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Dear Provider,

It is my pleasure to introduce you to Meridian Health Plan. As one of the fastest growing Medicaid managed care organizations in the State of Michigan, we know our success is based on the relationships we have with our providers. Meridian cultivates those relationships by offering several distinct services that differentiate it from others.

Sincerely,

[Signature]

David B. Cotton, MD
President/CEO
Meridian Health Plan
About Meridian

Our Mission
To continuously improve the quality of care in a low resource environment

Our Vision
• To be the premier service organization in healthcare
• To be the #1 Medicaid Health Plan in Michigan based on quality, innovative technology and service to our members

Corporate History
Meridian Health Plan is a Medicaid health plan contracted with the Michigan Department of Community Health (DCH) to provide health care services. Meridian was formed from the merger of two clinic plans, Central Michigan Health Plan (CMHP) and American Preferred Provider Plan of Michigan (APPPM). CMHP was founded by physicians at the Jackson Northwest Clinic located in Jackson, Michigan in December 1996.

In August 1997, Dr. David B. Cotton acquired a majority position in CMHP and assumed fiscal and administrative responsibility for the plan, which had approximately 1,400 members. CMHP acquired APPPM in January 1999 and ultimately became operational as Health Plan of Michigan (HPM) in May 1999. In January 2000, HPM acquired the Michigan membership of Family Health Plan of Ohio.


Service Description
Meridian provides a wide range of Medicaid covered benefits for its enrollees, including preventive care, physician office visits, diagnostic tests, home health care, inpatient hospital care and emergency department treatment. All services are provided based on the State of Michigan Medicaid benefit guidelines.
Key Features

Timely claims processing
- Meridian pays clean claims within 10 business days
- Electronically billed claims are paid even faster
- Majority of claims processed in 2-5 days

Simplified administration and authorization process
- Secure, online Provider Portal allows providers to view member eligibility, enter authorizations, verify claims status, request direct assistance from Care Coordination, Behavioral Health and Member Services, and review member health history, including previous utilization from other health plans
- Majority of routine outpatient surgeries are automatically approved online
- Authorizations are not needed for diagnostic lab or x-ray (including MRI, CT Scan, etc.)

Incentive programs
- Patient Centered Medical Home (PCMH) program with incentives ranging from $1 to $3 pmpm
- Generous incentives based on HEDIS measures ranging between $20 and $200 per service
- Paid over $11 million in quality bonuses to participating providers in 2014

Hassle-free policies and procedures
- Meridian will reimburse PCPs for well and sick visits provided during the same visit
- Meridian pays the co-pays so physicians do not have to collect them
- Comprehensive drug formulary - licensed pharmacist available at MeridianRx for consultation
- Assigned local provider representative to handle all questions and concerns

Meridian Health Plan
- Physician owned and operated since 1997
- Excellent Health Plan Accreditation rating from NCQA
- NCQA HEDIS Compliance Audit Certification

Population Management

Member Outreach
Each new member receives a welcome call within the first 30 days of enrollment to verify primary care provider selection, explain Meridian’s managed care processes, and perform a Health Risk Assessment. In addition, members receive periodic telephone calls to remind them of important preventive services such as well-child visits, immunizations, prenatal care and other screenings.
**Health Risk Assessment (HRA)**

**Meridian Health Plan members** are contacted via phone and interviewed regarding their medical history. Based on the results of the HRA, members are assigned to Disease Management programs or Care Coordination services, or screened for required preventive services, as appropriate. All data gathered through these activities is captured in Meridian’s state of the art Managed Care System (MCS). This data collection supports a comprehensive approach to preventive care and health management for our members and providers.

**Healthy Michigan Plan members** are mailed a paper HRA upon enrollment to bring with them to their first PCP visit. The member must fill out Sections 1-3. PCPs are instructed to fill out Section 4 of the Healthy Michigan Plan HRA with the Healthy Michigan Plan member, then sign as an attestation of the agreed upon healthy behavior and the appointment. A copy of the signed HRA should be provided to the member, and the completed HRA should be faxed to Meridian at 313-324-9120. A copy of the Healthy Michigan Plan HRA can be found www.mhplan.com/hmp under the Providers section titled “Healthy Michigan Plan HRA”.

**Care Coordination**

Meridian Care Coordination integrates the behavioral and physical needs of the member and coordinates referrals to maximize treatment success and outpatient care services. The Meridian Care Coordination model seeks to accomplish this by:

- Focusing attention on the individual needs of members
- Promoting and assuring service accessibility
- Maintaining communication with the member/caregiver, providers and community
- Identifying and removing barriers through collaboration with the PCP, specialists, member and family to develop a plan of care
- Integrating behavioral health and specialty care into care delivery
- Educating members on condition management, appropriate use of services and self-care techniques

Members enrolled in Care Coordination are stratified based on claims, historical and HRA data and are assigned to an acuity level of one through three, with three being the most complex. Target populations include:

- Pregnant members at all acuity levels
- Adults and children with special needs
- High-risk and high-cost populations with multiple health and social needs
- Members requiring post-hospitalization assessment and follow up
- High ER utilizers requiring education and communications with PCP
- Members with level three chronic conditions or more than one chronic diagnosis, regardless of risk stratification
- Members with medical needs who are also suffering from psychosocial and behavioral health risk factors

Providers may refer members to Care Coordination by clicking the “Notify Health Plan” button within our Provider Portal, or by calling Meridian at 888-437-0606.

