiatives under the California Department of Health Care Services (DHCS).

This department helps address the medical and social challenges faced by vulnerable members of the community through programs such as:

- Community Health Workers (CHWs)
- Enhanced Care Management (ECM)
- Community Supports (CS)
- Incentive Payment Program (IPP)
- Street Medicine
- Justice Involved Reentry Initiative



Contact the Enhanced Health Services Department at CalAIM@partnershiphp.org

CalAIM: Enhanced Care Management

Enhanced Care Management (ECM)

- ECM is a Medi-Cal benefit that provides a standardized set of case management services and interventions to improve quality of life.
- ECM referrals can come to Partnership from anyone, anywhere. There is no wrong door.
- Fill out the ECM Referral Form for [Adults](#) or [Youth](#) or contact Partnership directly.



For more information [click here](#)
For ECM/CS general questions, email
CalAIM@partnershiphp.org

Enhanced Care Management

ECM Populations of Focus

- Individuals experiencing homelessness
- Individuals at risk for avoidable hospital or ED Utilization
- Individuals with serious mental health and /or SUD needs
- Adults living in the community and at risk for long-term care institutionalization
- Adult nursing facility residents transitioning to the community
- Children/Youth enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM)
- Children/Youth involved in Child Welfare
- Justice
- Birth equity

For more information visit our [CalAIM Webpage](#)

More details on timeline and criteria: [Enhanced Care Management \(ECM\) Timeframes](#)



Enhanced Care Management

To qualify, members must meet DHCS criteria outlined – “Population of Focus”.

Goal is to provide a lead, community-based case manager to coordinate: medical, oral, behavioral health, long-term supports and community referral needs.

Authorizing ECM

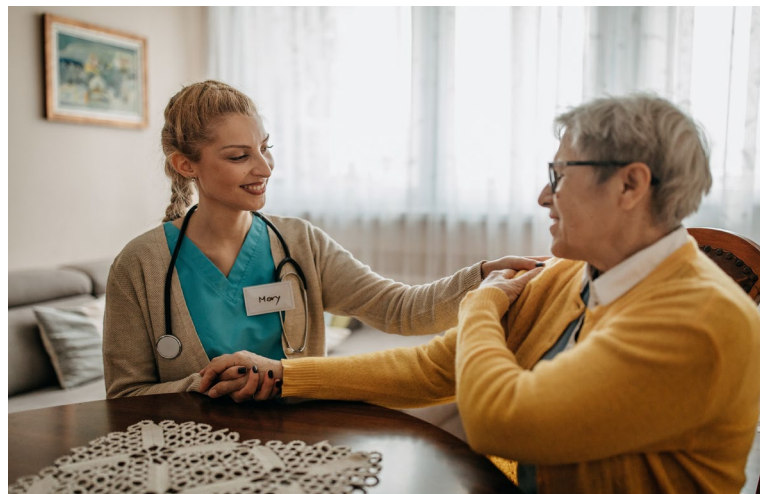
- ECM requires a Treatment Authorization Request (TAR)
- ECM provider will submit the TAR to Partnership via the provider portal or fax TAR form



CaAIM: Community Supports Services

Community Supports (CS)

- CS services are provided as cost-effective alternatives or in-lieu of, traditional medical services or settings.
- CS referrals can come to Partnership from anyone, anywhere. There is no wrong door.
- Fill out the [CS Referral Form](#) or contact Partnership directly.



For more information [click here](#)
For ECM/CS general questions, email
CaAIM@partnershiphp.org

Community Supports

Community Supports services:

Housing transition and navigation

Housing deposits

Housing tenancy and sustaining

Short-term post-hospitalization

Recuperative care (medical respite)

Personal care and homemaker services

Medically tailored meals/groceries

Respite care

Day Habilitation

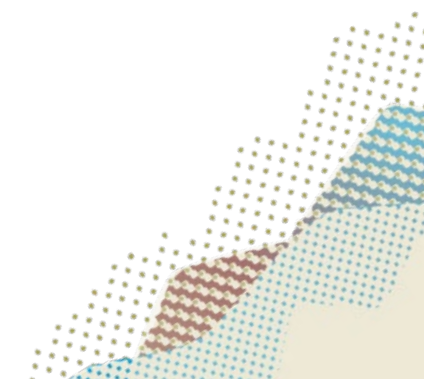
Asthma Remediation

*Transitional Rent

May not be used to cover eviction prevention—back rent or prospective rental assistance.
Referrals come thru County Behavioral Health

CS referrals can come from anyone. **There is no wrong door.**

<https://www.partnershiphp.org/Community/Pages/Community-Supports.aspx>



Community Supports

Examples of referral sources:

- ✓ PCPs/specialists
- ✓ ECM providers
- ✓ Hospitals
- ✓ SNFs
- ✓ Palliative care providers
- ✓ SUD providers
- ✓ Self-referrals – via Member Services team or Care Coordination
- ✓ Family referred

CS Providers	<input checked="" type="checkbox"/> Attach the completed CS referral form when submitting a TAR
<u>Non-CS Provider</u>	<input type="checkbox"/> Fill out the CS Referral form and send back to the CS helpdesk: CommunitySupports@partnershiphp.org <input type="checkbox"/> Members can connect with Member Services/Care Coordination (if applicable)



Claims

How to Submit Claims

Electronic Claims

- ✓ Electronic data interchange (EDI)
- ✓ Submission of HIPAA-compliant 5010 version 837P file
- ✓ Preferred submission method for faster reimbursement

Contact EDI Enrollment and Testing at:

Phone: **(707) 863-4527** or EDIEnrollment@partnershiphp.org

Paper Claims

- ✓ Submission of CMS-1500 format only
- ✓ Send to: Partnership HealthPlan of California (Medi-Cal)

P.O. Box 1368

Suisun City, CA 94585-1368

Claims customer service phone number: (707) 863-4130

How to Submit Claims

Provider Support

- General claims information
- Denied claims
- Claims submission process
- Remittance advice (RAs)
- Provider dispute resolutions (PDRs)

Services provided by EDI

- Assists providers with the set-up of electronic billing
- Supports each provider that is currently billing electronically
- Works with provider's clearing house
- 835 files
- 837 submission files

Claims customer service phone number: (707) 863-4130

Claims Mailing Addresses and Limits



Partnership HealthPlan of California (Medi-Cal)

P.O. Box 1368, Suisun City CA 94585-1368

- Billing limit = 365 days.
- PCP-QIP – note to receive PCP-QIP credit, billing limit is 90 days.
- Paper claims, PDRs, and appeals can be sent to address above.

