

SECTION A: PROVIDER ADMINISTRATIVE FUNCTIONS

- Provider Change Form
- Facility Standards



TOTAL HEALTH CARE, INC.

PROVIDER ADD/CHANGE/TERMINATION FORM

Date: _____

Provider Name: _____

Specialty: _____

Center #: _____

Network: _____

Action: **ADD, CHANGE, TERMINATE:** _____

Effective Date: _____

***Please list all the information that needs to be changed**

	Original Information		New Information
Name:		Name:	
Specialty:		Specialty:	
Tax ID:		Tax ID:	
Address:		Address:	
Suite #:		Suite #:	
City, Zip Code:		City, Zip Code:	
County:		County:	
Phone:		Phone:	
Fax:		Fax:	
After Hours #:		After Hours #:	
Hours:		Hours:	
Other:		Other:	

Comments: _____

Completed By: _____

Systems Updated On: _____

Initials: _____



FACILITY STANDARDS

The following provides an overview of the facility standards that Total Health Care. expects of its providers.

1. All staff must be familiar with the emergency and fire safety procedures for the office as well as for the building in which the Center is located. Fire/emergency drills must be held at least 2 times per year, preferably 4 times per year.
2. Evacuation (routing) maps must be posted throughout the office depicting the nearest exit.
3. Fire extinguishers must be present and be mounted to the wall and inspected regularly.
4. All patients' supplies must be kept above floor level. Patient care items are not to be stored directly on the floor and no items other than cleaning supplies can be stored under the sink.
5. Hazardous and toxic materials must be stored properly and away from treatment areas.
6. OSHA guidelines should be posted and followed including universal precautions.
7. Refrigerators:
 - when used for laboratory specimens or medications must not have food items stored in them.
 - temperatures must be monitored between 38° to 46° F (42° F is preferred).
8. Narcotics must be double-locked with restricted access to keys. A sign-out system must be maintained.
9. Syringes and needles must be:
 - stored where there is no patient access.
 - disposed of in secured (preferably attached to the wall) sharps container.
10. Opaque bags must be used for waste disposal.
11. Medications must be:
 - properly stored (i.e., refrigerated as needed) with no patient access.
 - checked on a routine bases with all expired medications (including samples) discarded.
 - labeled with the name of the medication and expiration date.
 - recorded on the Inventory Control Form and the Dispensing Control Form.
12. Bar soap should not be left in water. Preferably, soap dispensers should be installed. If this is not used, pump bottles of liquid soap should be provided at all sinks.
13. Disposable paper towels should be used at all sinks. Paper towels must be contained in a dispenser. Cloth towels should not be used.
14. All disinfectant containers must be clearly labeled "clean" or "dirty" with the type of solution and must be changed weekly and appropriately dated.
15. Autoclave supplies and instruments must be wrapped and labeled with the expiration date on the package.

16. A spore check should be run on the autoclave at least once per month and the results noted in the Log Book. A live spore test should be run on the autoclave at least once per year (or more frequently for high volume practices).
17. Corridors, hallways, and doorways must be free of all obstructions. All exits must be kept clear of obstructions.
18. Exits must be clearly marked with illuminated signs.
19. All x-ray equipment must be currently licensed by the State of Michigan with the license posted prominently. The BHS-100 Form must be posted.
20. Oxygen and other compressed gas tanks must be properly secured and away from the corridor, hallways, and doorways.
21. Work areas should be divided into "clean" and "dirty" areas and should never overlap.
22. Entire facility should be adequately lighted appropriate to the purpose in the area.
23. Ideally, there should be handicapped entrance with handrails on both sides of the ramps with sufficient lighting. A handicapped bathroom should be available in the office.
24. CLIA certificate must be posted
25. Medical Waste certificate must be posted.

SECTION B: RISK MANAGEMENT PROGRAM

- Risk Management Incident Report Form



TOTAL HEALTH CARE, INC.

**TOTAL HEALTH CARE, INC.
RISK MANAGEMENT
INCIDENT REPORT FORM**

NAME	ADDRESS	PHONE#	MEMBER#	DOB	SEX
NAME OF CALLER			RELATIONSHIP TO MEMBER		
(Check the number that best describes the type of incident you are reporting.) 1. Unanticipated death 2. Unanticipated major permanent loss of function 3. Rape/Assault/Harassment 4. Surgery on the wrong body part 5. Employee work related injury 6. On site visitor injury 7. Other			DATE OF EVENT _____ \ _____ \ _____		
			LOCATION (DOCTOR'S OFFICE, HOME, HOSPITAL, ETC.) _____		
			PATIENT'S GROUP: _____		
			DESCRIPTION OF INCIDENT: _____		

			(Provide additional information in separate sheet, if necessary) Is there additional information attached to this incident report? Yes___ No___		
SIGNATURE OF PERSON PREPARING REPORT			TITLE		DATE & TIME
SIGNATURE OF DEPARTMENT MANAGER			DATE		FORWARDED TO QI YES NO
COMMENTS					
FOR RISK MANAGEMENT USE ONLY					
REVIEWED BY: _____			DATE: _____		
INCIDENT NUMBER _____		FORWARDED TO DEPT MGR FOR COMMENT: _____			

This form is to be maintained for the use and benefit of Total Health Care liability insurer. This report is not intended to be a part of a member's record, but will be used by our attorney in any future litigation, which may develop.

