PINNACLE CLAIMS MANAGEMENT
PARTICIPATING PROVIDER GROUP AGREEMENT

THIS AGREEMENT is made and entered into effect this 1st day of January 2015, by and between **Santa Barbara County Public Health Department** (hereinafter "PROVIDER"); whose office is located at: 300 N. San Antonio Road, Bldg. 1, Santa Barbara, CA 93110 and PINNACLE CLAIMS MANAGEMENT (hereinafter "PCMI") whose corporate offices are located at: 17620 Fitch Street, Irvine, California 92614.

RECITALS

A. PROVIDER is a Public Health Department exempt from clinic licensure under California Health and Safety Code Section 1206 but the physicians and health care practitioners that provide medical services for the Public Health Department are a "licensee" as that term is defined under Business and Professions Code Section 2051.

B. PCMI makes available to eligible employers a variety of health benefit programs pursuant to and in accordance with the applicable requirements of the federal Employee Retirement and Income Security Act of 1974, as amended ("ERISA") which include coverage for the services which PROVIDER makes available in its facilities.

C. PROVIDER is interested in contracting for the provision of its services to persons eligible for payment of such services by PCMI and PCMI is interested in contracting with PROVIDER to pay for such services in accordance with the terms and conditions of this Agreement.

I. DEFINITIONS

Section 1.01 "Hospital Services": Those acute care inpatient and hospital outpatient services which are covered by the PCMI'S applicable Health Benefits Agreement.

Section 1.02 "Participating Hospital": A hospital which has entered into an agreement with PCMI to provide Hospital Services as a Participating Provider.

Section 1.03 "Participating Physician:" A physician who has entered into an agreement with the PCMI to provide Medical Services to Subscribers as a Participating Provider and is authorized by certificate to practice as required under California Business and Professions Code Section 2051 or otherwise authorized to practice under relevant and applicable state licensing laws and regulations.

Section 1.04 "Participating Provider": A hospital, other health facility, Provider, or other health professional which has entered into an agreement with PCMI to provide health care services to Subscribers.

Section 1.05 "Medical Services": Those services which are provided by a Participating Provider and covered by a PCMI Health Benefits Agreement.

Section 1.06 "Covered Services": Those Provider services which are included in the health benefits made available to a Subscriber under the terms of the Health Benefits Agreement between such Subscriber's employer and PCMI.

Section 1.07 "Non-covered Services": Those Provider services which are excluded from

coverage under the terms of the Health Benefits Agreement between a Subscriber's employer and PCMI.

Section 1.08 "Subscriber": An employee or family member or other dependent of an employee of an employer who is eligible to receive Covered Services under the terms of the employer's Health Benefits Agreement with PCMI.

Section 1.09 "Co-payments and Deductibles": Payments for which a Subscriber or such Subscriber's sponsor is responsible as a condition of receiving Covered Services.

Section 1.10 "Health Benefits Agreement": The agreement between an employer and the PCMI under which Subscribers are eligible to receive Covered Services. For purposes of this Agreement, the term "Health Benefits Agreement" shall also include any other agreement which may exist between a person (for example, a retired employee, or an employee who continues to be eligible for coverage following the termination of his employment) and PCMI.

Section 1.11 "Emergency": A medical condition manifested by sudden onset of acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably result in:

(1) Causing serious and/or permanent medical consequences to the Subscriber's health,
(2) Causing serious impairment to bodily functions, or
(3) Causing serious and permanent dysfunction of any bodily organ or part.

Section 1.12 "Medically Necessary": Services or supplies which, under the provisions of this Agreement, are determined to be:

(1) Appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition, and
(2) Provided for the diagnosis or direct care and treatment of the medical condition, and
(3) Within standards of good medical practice within the organized medical community, and
(4) Not primarily for the convenience of the Subscriber, the Subscriber's Provider or another provider, and
(5) The most appropriate supply or level of service which can safely be provided. For hospital stays, this means that acute care as an inpatient is necessary due to the kind of services the Subscriber is receiving or the severity of the Subscriber's condition, and that safe and adequate care cannot be received as an outpatient or in a non-acute care medical setting.