**“Clean” claims are processed within 30 days of receipt.
Current version CMS 1500**

Claim Corrections: Provider Dispute Resolution

- Providers have the right to submit a payment dispute if they disagree with a claim decision regarding the denial or compensation of a claim. Providers may submit disputes via provider online services or by mail.
- The provider claims dispute resolution mechanism is a fair and cost-effective process used by contracted and non-contracted providers for disputes regarding invoices, billing determinations or other contractual or non-contractual issues.

PROVIDER DISPUTE RESOLUTION REQUEST			
INSTRUCTIONS			
<ul style="list-style-type: none"> • Please complete the below form. Fields with an asterisk (*) are required. • Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME. • Attach supporting documentation to support the description of the dispute. Do not include a copy of a claim or invoice. • Mail the completed form to: Partnership HealthPlan of California Provider Dispute Resolution P.O. Box 1088 Sunnyvale, California 94085-0172 			
PROVIDER NPI: <input type="text"/>		PROVIDER TAX ID: <input type="text"/>	
PROVIDER NAME: <input type="text"/>			
PROVIDER ADDRESS: <input type="text"/>			
PROVIDER TYPE: <input type="checkbox"/> MD <input type="checkbox"/> Mental Health Professional <input type="checkbox"/> Mental Health Institutional <input type="checkbox"/> Hospital <input type="checkbox"/> ASC <input type="checkbox"/> DNT <input type="checkbox"/> DME <input type="checkbox"/> Rehab <input type="checkbox"/> Home Health <input type="checkbox"/> Ambulance <input type="checkbox"/> Other <input type="text"/> (Please specify type of other)			
* Patient Name: <input type="text"/>		Date of Birth: <input type="text"/>	
* CEN Number: <input type="text"/>	Patient Account Number: <input type="text"/> (Original Claim ID Number; if multiple claims, use selected appointment)		
Service "Month(s)" Date: <input type="text"/> (* Required for claim filing and reimbursement of Overpayment Disputes)	Original Claim Amount Billed: <input type="text"/>	Original Claim Amount Paid: <input type="text"/>	
DISPUTE TYPE:		<input type="checkbox"/> Overlooked Payment (Incorrect Amount)	
<input type="checkbox"/> Denial	<input type="checkbox"/> Billing Error (e.g. A/R, Underpayment)		
<input type="checkbox"/> Failure of Medical Necessity / Utilization Management Decision	<input type="checkbox"/> Contract Dispute		
<input type="checkbox"/> Mapping/Required for Reimbursement of Overpayment		<input type="checkbox"/> Other <input type="text"/>	
* DESCRIPTION OF DISPUTE: <input type="text"/>			
EXPECTED OUTCOME: <input type="text"/>			
Contact Name (please print): <input type="text"/>	Title: <input type="text"/>	Phone Number: <input type="text"/>	
Date: <input type="text"/>		Fax Number: <input type="text"/>	
<input type="checkbox"/> I CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED (Please do not staple)			
TRACKING NUMBER: <input type="text"/>		PROV ID# <input type="text"/>	
CONTRACTED: <input type="text"/>		NON-CONTRACTED: <input type="text"/>	

Claim Corrections: Provider Dispute Resolution

- Disputes can be submitted within 365 days from the original paid/denied date on the Partnership RA. Disputes received after one year are subject to automatic denial.
- Partnership will acknowledge receipt of the dispute immediately and will respond electronically indicating the outcome of the dispute review within 30 days.
- Provider dispute form can be downloaded from the Partnership website.
- [Provider Claims Dispute Resolution Request Form](#)

PROVIDER DISPUTE RESOLUTION REQUEST		
INSTRUCTIONS <ul style="list-style-type: none">• Please complete the below form. Fields with an asterisk (*) are required.• Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.• <u>Provide additional information</u> on to support the description of the dispute. Do not include a copy of a claim.• Mail the completed form to: Partnership HealthPlan of California Provider Dispute Resolution P.O. Box 1288 Sunnyvale, California 94095-3172		
PROVIDER NAME:	PROVIDER TAX ID:	
PROVIDER ADDRESS:		
PROVIDER TYPE: <input type="checkbox"/> MD <input type="checkbox"/> Mental Health Professional <input type="checkbox"/> Mental Health Institutional <input type="checkbox"/> Hospital <input type="checkbox"/> ASC <input type="checkbox"/> SNF <input type="checkbox"/> DME <input type="checkbox"/> Rehab <input type="checkbox"/> Home Health <input type="checkbox"/> Ambulance <input type="checkbox"/> Other _____ (please specify type of facility)		
* Patient Name:	Date of Birth:	
* CIN Number:	Patient Account Number:	Original Claim ID Number: (if multiple claims, use claim(s) associated)
Service "Reason" Date: (*) (required for claim, billing, and reimbursement of claim(s))	Original Claim Amount Billed:	Original Claim Amount Paid:
DISPUTE TYPE: <input type="checkbox"/> Claim <input type="checkbox"/> Down Coding/Payment Selection Advantage <input type="checkbox"/> Appeal of Medical Necessity / Utilization Management Decision <input type="checkbox"/> Denial/Reversal of A Billing Determination <input type="checkbox"/> Disputing Request for Reimbursement of Claim(s) <input type="checkbox"/> Other: _____		
* DESCRIPTION OF DISPUTE:		
EXPECTED OUTCOME:		
Contact Name (please print):	Title:	Phone Number:
	Date:	Fax Number:
I CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED (Please do not staple)		
TRACKING NUMBER		PROVIDER
CONTRACTED		NON-CONTRACTED

Taxonomy Codes

- Taxonomy codes for billing providers are required for ALL claim submissions. Taxonomy codes for rendering providers are required when submitting rendering provider information on claims.
- Please engage with your clearing house to ensure claims are submitted with a valid taxonomy code.
- **Claims submitted without a valid taxonomy code for either the billing or rendering provider may be rejected, resulting in NO PAYMENT.**

Please make sure to use the appropriate taxonomy code for services rendered. For example, if billing lab services, you will use your lab taxonomy code not the group taxonomy code.