MAKE NO COPIES SUBMIT WITHOUT DELAY

**CONFIDENTIAL - DO NOT DISCLOSE TO THIRD PARTIES
IMPORTANT - FILL IN TOP PART COMPLETELY**

SECTION C: MEDICAL MANAGEMENT

- Instructions to Complete Consent for Sterilization Form
- Consent for Sterilization Form
- Acknowledgement of Receipt of Hysterectomy Information
- Certification for Induced Abortion
- Beneficiary Verification of Coverage

These forms are also available on our website at www.totalhealthcareonline.com; **Provider;**
Downloadable Forms.

INSTRUCTIONS TO COMPLETE CONSENT FOR STERILIZATION FORM

1. Name of the physician or clinic giving information to the beneficiary. The "M.D." or "D.O." designation must be included.
2. Name of the sterilization procedure to be performed (e.g., Tubal Ligation or Vasectomy).
3. Beneficiary's complete birth date (month, day, and year). The beneficiary must be 21 years of age at the time they sign the form.
4. Beneficiary's full name. If a name change is indicated on the Medicaid card by the time surgery is performed, both names must be indicated.
5. Name of physician performing the sterilization. If the physician is unknown, "doctor on call" may be indicated.
6. Name of surgery to be performed (e.g., Tubal Ligation or Vasectomy).
7. Beneficiary's handwritten signature. A beneficiary who cannot write should sign with an "X." The "X" signature must be witnessed. The witness' handwritten signature must appear below item 7.
8. Date the consent form was signed (month, day and year). This date must be more than 30 days and less than 180 days before the date the sterilization is performed. If it is less than 30 days, see instructions for "alternative final paragraphs."
9. Race and ethnicity designation is optional.
10. Interpreter's Statement. This information is only required if the beneficiary is unable to understand English. The language used for interpretation must be specified (e.g., Spanish). The interpreter's handwritten signature and date must appear. The date must be the same date the beneficiary signed the form.
11. Name of beneficiary.
12. Name of sterilization procedure (e.g., Tubal Ligation or Vasectomy).
13. The handwritten signature of the person obtaining consent.
14. Date consent is taken (month, day and year). This date must be before the date sterilization is performed (#18).
15. Name of provider or clinic (e.g., office of John Doe, M.D., doctor's office, ABC Clinic, XYZ Hospital).
16. Street address, city, state, and zip code. No P.O. boxes allowed.
17. Beneficiary's full name.
18. Date of sterilization (month, day, and year). The surgery date must be the same as indicated on the claim.
19. Name of sterilization procedure (e.g., Tubal Ligation, Vasectomy).
20. Instructions for use of alternative final paragraphs.
21. If at least 30 days have passed since the date the beneficiary signed the consent form and the date of sterilization, paragraph "1" applies and paragraph "2" should be crossed out.
22. If the date the sterilization was performed is less than 30 days and more than 72 hours of the beneficiary signing the consent form, paragraph "2" applies and paragraph "1" should be crossed out. The applicable box should be checked.
23. For premature delivery, the expected date of delivery must be given.
24. Physician's signature. This can be a stamped signature if counter initialed.
25. Date physician signed the consent form. This date must be on or after the date of surgery. This can be typed or stamped.

If abdominal surgery was performed, the circumstances must be explained and operative notes submitted with the claim.

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is Voluntary, but is required if Medical Assistance program payment is desired.

The Michigan Department of Community Health is an equal opportunity employer, services and programs provider.

CONSENT FOR STERILIZATION
Michigan Department of Community Health

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from _____
_____. When I first asked for the
(Doctor or Clinic)
information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on _____
(Month / Day / Year)

I, _____
(Name of Individual Being Sterilized)
hereby consent of my own free will to be sterilized by

(Name of Doctor and Professional Degree)
by a method called _____.

My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Human Services OR Employees of programs or projects funded by that Department but only for determining if Federal laws were observed. I have received a copy of this form.