Section 1.13 "Utilization Review Program": Means the Utilization Review Program developed, established and administered by PCMI for the review of the Medical Necessity of Covered Services provided to Subscriber, a summary of which is attached as Exhibit A-1 and Exhibit A-2 to this Agreement.

II. SERVICES TO BE PROVIDED BY PROVIDER

Section 2.01 PROVIDER shall provide medical services which are Medically Necessary, in accordance with and subject to the terms and conditions of this Agreement, to all Subscribers seeking such services from PROVIDER.

Section 2.02 PROVIDER shall, to the extent possible, seek, accept, and maintain evidence of assignment for the payment of Medical Services provided to Subscribers by PROVIDER and the applicable Health Benefits Agreement.

Section 2.03 PROVIDER agrees to admit or arrange for admission of Subscribers only to Participating Hospitals unless otherwise determined by PROVIDER and agreed to by the Subscriber. In the case of an Emergency, PROVIDER agrees to the use of a Participating Hospital whenever possible.

Section 2.04 PROVIDER agrees to refer Subscribers only to other Participating Providers unless otherwise determined by PROVIDER and agreed to by the Subscriber.

Section 2.05 PROVIDER shall promptly notify PCMI of any change in its principal place of business, within thirty (30) days of such change.

Section 2.06 PROVIDER will participate in Utilization Review and-acknowledges that decisions resulting from that review will limit the PCMI's repayment to Provider. Provider may seek review of the PCMI decision subject to the rights of reconsideration, review and arbitration provided in the PCMI'S Utilization Review Program. If Provider believes that minimum care requires additional charges to the patient, these charges will be the sole responsibility of the patient subject to any recourse the patient may have against the PCMI.

III. SERVICES TO BE PROVIDED BY PCMI

Section 3.01 PCMI agrees to identify PROVIDER as a Participating Provider on informational materials to Subscribers, and to direct such Subscribers to PROVIDER.

Section 3.02 PCMI agrees to continue listing PROVIDER as a Participating Provider until this Agreement terminates pursuant to this Agreement.

Section 3.03 PCMI agrees to provide PROVIDER with a list of all Participating Providers, Participating Hospitals and other Participating Providers.

IV. BILLING AND PAYMENT FOR SERVICES

Section 4.01 "Deductibles and Copayments": PROVIDER is entitled to bill and has the responsibility to collect from a Subscriber or other person assuming financial responsibility for such Subscriber's care, any applicable deductibles or copayments for Covered Services in accordance with the applicable Health Benefits Agreement under which such Subscriber is entitled to receive services pursuant to this Agreement.

Section 4.02 "Coordination of Benefits": PROVIDER shall be entitled to seek additional payments, up to one hundred percent (100%) of its usual and customary charges for all services rendered to Subscribers pursuant to this Agreement, in the event that any Subscriber is entitled to coverage under any other third party insurance or other applicable program providing for the payment of benefits to such Subscribers for such services. This provision shall not affect PCMI'S obligations under the other provisions of this Agreement, which shall be limited to the appropriate fee schedules, pursuant to Section 4.08, less any applicable deductibles or coinsurance responsibility of the Subscriber, and subject to all PCMI plan maximums and limitations.

Section 4.03 "Collection from Subscribers": If, for any reason, PCMI fails or refuses to make any payment for which it is obligated hereunder, PROVIDER shall retain the right, except as otherwise prohibited by applicable law, to seek payment for such services at the rates provided for herein from a Subscriber or other person responsible for payment of the Subscriber's account with PROVIDER.

Section 4.04 "Assignment of Benefits Form": PROVIDER shall utilize its customary assignment of benefits form in obtaining an assignment of benefits from each Subscriber to whom services are rendered for which payment may be made pursuant to this Agreement.