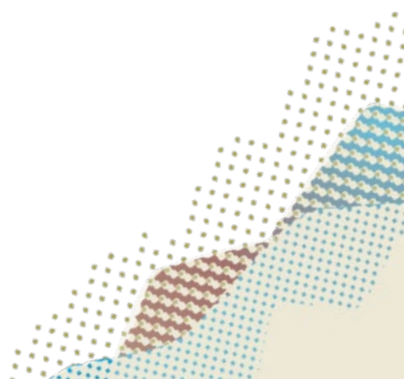
Claims billed electronically via 837P and 837I formats should follow instructions from Partnership's professional and institutional companion guides for billing taxonomy codes.

837I

Data Element	Loop	Segment ID	Example of Billing Provider NPI and Taxonomy
Billing Provider Taxonomy Code	2000A	PRV03	PRV*BI*PXC*282NR1301X~
Billing Provider NPI	2010AA	NM109	NM1*85*2*Dr. Mickey Mouse***XX*1234567890~

837P

Data Element	Loop	Segment ID	Example of Billing Provider Taxonomy
Billing Provider Taxonomy Code	2000A	PRV03	PRV*BI*PXC*207Q00000X~
Data Element	Loop	Segment ID	Example of Rendering Provider Taxonomy
Rendering Provider Taxonomy Code	2310B	PRV03	PRV*PE*PXC*1223G0001X~



Taxonomy Codes

- For paper CMS1500 claims, bill using rendering provider NPI in box **24J**.
- The taxonomy code should be placed in the shaded portion of box **24J** for the rendering and in box **33b** for the billing provider.

CMS 1500 Professional Claims

The image shows a CMS 1500 Professional Claims form. Two red boxes highlight specific areas: one around box 24J (Rendering Provider NPI) and another around box 33b (Billing Provider NPI). A green arrow points to box 24J, and another green arrow points to box 33b. The form includes sections for patient information, diagnosis, procedure codes, and provider information.

UB04 Institutional Claims

The image shows a UB04 Institutional Claims form. A green arrow points to box 81CC (Billing Provider NPI). The form includes sections for procedure codes, dates, and provider information.

UB-04 CMS-1450

APPROVED OMB NO. 0938-0997

NUBC National Uniform Billing Committee

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

- For paper UB04 institutional claims, the billing taxonomy code should be placed in box **81CC** and attending provider needs to go in box **76**.

Electronic Visit Verification (EVV)

On January 1, 2023, the Department of Health Care Services (DHCS) required all managed care plans to ensure that providers document their in-home service visits through an electronic visit verification platform (EVV), and include the following information:

- **Type of service performed**
- **Location of service delivery**
- **Individual receiving the service**
- **Individual providing the service**
- **Date of service**
- **Time the service begins and ends**

If a provider renders Medi-Cal services subject to EVV requirements, the provider must comply with all applicable requirements before billing for services, or Partnership HealthPlan of California may **withhold payments for services rendered**.

Those who provide personal care services (PCS) and home health care services (HHCS) are required to register in the [Provider Self-Registration Portal](#).

Please Note: When filling out the provider self-registration form, at least one **Provider identifier** must be added. Provider identifiers are used by Partnership to recognize your practice and verify your electronic visits. Partnership must be added or your EVV claims may be denied. More information on Provider identifiers can be found within the [CalEVV Self-Registration Quick Reference Guide](#).

Please view [All Plan Letter 22-014](#) for more information on EVV Requirements.



EVV (continued)

Weekly CalEVV Drop-In Hours

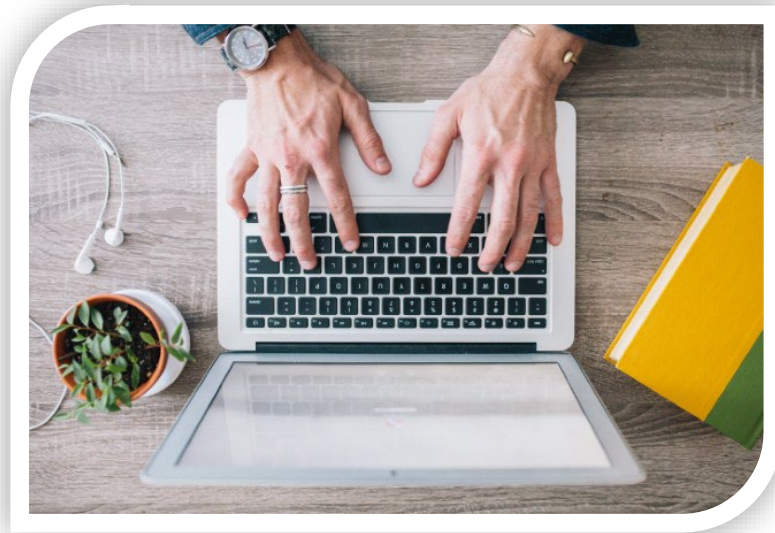
- Every Friday from 1:30 – 2:30 p.m. (PST)
- Meeting ID: 282 705 744 583 80
- Passcode: SU75UJ3z
- Phone Dial-in: +1 279-895-6425

For questions regarding the CalEVV:

- EVV@dhcs.ca.gov

For technical assistance:

- CACustomerCare@sandata.com
- (855) 843-6070



For more information, including excluded provider types, please visit [California Electronic Visit Verification | DHCS](#)

Balance Billing

- DHCS reminds all providers that balance billing Medi-Cal beneficiaries is prohibited by federal and state law.
 - Medi-Cal beneficiaries should not pay for physician visits and other medical care when they receive covered services from a provider in their provider network.
 - This means beneficiaries cannot be charged for co-pays, co-insurance, or deductibles.
 - Billing Medi-Cal beneficiaries violates federal law as outlined in section 1902(n)(3)(B) of the Social Security Act (SSA), as modified by section 4714 of the Balanced Budget Act of 1997. This section is available at http://www.ssa.gov/OP_Home/ssact/title19/1902.htm





Network Services

Network Services

The Network Services Department is responsible for all provider data, ensuring accuracy and availability so that the provider network remains visible and accessible to our members. Some key responsibilities include:

Credentialing

- The credentialing team Credentialing@partnershiphp.org verifies the qualifications, licenses, and backgrounds of our providers.