(Signature of Person Giving Consent) Date: _____
(Month / Day / Year)

You are requested to supply the following information, but it is not required: *Ethnicity and race designation (please check)*

- Ethnicity:** Hispanic or Latino Not Hispanic or Latino
- Race (mark one or more):** American Indian or Alaska Native Asian Black or African American Native Hawaiian or Other Pacific Islander White

INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized:
I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____
language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

(Interpreter's Signature) Date: _____
(Month / Day / Year)

STATEMENT OF PERSON OBTAINING CONSENT

Before _____ signed the
(Name of Individual)
consent form, I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

(Signature of person obtaining consent) _____ (Date)

(Facility)

(Facility Address)

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon _____
(Name of individual to be sterilized) on _____
(Date of sterilization)

I explained to him/her the nature of the sterilization operation _____, the fact that it is intended
(specify type of operation)

to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- Premature delivery
Individual's expected date of delivery: _____
- Emergency abdominal surgery: _____
(describe circumstances)

(Signature of Physician and Professional Degree) Date: _____
(Month / Day / Year)

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is Voluntary, but is required if Medical Assistance program payment is desired.

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ACKNOWLEDGMENT OF RECEIPT OF HYSTERECTOMY INFORMATION

Michigan Department of Community Health

RECIPIENT STATEMENT:

I, _____, was told before the
(Print or Type Recipient Name)

hysterectomy was done that after the hysterectomy I would not be able to become pregnant.

(Recipient or Representative Signature)

(Date)

(Interpreter Signature, if required to inform the recipient of the above information)

(Date)

PHYSICIAN STATEMENT:

The hysterectomy for the above named recipient is solely for medical indications. This hysterectomy is not primarily or secondarily for family planning reasons, to render the above named recipient permanently incapable of reproducing, i.e. sterilization. It was explained to the above named recipient prior to the hysterectomy that the hysterectomy will render her permanently incapable of reproducing.

(Physician Signature)

(Date)

Authority: Title XIX of the Social Security Act Completion: Is Voluntary, but is required if Medical Assistance program payment is desired.	The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to the Family Independence Agency office in your county.
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CERTIFICATION FOR INDUCED ABORTION

Medicaid, Adult Benefits Waiver (ABW), or MIChild payments for abortion services are limited to cases in which the life of the mother would be endangered if the pregnancy were continued or cases in which the pregnancy was the result of rape or incest. Although this procedure may be covered for a woman while enrolled in the ABW program, the beneficiary should also be applying for Medicaid. To receive payment for abortion services, a physician must determine and certify that the abortion is necessary to save the life of the mother or is to terminate a pregnancy that resulted from rape or incest.

INSTRUCTIONS:

- TYPE or PRINT ALL information below.
- The Physician completing this form is responsible for providing a copy of the completed form to any other provider assisting in this procedure (e.g., hospital, anesthesiologist, laboratory) for billing purposes.
- Send a completed copy of the completed form with claim. (Refer to the Medicaid Provider Manual, Directory Appendix, Claim Submission/Payment.)

Any questions regarding this form should be referred to Provider Inquiry at 1-800-292-2550 or e-mail ProviderSupport@michigan.gov.

Beneficiary Name		MIhealth Number or MIChild Number		Date of Service	
Beneficiary Address (no. & street, apt./lot #, etc.)		City		State	ZIP Code
<p>Appropriate box must be checked for payment to be made.</p> <p>By signing below, I certify that:</p> <p><input type="checkbox"/> the life of the mother would be endangered if the pregnancy were continued. (List the medical condition(s) that exists.)</p> <p>_____</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> the pregnancy terminated through this procedure was the result of rape or incest. Information included in the medical record supports this claim.</p>					
In cases of rape or incest, was a police report filed? <input type="checkbox"/> YES <input type="checkbox"/> NO (If NO, explain)					
If appropriate, was a report filed with the local DHS office? <input type="checkbox"/> YES <input type="checkbox"/> NO (If NO, explain)					
NOTE Payment for service is not dependent upon a report being filed with the police or the local DHS office.					
Physician Name (Type or Print)			Handwritten Signature of Physician		
Address (No. & Street, Ste., etc.)					
City	State	ZIP Code	Date Signed	Provider NPI Number	

Authority: Title XIX and Title XXI of the Social Security Act.
 Completion: Is Voluntary, but is required if payment from Medicaid, ABW, or MIChild program is sought.

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BENEFICIARY VERIFICATION OF COVERAGE

I understand that Medicaid, Adult Benefits Waiver (ABW), or MICHild only covers payment for elective abortions under limited circumstances. Although this procedure may be covered for a woman while enrolled in the ABW program, the beneficiary should also be applying for Medicaid.

These are:

- Elective abortion to terminate a pregnancy to save the life of the mother,
- Elective abortion to terminate a pregnancy that was the result of rape, or
- Elective abortion to terminate a pregnancy that was the result of incest.