Section 4.05 "Billing Forms": PROVIDER will use its customary billing form in making claims for payment hereunder. Such form shall identify PROVIDER's usual and customary rate for Covered Services payable by PCMI, together with a statement of the amount due for such services in accordance with the terms of this Agreement, as well as the amount of any applicable deductibles, copayments, and any services for which PROVIDER is seeking payment from any third party, pursuant to Section 4.02 above. The bill shall provide sufficient information to identify all services provided.

Section 4.06 "Timing of Billing": Unless billing is delayed for any reason beyond the reasonable control of PROVIDER, PROVIDER will submit all bills for Covered Services to PCMI within sixty (60) _days from the date of service rendered or the date of any other service for which payment may be made hereunder.

Section 4.07 "Payment": Payment of all billings submitted by PROVIDER shall be made by PCMI within thirty (30) days of their receipt by PCMI, which shall be presumptively established to have occurred, in the absence of clear and unambiguous evidence of later receipt, on the third business day following the date of mailing of such billing. Any amount paid by PCMI to PROVIDER under this Agreement, determined subsequently by PCMI to have been an overpayment, or any amount owed by PROVIDER to PCMI for any reason, will be considered indebtedness of PROVIDER to PCMI. PCMI will have a first lien in the amount of such indebtedness and may, at sole option, recover such indebtedness by (i) requesting a refund from PROVIDER; or (ii) deducting from and off setting any amount or amounts due and payable from PCMI to PROVIDER at anytime under this Agreement or any other Agreement between PCMI and PROVIDER, or for any reason an amount or amounts equal to such indebtedness of PROVIDER.

Section 4.08 "Compensation": Provider agrees to accept the fee schedule as provided in Exhibit A-1 and Exhibit A-2, attached and made part of this Agreement or Providers billed charges, whichever is less, as payment in full for all medical services provided to Subscribers. Such payment shall be for medical services provided on or after effective date of this Agreement.

V. RECORDS MAINTENANCE, AVAILABILITY, INSPECTION, AND AUDIT

Section 5.01 "Records:" PROVIDER agrees to allow review and duplication of any data and other records maintained on Subscribers which relate to this Agreement. Medical records shall be made available as necessary for provision of medical services and as otherwise necessary to carry out the terms of this Agreement. Such availability, review and duplication shall be allowed upon reasonable notice during regular business hours and shall be subject to all applicable laws and regulations concerning the confidentiality of such data or records.

Section 5.02 "Confidentiality of PROVIDER Rates": PROVIDER agrees that the fee schedule set forth in Exhibit A-1 and Exhibit A-2 of this Agreement are confidential and that, to be the extent reasonably possible, such fee schedule will not be divulged to any person who is not directly involved in the management of PROVIDER's affairs with respect to this Agreement or in implementation of this Agreement without prior express written consent of PCMI, unless required by law.

VI. INSURANCE AND INDEMNIFICATION

Section 6.01 "PROVIDER's Insurance": PROVIDER at its sole cost and expense, shall maintain in force, throughout the term of this Agreement, adequate general and professional liability insurance, or other commercially reasonable means of providing assurance against such risks in the amount similar to that maintained by other members of his/her professions.

Section 6.02 "Indemnification": The parties hereto mutually agree to indemnify and hold each other (including each parties respective officers, agents, and employees) harmless against any and all claims, demands, damages, liabilities, and costs incurred by the other party, including reasonable attorneys' fees, arising out of or in connection with, either directly or indirectly, the performance of any service, or any other act or omission by or under the direction of the indemnifying party or its employees or agents; it being specifically agreed and understood, however, that this indemnification provision is not intended nor should it be construed to create any liability or responsibility of either party to the other with respect to such claims which arise solely by reason of the acts or omissions of any independently contracting or practicing participating Provider or other professional provider of health care services. PROVIDER or its agents or representatives shall not be liable for any cause of action arising out of or in connection with the PCMI administration of claims under the Agreement.