Practitioner and Facility Data

- The systems team ensures accurate provider setup into our payment and directory systems. The team also handles daily provider updates and changes via provider change forms. ChangesProviders@partnershiphp.org

Compliance

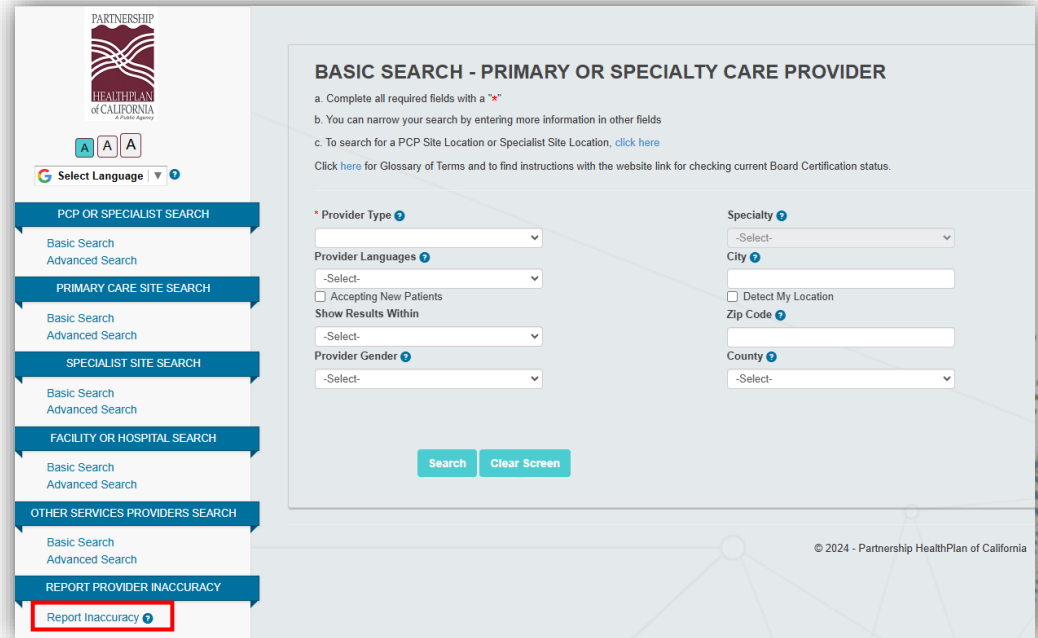
- The compliance team ensures that Partnership is meeting the regulatory standards set by DHCS, NCQA, and CMS

❖ Please note contracting is now its own department, Provider Contracting. If you have questions about your contract, please contact them at contracting@partnershiphp.org

Network Services Directory

Partnership has a searchable online provider directory with interactive tools. The online directory is updated daily to reflect changes made the previous business day. If you believe that you have found an error you can email PHCDirectory@partnershiphp.org


You can also report an error in the directory by clicking *Report Inaccuracy* and completing the questions.



Network Services Directory

Directory changes can be submitted by completing an electronic change form to changesproviders@partnershiphp.org or by faxing the form to **(707) 863-4599**. Please ensure you are keeping us up to date with provider and clinic changes, moves, additions, and closures as per DHCS regulatory requirements.

Partnership must be notified 90 days prior to closing the site.

		PROVIDER INFORMATION CHANGE FORM		<i>For Partnership Use Only</i> PR Rep: _____ Partnership: _____ <input type="checkbox"/> PCP <input type="checkbox"/> SPEC <input type="checkbox"/> Other <input type="checkbox"/> Non Visit Directory	
Practice/Facility Name as Currently Listed in Provider Directory:		County:		Billing NPI #	
Street:		City:		State:	Zip:
Instructions: Please indicate the type of change you would like to make and complete all the information in the corresponding section of the form.					
<input type="checkbox"/> Change Practice Name, Address, Phone, or Fax – Section A <input type="checkbox"/> Change Tax ID or NPI – Section B <input type="checkbox"/> Change Pay to information – Section C			<input type="checkbox"/> Change Member Assignment (PCP Only) – Section D <input type="checkbox"/> Change Office Hours – Section E <input type="checkbox"/> Change information for an individual practitioner (name, employment status, location, languages spoken) – Section F		

The Change Form can be found [here](#)







Provider Relations

Provider Relations




Provider Communications

- 
Provider newsletter: [Click Here](#)
- 
Provider bulletins: [Click Here](#)
- 
Provider resources: [Click Here](#)
- 
Policies: [Click Here](#)


PROVIDER RELATIONS

Supporting Our Providers


The Provider Relations Department is responsible for supporting Partnership providers in helping keep the communities we serve, be healthy. The department is responsible for contracting, credentialing, provider education and the Provider Directory. If you have any questions, please reach out to a Provider Relations Representative or call the Provider Relations Department at (707) 863-4100.

 **Provider Resources**


- Provider Manuals
- Provider Bulletin
- Partnership Provider Learning Portal
- Provider Changes Requirements
- Cultural Competency for Providers
- Telehealth Toolkit
- New Provider Education Packet
- Interpretive Services | Adding Video App to Device
- Video App Request Form | VRI Training Video
- Local Code Crosswalk
- 25-1 to UB-04 Conversion Crosswalk

 **Provider Directory**

Medi-Cal Provider Directory


 **Policy Updates**

2024 Policy Updates

 **Forms**

Common Forms

- NEMT Required Justification Form (PCS)
- Provider Request to Discharge Member
- Medicare/Medi-Cal Crossover Claim Form
- Medical Equipment Distribution Services Guidelines | Request Form | Instructions
- Growing Together Referral Form
- Referral Authorization Form (RAF)
- Treatment Authorization Request (TAR) Form
- Missed Appointment Form
- Provider Change Form
- Interested in Contracting with Partnership? Click here
- Partnership Contracted Providers Adding New Sites, click here