I certify that I am eligible for Medicaid, ABW, or MICHild coverage for an elective abortion based upon the circumstance that I have checked above. I understand that if I have given false information to obtain coverage for an elective abortion I can be prosecuted for fraud. I also understand that a copy of this verification will be sent to the local Department of Human Services (DHS) office or to a police agency when appropriate.

Beneficiary Name (typed or printed)			Beneficiary Signature	
Beneficiary Address				
City	State	ZIP Code		

WITNESSED BY:

Witness Name (typed or printed)			Witness Signature	
Witness Address				
City	State	ZIP Code		

Authority: Title XIX and Title XXI of the Social Security Act.
Completion: Is Voluntary, but is required if payment from the Medicaid, ABW, or MICHild program is sought.

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SECTION D: PHARMACY

- Request for Prior Authorization Form
- Drug Authorization Request Form
- Plavix Prior Authorization Form

These forms are also available on our website at www.totalhealthcareonline.com; Provider; Pharmacy Prior Authorization Forms.



Request for Prior Authorization
 Total Health Care
 (To be completed by a healthcare professional only.)

Fax to: Prior Auth Desk (866) 855-2658

Date of Request: _____

Name of person completing this form: _____

Physician's Name: _____ Physician's Specialty: _____

Physician's Phone #: _____ Physician's Fax #: _____ Physician's DEA #: _____

Patient's Name: _____ ID #: _____ DOB: ___/___/___ Gender: _____

Patient's Diagnosis: _____

Medication Needed: _____ Strength: _____

Quantity: _____ Directions: _____ Duration: _____

Has this patient tried other medications for this condition? (List drug and duration)

Clinical rationale for selected drug usage: _____

Pertinent laboratory tests or procedures and results: _____

Is patient currently taking drug? Yes No If yes, how long? _____

***** All fields must be complete for Prior Authorization Review *****

FOR OFFICE USE ONLY		
	Approved	Denied
Rationale: _____	Pending	
Date: _____		Initials: _____



TOTAL HEALTH CARE, INC.

Drug Authorization Request Form

Toll-free: 1-866-516-7611 / Fax: 1-877-889-3401

Part 1: Name of Person Completing form _____ Date _____

Requesting Provider _____ Provider Specialty _____

Provider's Phone # _____ Provider's Fax # _____ Provider's DEA # _____

Patient's name _____ Date of Birth ____/____/____ Telephone # _____

Address _____ City _____ State/ZIP _____

Patient's ID # _____

Part 2:

Drug requested and directions for use (e.g. mg/day) _____

Diagnosis: _____

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Is patient currently taking drug (yes, no)? _____ If yes, for how long? _____

Other drugs previously tried:

Name of drug, dose and date _____

Outcome (reason why it failed or wasn't tolerated) _____

Other reason(s) why this particular drug was selected (attach chart notes, pertinent laboratory tests or procedures and results, letter or supporting literature as appropriate)

DRUG/CLINICAL INFORMATION

Initial request Renewal Drug requested: _____ Proposed duration of therapy: _____

Strength/Quantity: _____ Daily dose: _____ Height: _____ Weight: _____

Sig. _____

Supplies package (no charge): sharps disposal unit (regular or large), alcohol wipes (100 per box), syringes as necessary

(NDC _____, qty _____) PRN refills.

Prescriber's Name _____ Date _____

Print Name

Signature _____

FOR PRIOR AUTHORIZATION, PLEASE FAX TO: 1-877-889-3401



Plavix Prior Authorization Form

(To be completed by a healthcare professional only.)

Fax to: Prior Auth Desk (866) 855-2658

Date of Request: _____

Name of person completing this form: _____

Physician's Name: _____ Physician's Specialty: _____

Physician's Phone #: _____ Physician's Fax #: _____ Physician's DEA#: _____

Patients Name: _____ ID#: _____ DOB: _____

Patient's Diagnosis: _____

Please indicate reason for therapy

- unstable angina
- Acute coronary syndrome(NSTEMI or STEMI)
- Coronary Artery Bypass Graft (CABG) (Date of CABG _____)
- Post PCI/stent placement (Date of stent _____)
- Documented aspirin allergy (anaphylaxis, bronchospasm)
- Intracranial stent (Date of stent _____)
- Carotid stent (Date of stent _____)
- Brachytherapy
- Peripheral stent (renal, inguinal, popliteal) (Date of stent _____)
- Cerebrovascular disease with recurrent ischemia
- Other

Intended Duration of therapy

- 1 month
- 3 months
- 9 months
- 12 month
- indefinite
- peripheral stent duration _____ months
- other

Contraindications

- Active bleeding
- History of bleeding diathesis
- Known hypersensitivity to clopidogrel or any component of the product

Medication Needed: _____ **Plavix** _____ Strength: _____

Quantity: _____ Directions: _____ Duration: _____