VII. LIAISON; INDEPENDENT CONTRACTORS

Section 7.01 "Liaison": The parties agree that to the extent compatible with the separate and independent management of each party they shall at all times endeavor to maintain an effective liaison and close cooperation with each other in implementing this Agreement. To this end, each party agrees to designate and advise the other party of the identity of a single individual who shall act as the principal contact person with respect to all matters relating to this Agreement and its implementation.

Section 7.02 "Parties Are Independent Contractors":
Nothing contained herein is intended nor shall it be construed to create any relationship between PCMI and PROVIDER other than that of independent entities contracting with each other hereunder solely for the purpose of effecting the provisions of this Agreement. Neither of the parties, nor any of their respective officers, directors, agents, or employees, shall be construed to be the agent, employee, nor is representative of the other and neither party authorized to represent the other party for any purpose whatsoever without the prior express written consent of such other party. Nothing contained herein is intended nor shall it be construed to create any rights or remedies in any third party.

VIII. TERM AND TERMINATION

Section 8.01 "Term:" This Agreement shall initially be effective as of the date set forth in the first paragraph, referred to as the "Anniversary Date" and shall continue in effect for a term of one year (1) and six (6) months ("Initial Term"). The Agreement shall thereafter automatically renew for additional one (1) year terms ("Renewal Term") unless terminated in accordance with Section 8.02.

Section 8.02 "Annual Review:" The Agreement is subject to annual review by County Board of Supervisors, and County retains the right to terminate without cause at the end of the Initial Term or any Renewal Term, upon 30 days' advance notice to PCMI .

Section 8.03 "Termination for Cause:" At any time, either party may terminate this Agreement upon thirty (30) days prior written notice if the other party is in breach of any material provision of this Agreement; provided that such notice shall be deemed to have been withdrawn if the breaching party remedies such breach within the thirty (30) day notice

period to the satisfaction of the other party.

Section 8.04 "Rights Following Termination:" Termination shall have no effect upon the rights and obligations of the parties arising out of any transactions occurring prior to effective date of such Termination. In the event a Subscriber is receiving Medical Services as of the date of Termination, PROVIDER shall continue to be entitled to payment, determined in accordance with the terms of this Agreement for all Covered Services rendered to such Subscriber until treatment is completed for the particular condition, or care can be transferred to another contracted provider.

Section 8.05 "Notification to Subscribers:" In the event of Termination, the parties shall cooperate in the development of appropriate means of notifying Subscribers of such Termination.

IX. ADVERTISING AND PROMOTIONAL REFERENCES TO PROVIDER

Section 9.01 "Informational Use of PROVIDER's Name": PROVIDER agrees that PCMI may list PROVIDER's name, address, telephone number, and a description of its facilities and services in any informational material routinely distributed to participating employers and eligible Subscribers, and for other purposes reasonably related to the administration of Health Benefits Agreements under which Covered Services are made available to Subscribers.

Section 9.02 "Deletion of References to PROVIDER Following Termination": In the event of termination of this Agreement, PCMI shall use all reasonably feasible means to remove any references to PROVIDER in any advertising, promotional, marketing, or informational materials as soon as reasonably practicable.

X. DISPUTE RESOLUTION

Section 10.01 "Dispute Resolution:" In the event that a dispute between the parties arises out of or relating to this Agreement, the parties agree that they shall first attempt, in good faith, to resolve the matter informally. The parties shall execute a mutually agreed upon timeframe for informal resolution. If the parties fail to agree upon a timeframe and/or fail to reach a resolution the dispute shall be subject to the jurisdiction of the courts located in the state of California, county of Santa Barbara, city of Santa Barbara.

XI. GENERAL AND MISCELLANEOUS PROVISIONS

Section 11.01 "Time of the Essence": Time shall be of the essence with respect to the performance by the parties of each and every covenant and obligation of this Agreement.