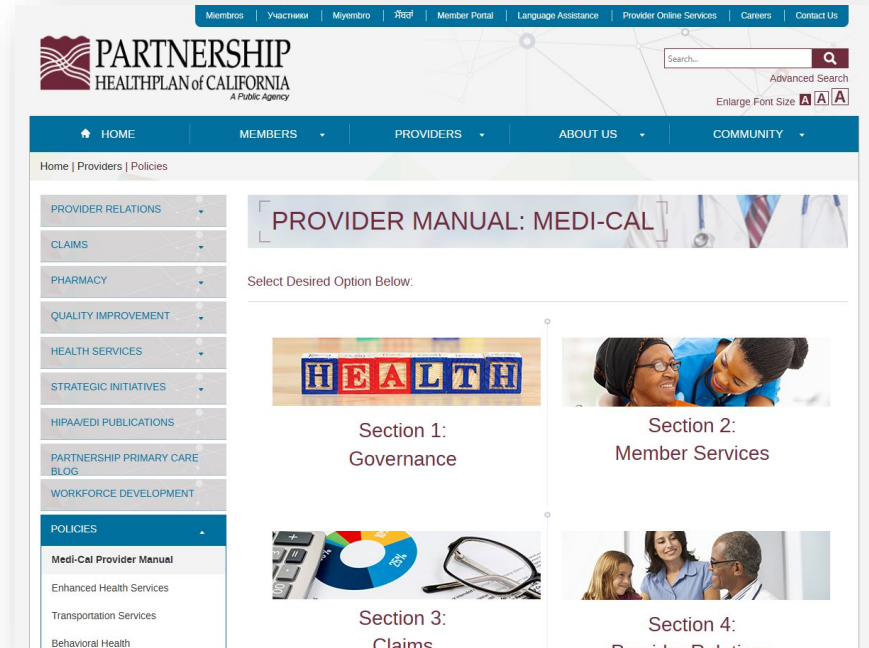
 **Additional Resources**

- Community Information Security Updates
- Provider Grievance Process
- BHT Provider Best Practices

Provider Manual and Partnership Policies

The Partnership provider manual is designed as a reference guide and communications tool for Partnership providers and their staff related to providing comprehensive, effective, and quality medical services to Partnership members.

Please visit the Partnership website at <https://www.partnershiphp.org/Providers/Policies/Pages/default.aspx> for updated policies and procedures as they relate to Partnership providers and members.



The screenshot displays the Partnership HealthPlan of California website. The header includes navigation links for Members, Участники, Membros, 会员, Member Portal, Language Assistance, Provider Online Services, Careers, and Contact Us. The main navigation bar features HOME, MEMBERS, PROVIDERS, ABOUT US, and COMMUNITY. The page title is "PROVIDER MANUAL: MEDI-CAL". Below the title, there is a search bar and an "Advanced Search" button. The main content area is divided into four sections: Section 1: Governance, Section 2: Member Services, Section 3: Claims, and Section 4: Provider Relations. Each section is accompanied by a representative image. The left sidebar contains a list of menu items under "POLICIES", with "Medi-Cal Provider Manual" highlighted.

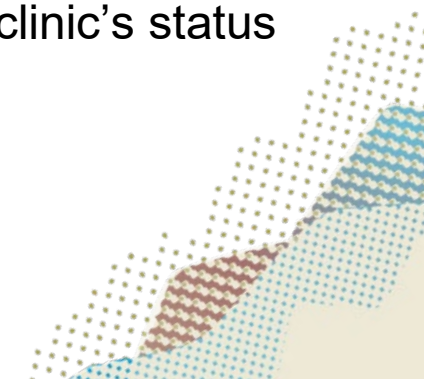
Provider Emergency Notification (PEN)

The provider emergency notification is designed for the PCP network to notify Partnership the status of the site during a state of emergency, public safety power shutoff, office closure due to COVID-19 or devastation such as fire, earthquake, or flood.

It is important to send your notification e-mail the night before possible closure or before 9 a.m. the following morning.

In an emergency, we encourage you to notify Partnership of your clinic's status with the following information:

- Daily clinic status (open or closed)
- Alternative phone numbers (if applicable)

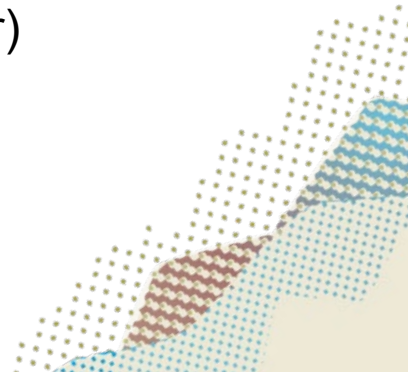


Provider Emergency Notification (PEN)

PEN-NR@partnershiphp.org - **Northern region** counties (Del Norte, Siskiyou, Modoc, Humboldt, Trinity, Shasta, Lassen)

PEN-SR@partnershiphp.org - **Southern region** counties (Mendocino, Lake, Sonoma, Napa, Yolo, Solano, Marin)

PEN-ER@partnershiphp.org – **Eastern region** counties (Tehama, Glenn, Colusa, Sutter, Butte, Plumas, Sierra, Yuba, Nevada, Placer)



Initial Health Appointment

- On January 1, 2023, the Initial Health Assessment was changed to **Initial Health Appointment (IHA)** pursuant to APL 22-030. In addition, the Individual Health Education Behavioral Assessment (IHEBA) or a Staying Healthy Assessment (SHA) will no longer be required components of the IHA.
- An IHA must be completed within 120 days for newly enrolled members and periodically administered according to requirements in the population health management policy guide and Partnership contract.

Initial Health Appointment

An IHA must include:

- A history of the member's physical and mental health
- An identification of risks
- Assessment for preventative screening/services
- Health education
- Diagnosis and plan for treatment of any diseases

For more information visit:

<https://www.dhcs.ca.gov/APL2022/APL22-030.pdf>



After-Hours Access to Care

All PCPs and Specialists are required to have phone coverage 24 hours a day, 7 days a week. After-hours access must include triage for emergency care and direction to call 911 for an emergency medical condition. A physician or mid-level provider must be available for contact after hours, either in person or via telephone. All after-hours member calls must be documented in the member's permanent medical records. If a provider who is not the member's PCP treats the member, the treating provider must forward documentation of services received to the member's PCP.

After-Hours Access to Care (cont.)

Information Needed	Expected Standard
Answer machine vs. answer service	After normal business hours, the phone must be answered by either an automated system or an answering service. Some practices utilize both options. An office with a phone that rings without an answer of any kind doesn't meet the standard.
Call 911 or go to ER	Provider must direct the caller to call 911 or go to the nearest emergency location. If the message directs the caller to the ER, it meets the criteria.
Instruction to reach medical doctor or advice nurse	The messaging must provide instructions to reach an on-call provider or the health plan's advice nurse. A statement such as "Call your health plan's advice line" meets the criteria for Partnership advice nurse.
Wait time for provider to return members call	It is expected that providers will respond to member's call within 30 minutes.

California Children's Services Moves to Whole Child Model

- Partnership's Whole Child Model (WCM) program provides diagnostic, treatment and case management services for children under age 21 who have been diagnosed with a condition eligible for California Children's Services (CCS).
- Authorized by Senate Bill (SB) 586, the WCM program incorporates CCS program covered services for Medi-Cal eligible CCS children and youth into a Medi-Cal Managed Care Plan (MCP) contract. This is to improve care coordination for primary, specialty, and behavioral health services for CCS and non-CCS conditions.



California Children's Services Moves to Whole Child Model

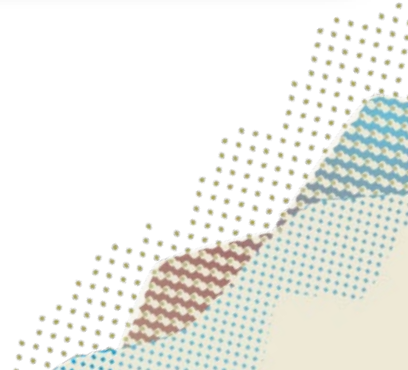
CCS eligibility is determined by the county. CCS eligibility referrals must include medical records, and the medical records must be signed or co-signed by a CCS paneled provider. Please send all CCS referrals to the members county CCS office.

Interested in becoming a CCS provider? Click [here](#).



A list of CCS-eligible conditions can be found at the link below:
<https://www.dhcs.ca.gov/services/ccs/Pages/medicaleligibility.aspx>

For more information on Partnership's WCM program, click [here](#)



California Children's Services County Offices

County	Phone	Fax	County	Phone	Fax
Butte	(530) 552-3891	(530) 895-6557	Placer	(530) 886-3630	(530) 886-3613
Colusa	(530) 458-0380	(530) 458-4136	Plumas	(530) 283-6330	(530) 283-6110
Del Norte	(707) 464-0861	(707) 464-0847	Shasta	(530) 229-8107	(530) 225-5355
Glenn	(530) 934-6588	(530) 934-6463	Sierra	(530) 993-6700	(530) 993-6790
Humboldt	(707) 445-6212	(707) 441-5686	Siskiyou	(530) 841-2132	(530) 841-4075
Lake	(707) 263-5806	(707) 263-5872	Solano	(707) 784-8650	(707) 421-7484
Lassen	(530) 251-8183	(530) 251-2668	Sonoma	(707) 565-4500	(707) 565-4520
Marin	(415) 499-6877	(415) 499-6396	Sutter	(530) 822-7215	(530) 755-0741
Mendocino	(707) 472-2600	(707) 472-2735	Tehama	(530) 527-6824	(530) 527-0362
Modoc	(530) 233-6311	(530) 233-6279	Trinity	(530) 623-1358	(530) 623-1297
Napa	(707) 253-4391	(707) 299-2123	Yolo	(530) 666-8333	(530) 666-1283
Nevada	(530) 265-1450	(530) 271-0841	Yuba	(530) 749-6340	(530) 749-6830

For a list of CCS-eligible conditions, click [here](#).

Blood Lead Screening

Federal and State law *requires* clinicians caring for Medi-Cal patients to conduct blood lead screening on **all** children at 12 and 24 months of age, and to talk about potential lead exposures at **every** well child visit from six months to six years of age.

Partnership will reach out to all members aged six months to six years of age who have no recorded blood lead screening to recommend completing it. Partnership will pass this list to PCPs who are expected to reach out to these members to remind them to get tested.

- If providers elect not to order the screening, they must:
 - document in detail the reason for not conducting the screening
 - include the signature of the parent/guardian who refused the screening
 - state the reason the signature could not be collected

Quality Improvement Program

Partnership offers several improvement programs, including the Primary Care Provider Quality Improvement Program (PCP QIP) offering financial incentives, data resources, and technical assistance to providers who serve our members so that significant improvements can be made in the following areas:

Prevention
and
screening

Chronic
disease
management

Appropriate
use of
resources

Primary care
access and
operations

Patient
experience

For more information visit: [PCP Quality Improvement Program](#)

Additional resources: [Provider Learning Portal](#)

Behavioral Health Treatment (BHT) for members under the age of 21

Partnership is responsible for providing early and periodic screening, diagnostic and treatment services for members under the age of 21.

Services include BHT services that are determined to be medically necessary to correct or ameliorate any physical behavioral conditions.

Providers can check member eligibility online through the provider portal: [click here](#)

Refer to the provider directory for a list of contracted BHT providers: [click here](#)

Developmental Screening

All children enrolled in Medi-Cal are entitled to receive developmental screening, a required service for children under the Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit.

National guidelines recommend developmental screening for all children at nine months, 18 months, and 30 months of age and as medically necessary when risk is identified on developmental surveillance.

Developmental Screening

CPT Code 96110.KX

- Payable per year, age (two months to <20) without a TAR.
- Used for screening that does not include one of the nine screening tools approved by DHCS.
- Autism only screening, socio-emotional screens, and others must use 96110.KX
- Paid fee for service

CPT Code 96110

- Payable per year, age (two months to <20) without TAR.
- Used for screening that includes one of the nine screening tools approved by DHCS.
- Paid fee for service

Vaccines for Children Program

The Vaccines for Children (VFC) Program was established in 1993 by the United States Federal Government, the VFC program is administered nationally by the Centers for Disease Control and Prevention and the National Center for Immunization and Respiratory Diseases.

Providers who administer vaccines to persons younger than 19 years of age must enroll separately in the VFC program. To learn more about how to become a VFC-enrolled provider, please contact the MyVFCvaccines@cdph.ca.gov or **(877) 243-8832**.



Vaccines for Children Program

Vaccines available through the VFC Program

Diphtheria	Meningococcal
Haemophilus influenza type b	Mumps
Hepatitis A	Pertussis (whooping cough)
Hepatitis B	Pneumococcal
Human Papillomavirus	Poliomyelitis
Influenza	Rotavirus
Measles	Tetanus

Adverse Childhood Experiences (ACEs) Screening Services

Partnership would like to inform providers of training provided by DHCS; ACEs-oriented trauma-informed care training for providers and their ancillary office staff.