Section 11.02 "Notices": Any notice required or permitted to be given under this Agreement shall be in writing and shall either be delivered personally, sent electronically to the appropriate contacts listed in this agreement, or sent by registered or certified mail in the United States Postal Service, return receipt requested, postage prepaid, or by other delivery service providing evidence of the delivery of such notice, and shall be sent to the addresses of the parties set forth in the first paragraph of this Agreement or to such other address as may be established for such purpose by notice given in accordance with the provisions of this Section.

Section 11.03 "Amendments and Modifications": Any Amendment or modification to this Agreement shall be in writing and must be executed by both parties in order to be effective.

Section 11.04 "Nonassignability": Neither this Agreement, nor any right or obligation established

hereunder may be assigned by either party without the express written consent of the other party. Any attempted assignment in violation of this Section shall be void and of no force or effect whatsoever and shall constitute grounds for termination by the other party pursuant to Section 8.03 above.

Section 11.05 "Non-Waiver; Breach": The waiver by either party of any breach of any provision of this Agreement or of any warranty or representation set forth herein shall not be construed as a waiver of any subsequent breach of the same or any other provision. The failure by a party to exercise any right hereunder shall not operate as a waiver of such right. All rights and remedies provided for hereunder or otherwise available to a party under applicable law are cumulative.

Section 11.06 “Governing Law": This Agreement shall be governed and construed in all respects by and in accordance with ERISA California Law.

Section 11.07 "Severability": If any provision of this Agreement is held to be illegal, invalid, or unenforceable under present or future laws as may be deemed applicable during the term hereof, such provision shall be considered severable and the remainder of the Agreement shall continue in effect and may be construed and enforced disregarding such illegal, invalid, or unenforceable provision; provided, however, that if the determination of illegality, invalidity, or unenforceability shall cause a material financial or other material detriment to either party, at such party's request, both parties shall meet and confer in good faith to determine whether an appropriate amendment or modification can be mutually agreed upon to respond to the requesting party's concerns. If the other party refuses to respond to such request, or if the parties are unable to arrive at a mutually acceptable solution to the problem, then the party suffering the detriment shall have the right to terminate the Agreement upon thirty (30) days prior written notice to the other party.

Section 11.08 "Entire Agreement": This Agreement, together with any Attachments or Exhibits referred to and incorporated by reference herein, contains and constitutes the entire agreement of the parties with respect to the subject matter hereof and respecting their rights, duties, and obligations hereunder. Any prior agreements, promises, negotiations, or representations, either oral or written, relating to the subject matter of this Agreement not expressly set forth in this Agreement, or in such an Attachment, Exhibit, or a duly executed Amendment or modification hereto shall be of no force or effect whatsoever.

Agreement to provide eligible medical services between the **County of Santa Barbara** and **Pinnacle Claims Management.**

IN WITNESS WHEREOF, the parties have executed this Agreement to be effective January 1, 2015.

COUNTY OF SANTA BARBARA

____
Chair, Board of Supervisors

Date: ________________

ATTEST:
MONA MIYASATO
CLERK OF THE BOARD

By: ________________________________
Deputy Clerk

APPROVED AS TO FORM:
MICHAEL C. GHIZZONI
COUNTY COUNSEL

By: ________________________________
Deputy County Counsel

APPROVED AS TO ACCOUNTING FORM:
ROBERT W GEIS, CPA
AUDITOR-CONTROLLER

By: ________________________________
Deputy

APPROVED:
TAKASHI WADA, MD, MPH
DIRECTOR/HEALTH OFFICER
PUBLIC HEALTH DEPARTMENT

By: ________________________________
Director

APPROVED AS TO FORM:
RAY AROMATORIO, ARM, AIC
RISK MANAGER

By: ________________________________
Risk Manager

Agreement to provide eligible medical services between the **County of Santa Barbara** and **Pinnacle Claims Management.**

IN WITNESS WHEREOF, the parties have executed this Agreement to be effective January 1, 2015.