More information about training and registration links are available at:
<https://www.acesaware.org/learn-about-screening/training/>

Adverse Childhood Experience (ACEs) Screening Services

Join the “Becoming ACEs Aware in California” core training for a **free**, two-hour training for clinicians and clinical team members to receive 2.0 Continuing Medical Education and/or 2.0 Maintenance of Certification credits upon completion.

The training provides information about:

- ACEs aware
- Toxic stress
- Screening
- Risk assessment
- Evidence-based care to effectively intervene



Annual Cognitive Health Assessment

Partnership providers must cover an annual cognitive health assessment for members who are 65 years of age or older and who do not have Medicare coverage.

In order to appropriately bill and receive reimbursement, providers must do the following:

- Administer the annual cognitive health assessment
- Document the following in the member's medical record
 - Screening tools used in assessment (at least one cognitive assessment tool)
 - Verification that screening results were reviewed by the provider
 - Results of screening
 - The interpretation of results
 - Details discussed with the member and any appropriate actions taken in regard to screening results.
 - Use allowable CPT codes

Mental Health

As of September 29th, 2025, Partnership HealthPlan of California has assumed call center responsibilities for both providers and members from our contracted behavioral health vendor, Carelon Behavioral Health.

Members can call **(855) 765-9703** to receive assistance in coordinating referrals and services for members with behavioral health needs. The phone number will now be answered by Partnership's new behavioral health access guides.

Carelon is responsible for overseeing credentialing, contracting & claims. Mental health providers can call **(207) 910-1267** for assistance.

Providers and members can call 24 hours a day, 7 days a week, to access services.

Partnership/Carelon contact information: Phone number: **(855) 765-9703**

Fax number: **(707) 914-0453**

Email: BH-Access@partnershiphp.org

Visit our mental health services page for more resources:

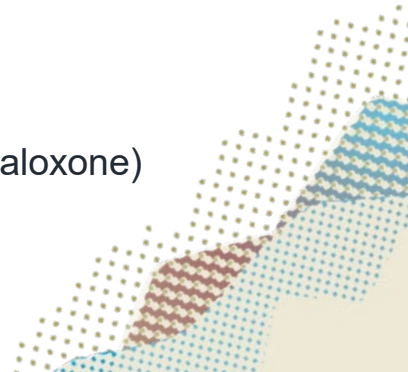
<http://www.partnershiphp.org/Providers/BehavioralHealth/Pages/Mental-Health-Services.aspx>

Wellness and Recovery

As of July 1, 2020, Partnership HealthPlan of California, along with seven of its 24 member counties— **Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano** – administers the substance use disorder (SUD) services program.

Wellness & Recovery Program includes:

- Outpatient treatment (by a licensed professional or certified counselor, up to nine hours per week for adults)
- Intensive outpatient treatment for individuals with greater treatment needs (by a licensed professional or certified counselor, structured programming, 9-19 hours per week for adults)
- Detoxification services (withdrawal management)
- Residential treatment (DHCS licensed facility, certified staff)
- Medically assisted treatment (methadone, buprenorphine, disulfiram, naloxone)
- Case management
- Recovery services (aftercare)



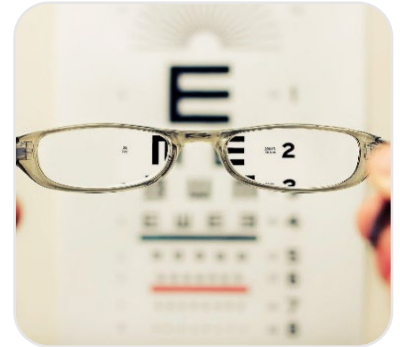
Laboratory Services

- Partnership members in Marin, Napa, Sonoma, Solano, and Yolo counties are capitated to Quest Diagnostics for routine lab services.
- Members in Butte, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Nevada, Placer, Plumas, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity and Yuba counties can visit contracted providers, Quest and Lab Corp for routine lab services
- Check member's eligibility to determine if member is capitated for lab.



Vision Services

- Partnership members are covered through Vision Services Plan
- Members can refer to the provider directory for a list of contracted vision providers
- No referral is necessary



Provider Online Services (OLS)



- Check eligibility/Member redetermination
- Submit referrals
- View status of authorizations
- View status of claims
- Submit provider dispute resolution form (PDR)

Provider online services: <https://provider.partnershiphp.org/ui/login.aspx>

For portal inquiries and trainings, please contact eSystemsSupport@partnershiphp.org

Eligibility

Identify member's PCP and other capitated entities:

Lab Services
**Quest
Diagnostics**

Vision Care
**Vision Service
Plan**

Hospital
(if applicable)

Mental Health– outpatient
mild-to-moderate
Partnership/Carelon
Behavioral Health

Verify eligibility:

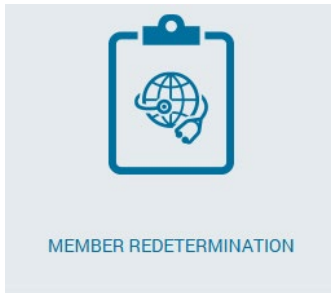
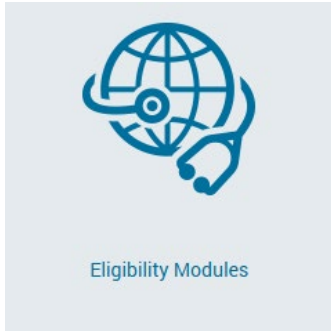
Partnership website:
[Click here](#)


Monday - Friday
8 a.m. to 5 p.m.
(707) 863-4120


If not a Partnership
member contact
the State of California
www.medi-cal.ca.gov

Member Redetermination

Select your **Provider Profiles**, then choose which specialty to **view**.
 Relevant member redetermination data will populate below.



Member Redetermination 

All items checked 

Program	Region	Affiliation	Provider Name	Specialty	Member Redetermination
YO				INTERNAL MEDICINE	<input type="button" value="View"/>
YO				INTERNAL MEDICINE	<input type="button" value="View"/>
YO				PEDIATRICS	<input type="button" value="View"/>

1 2 3 Page 1 of 3, items 1 to 3 of 8.

Medi-Cal Redetermination Report as of 10/30/2025
 Provider Name: _____

Note: Partnership Health Plan of California receives the Medi-Cal Redetermination data from DHCS. The purpose of this report is to inform PCPs who wish to assist their assigned Medi-Cal beneficiaries with their redetermination.

PDF XLS Extended Format

Member Name	Record#	RP	Eff Date	End Date	Birth	Sex	Age	Other Insurn:	BIC#/HIK#	New Memb:	Residential Address	Mailing Address	Email Address	Langu: Spoken	Langu: Written	Renewal Date
														English	English	8/31/2025
														Spanish	Spanish	10/31/2025

Member redetermination data comes from DHCS and is uploaded directly into the provider portal in its entirety.

Keep Your Medi-Cal Resources

Starting January 1, 2026, Medi-Cal will be changing for some undocumented adults. Partnership launched the *Keep Your Medi-Cal* campaign to provide timely information and resources to our community regarding these changes.



Keep Your Medi-Cal Resources

The *Keep Your Medi-Cal* main webpage includes:

- Links to county offices
- Information on keeping Medi-Cal benefits
- Future Medi-Cal changes
- Resources



To visit the Keep Your Medi-Cal webpage scan the QR code.

The *Keep Your Medi-Cal Toolkit* webpage features creative assets available for download and distribution, including:

- Flyers (in all threshold languages)
- Social media toolkit (in English and Spanish)
- PSA scripts (in English and Spanish)



To visit the Keep Your Medi-Cal Toolkit webpage scan the QR code.



Medi-Cal Rx

What changed?	What stayed the same?
<ul style="list-style-type: none">• Medi-Cal RX includes all pharmacy services billed as a pharmacy claim, including but not limited to:<ul style="list-style-type: none">✓ Outpatient drugs (prescription and over-the-counter), including physician if ordered from pharmacy✓ Administered drugs (PADs)✓ Enteral nutrition products✓ Medical supplies	<ul style="list-style-type: none">• The scope of existing Medi-Cal pharmacy coverage.• Provision of pharmacy services billed on medical or institutional claims and/or as part of a bundled/all-inclusive billing structure in an inpatient or long-term care setting, including skilled nursing facilities (SNF) and other intermediate care facilities, regardless of delivery system.• Existing Medi-Cal managed care pharmacy carve-outs• Any pharmacy services billed as a medical and/or institutional claim instead of a pharmacy claim.

Medi-Cal Rx

Medi-Cal Pharmacy Benefits (Medi-Cal Rx) is administered through the Fee-For-Service (FFS) delivery system.

For more information, go to

<http://www.partnershiphp.org/Providers/Pharmacy/Pages/default.aspx>

Magellan is the pharmacy benefit manager for Medi-Cal Rx.



Partnership Medical Drug List Navigator

The Medical Drug List (MDL) is used to find the coverage status and billing requirements for drugs administered directly to Partnership Medi-Cal members in a clinical setting by a medical professional.

- ✓ Searchable by drug name, NDC, or HCPCS code
- ✓ Allows you to see criteria for TAR authorization
- ✓ Shows any billing requirements or limitations such as age, dose, diagnosis, place of service, etc.

Search by Drug Name, NDC, HCPCS Code, or Code Description

Enter search term, select search type from drop-down

▸ Apply Filters

Return to:

- Partnership [Pharmacy Pages](#)
- Partnership [Provider Pages](#)
- Partnership [Claims Pages](#)
- Partnership [PAD TAR Form](#)

MDL ID#:	24799
MDL Effective Date:	01/01/2026
Updated:	03/2026
MDL Approval Date:	01/01/2026
MDL Version:	5

To access Partnership's MDL navigator, please [click here](#)

For instructions and tips on using Partnership's MDL Navigator, please [click here](#)

Data Sharing

Partnership shares data with its providers through the provider portal and the Partnership website.



Partnership shares information with members through the member portal and the Partnership website.

Compliance and Regulatory Affairs

PRIVACY INCIDENTS

It is the acquisition, access, use, or disclosure of protected health information (PHI) in a manner not permitted under the HIPAA privacy rule, which compromises the security or privacy of PHI. Privacy incidents must be reported immediately even if you don't have all the details. When in doubt, report it to Partnership:



**Unsecure email
with PHI**



**Mistakenly sent
fax with PHI**



**Computer
breach**



**Malware
detection**

Report discovery of incident within 24 hours by:

Email: RAC_Reporting@partnershiphp.org

Fax: **(707) 863-4363**

Phone: **(800) 601-2146**

Fraud, Waste, and Abuse

Partners in Fighting Fraud

We ask our providers help us combat fraud by reporting suspicious and fraudulent activity. DHCS and CMS require us to maintain a robust anti-fraud plan and share it with our providers, members, and employees.

- Partnership Anonymous Fraud Hotline **(800) 601-2146**
- Medi-Cal Fraud Issues **(800) 822-6222**
- Medicare Fraud Issues **(800) 633-4221**

Examples

- Charging excessive costs for services or supplies
- Billing for services at a higher rate than justified
- Providing medically unnecessary services

Fraud, Waste, and Abuse

FRAUD

- An intentional act of deception, misrepresentation, or concealment in order to gain something of value.

WASTE

- Over-utilization of services (not caused by criminally negligent actions) and the misuse of resources.

ABUSE

- Excessive or improper use of services or actions that is inconsistent with acceptable business or medical practices. This refers to incidents that, although not fraudulent, they may directly or indirectly cause financial loss.

Required Trainings

- ❑ Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Provider Training (For providers who treat patients under 21)
- ❑ Partnership C.A.R.E.S (Any provider that is credentialed with Partnership)

Provider Relations:

<https://www.partnershiphp.org/Providers/Medi-Cal/Pages/default.aspx>

Contact Partnership

Health Equity	• healthequity@partnershiphp.org
Transportation Services	• (866) 828-2303
Network Services	• Credentialing@partnershiphp.org • ChangesProviders@partnershiphp.org
Provider Relations	• (707) 863-4100
Contracting	• (707) 366-3885
FIS Integrated Payables (EFT)	• (877) 330-4950
Business Hours	• Monday – Friday, 8 a.m. to 5 p.m.
Partnership Website	• www.partnershiphp.org

Just a reminder if you are sending PHI by email, please utilize your internal secure email system to meet HIPAA standards. If your unable to initiate a secure email, please reach out to Partnership and we can initiate the secure email from our end.