PINNACLE CLAIMS MANAGEMENT

____
David Zanze
Sr. Vice President

Date: ______________________

Exhibit A-1

Provider Fee Schedule

Applicable to Pinnacle Claims Management (PCMI) EPO Plan Only
Santa Barbara County Health Care Clinics

Provider claims shall be coded and submitted to PCMI using the most recent version of Current Procedural Terminology (CPT) codes. PCMI will pay Providers a percentage of Medicare's Resource Based Relative Value Scale ("RBRVS") for CPT codes submitted under the following categories indicated below:

CPT Code Allowed:	Payment Amount
Medicine	110% of Medicare allowable Area 99
Surgery	110% of Medicare allowable Area 99
Radiology	110% of Medicare allowable Area 99
Durable Medical Equipment	110% of Medicare allowable Area 99
Pathology	110% of Medicare allowable Area 99
Supplies	Invoice Cost plus 10% - Must include purchase invoice with claim
Anesthesiology ASA Codes	$38.00 per unit

In addition to Primary Care Services, Primary Care Clinics will be responsible to provide all lab & radiology services when and where available and will be reimbursed at the above fee schedule.

Exhibit A-2

Provider Fee Schedule
Specialists

Applicable to Pinnacle Claims Management (PCMI) EPO Plan Only

Provider claims shall be coded and submitted to PCMI using the most recent version of Current Procedural Terminology (CPT) codes. PCMI will pay Providers a percentage of Medicare's Resource Based Relative Value Scale ("RBRVS") for CPT codes submitted under the following categories indicated below:

CPT Code Allowed:	Payment Amount
Medicine	100% of Medicare allowable Area 99
Surgery	100% of Medicare allowable Area 99
Radiology	100% of Medicare allowable Area 99
Durable Medical Equipment	100% of Medicare allowable Area 99
Pathology	100% of Medicare allowable Area 99
Supplies	Invoice Cost plus 10% - Must include purchase invoice with claim
Anesthesiology ASA Codes	$38.00 per unit

EXHIBIT B
PINNACLE CLAIMS MANAGEMENT
UTILIZATION MANAGEMENT PROCEDURES

I. INTRODUCTION

A. Pinnacle Claims Management (PCMI) has established a Utilization Management program to conduct Utilization Management as provided in Section 1.13 of the PARTICIPATING PROVIDER AGREEMENT. PCMI and/or any and all Review Organizations with which PCMI may contract shall establish and maintain review procedures and screening criteria which take into account locally acceptable professional standards for quality medical care.

B. The Utilization Management process has two primary objectives:

(1) To assure that Medical Services provided to Subscribers are Medically Necessary; and

(2) To assure that Medical Services meet locally developed community standards for quality care and are provided at the appropriate level of care.

II. DEFINITIONS

The following definitions are in addition to any definitions provided in Article I of the PARTICIPATING PROVIDER AGREEMENT:

A. “Certification Letter” means a document on which is stated PCMI determinations regarding the Utilization Management performed pursuant to this AGREEMENT.

B. “Review Coordinator” means a professionally qualified person who is competent to conduct initial review, data analysis and other functions involved in the Utilization Management performed pursuant to this AGREEMENT.

C. “Physician Advisor” means a validly licensed physician who is employed by or on contract to PCMI to carry out Utilization Management.

D. “Norms” means numerical or statistical measures of observed performance of health care services derived from aggregated information related to the health care services provided to a statistically significant number of persons, as developed by PCMI.

E. “Screening Criteria” means those written guidelines adopted by PCMI pursuant to this EXHIBIT B.

III. RESPONSIBILITIES OF PARTICIPATING PROVIDERS, AND THE REVIEW ORGANIZATION

A. Responsibilities of PCMI:

(1) PCMI shall develop, update and maintain Screening Criteria.

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a. Screening Criteria shall be based on professional expertise, current professional literature, and cumulative information on health care services provided within the community to a statistically significant number of persons.

b. Screening Criteria shall be developed to enable the Review Coordinator to select for review by Physician Advisor only those cases which appear outside locally accepted professional norms.

(2) PCMI shall utilize professionally qualified review personnel to perform the duties of Review Coordinators. Such Review Coordinators shall have authority to use the Screening Criteria to provide /pre-service authorization. Denials shall be determined by a Physician Advisor only.

(3) PCMI shall respond to requests for pre-service review by providing a determination by telephone within three (3) Working Days of such requests. A control number shall be given to the PROVIDER or his or her authorized representative.

(4) PCMI shall provide written notifications of approved requests for pre-service review on a Precertification Letter within three (3) Working Days of the requests.

(5) PCMI shall respond to requests for reconsideration of denied pre-service requests by making a redetermination and communicating the results to the PROVIDER by telephone and in writing within three (3) Working Days of the request.

(6) In making any determination regarding whether an inpatient hospital admission or a continued inpatient hospital stay is Medically Necessary, PCMI shall consider all relevant information. PCMI shall document its actions and the rationale for its determinations.

B. Responsibilities of the PROVIDER:

(1) The PROVIDER shall request a pre-service review from PCMI at least three (3) Working Days prior to a scheduled procedure for outpatient services listed in Subscriber's Health Benefit Agreement, in order to avoid retrospective denial of payment for such services provided to Subscribers. Such services include but are not limited to:

a. Diagnostic radiology,
b. Durable Medical Equipment,
c. Gastric bypass,
d. Home infusion therapy,
e. Home nursing care,
f. Oral pharynx procedures,
g. Therapeutic radiology,
h. Orthotics and prosthetics,
i. Outpatient procedures,
j. Sleep Management program,
k. Speech Therapy. Physical therapy & Occupational therapy
l. Spinal procedures

(2) The PROVIDER shall request a pre-service review from PCMI at least two (2) Working Days prior to a scheduled service for specialty care visits for all non-emergency services. Specialty care is defined as all services other than: a) family practice; b) internal medicine; c) pediatrics; d) OB/GYN.

(3) At least the following information shall be provided by the PROVIDER to PCMI at the time of the request for preauthorization:

a. patient's name and i.d. number,
b. patient's age and sex,
c. diagnosis,
d. reason for admission,
e. scheduled date of admission,
f. planned procedure or surgery,
g. date of planned procedure or surgery,
h. name of hospital to which the member will be admitted,
I. name and telephone number of PROVIDER,
j. other information as may be requested by PCMI.

(4) In cases of requests for organ/tissue transplants, the requesting PROVIDER shall complete and submit a clinical questionnaire provided by PCMI, as well as submit copies of laboratory and other diagnostic testing documentation as requested by the Physician Advisor.

IV. OTHER PROCEDURES AND INFORMATION

A. Utilization Management and Payment of Claims:

(1) The certification number shall be written on the claim form when the claim form is submitted to PCMI for payment. Claim forms without the certification number will be returned to the PROVIDER. All Participating Providers must submit certification numbers with claim forms.

(2) Participating Providers submitting claims by way of electronic data entry shall indicate, in the appropriate space on the screen that the Certification Letter is on file with the PROVIDER. Claims without that indication will be denied.

B. Responsibility for Payment Determination:

The Utilization Management decision is solely for the purpose of determining whether Medical Services are Medically Necessary. Claim processing and payment determination shall be the sole responsibility of PCMI in accordance with the applicable Benefit Agreement coverage.

V. REFERRAL CARE

A. Referral to Specialty Care providers is required in order to receive the maximum benefits available under the Health Benefits Agreement. The PROVIDER shall request a pre-service review from PCMI at least two (2) Working Days prior to a scheduled service for specialty care visits for all non-emergency services. Specialty care is defined as all services other than: a) family practice; b) internal medicine; c) pediatrics; d) OB/GYN.