**CSHCS**

Effective October 1, 2012 the Michigan Department of Community Health (MDCH) began enrolling beneficiaries that have both Medicaid and Children’s Special Health Care Services (CSHCS) to Meridian Health Plan.

All of Meridian’s CSHCS members will be enrolled into our Care Coordination program.

To assist our contracted Primary Care Providers with the added coordination of care for these beneficiaries, Meridian will pay a per-member per-month (PMPM) administrative payment for the CSHCS population. For beneficiaries that are part of the CSHCS-ABAD program, Meridian will pay an $8 PMPM, and for beneficiaries that are part of the CSHCS-TANF program, Meridian will pay a $4 PMPM.
Complex Case Management
Meridian members who are considered high-risk due to multiple chronic conditions, physical or developmental disabilities, serious mental illness, severe injuries and other needs are enrolled in Complex Case Management. These members require treatment and interventions across a variety of care domains including medical, social and mental health. These members typically see multiple providers at multiple locations and require assistance in coordinating their complex care. Members have the option to accept or decline Complex Case Management for their care; it is not a requirement. This program is provided to members free of charge. Providers may refer members to Complex Case Management by clicking the “Notify Health Plan” button within our Provider Portal, or by calling Meridian at 888-437-0606.

Disease Management
Meridian has developed Disease Management programs that are available to all eligible members. These programs include diabetes, asthma, cardiovascular and COPD. Members in the Disease Management programs are stratified based on claims data and are assigned to a level of one through three, with three being the most complex. These members will be identified on your monthly enrollment list. The Disease Management department provides education and outreach to members and providers. Providers may refer members to Disease Management by clicking the “Notify Health Plan” button on our Provider Portal, or by calling Meridian at 888-437-0606.

Provider Manual

Meridian Health Plan would like to inform our providers about the availability of our Provider Manual.

The Provider Manual offers detailed information about Meridian’s policies and procedures and the rights and responsibilities of our providers and members. You can access the Provider Manual by:
- Downloading it from the Meridian website, located at www.mhplan.com/mi/providers under “Provider Manual”
- Requesting a CD version or printed copy from your Provider Network Development Representative

NCQA Excellent

Meridian Health Plan holds Excellent Health Plan Accreditation through the National Committee for Quality Assurance (NCQA).

NCQA is the most widely recognized accreditation program in the United States. Their commitment to comprehensive research and dedication to quality has helped improve the managed care experience for health plans, patients, care providers and employers.

To learn more about NCQA and its accreditation standards, please visit www.ncqa.org.
Commitment to Quality

The State of Michigan uses the nationally recognized Healthcare Effectiveness Data and Information Set (HEDIS®) to compare quality among the health plans serving the Medicaid population. Meridian has made HEDIS improvement a corporate priority, with a goal of becoming the Top Medicaid health plan in the State of Michigan based on HEDIS performance.

In 2014, Meridian was among the top five Medicaid health plans in the State of Michigan for the following HEDIS measures based on the 2014 Quality Compass Reports:

- Adolescent Well-Child Visits
- Adults’ Access to Preventive/Ambulatory Health Services (20-44 Yrs)
- Adults’ Access to Preventive/Ambulatory Health Services (45-64 Yrs)
- Adult BMI
- Breast Cancer Screening (Combined Rate)
- Cervical Cancer Screening
- Child BMI
- Children and Adolescents’ Access to PCP (12-24 Months)
- Children and Adolescents’ Access to PCP (25 Months-6 Yrs)
- Children and Adolescents’ Access to PCP (7-11 years)
- Children and Adolescents’ Access to PCP (12-19 Yrs)
- Chlamydia Screening (Combined Rate)
- Comprehensive Diabetes Care- HbA1c Testing
- Controlling High Blood Pressure
- Lead Screening
- Prenatal Care
- Well-Child Visits 0-15 Months - 6+ Visits

Throughout the year, Meridian monitors its HEDIS performance and conducts improvement activities to meet its goals, including education and outreach to members and providers.

Eligibility

All Meridian members are issued an ID card upon enrollment and are asked to present this card at each appointment. Member Eligibility may be checked via the Meridian Provider Portal, CHAMPS, WebDENIS or Netwerkes. You may also use Meridian’s Eligibility Verification Line. Just call 855-291-5228 and follow the directions as prompted. The system will verify if the member is eligible on the date of service indicated. You may also verify eligibility by calling the Meridian Member Services department at 888-437-0606. PCPs will also receive monthly enrollment via fax by the first of every month.

No Co-Pays

Instead of lowering your reimbursement and burdening your office with the responsibility of collecting co-pays, Meridian has made the decision not to implement co-pays for our Medicaid members in cooperation with our provider partners.
Behavioral Health

No prior authorization is required for the first 3 visits. Notification from the Behavioral Health Provider to Meridian is requested for the remaining 17 visits.

The PCP does not have to be involved with the coordination of behavioral health care.

The Continued Outpatient Treatment Notification form is available at www.mhplan.com/mi/providerdocuments.

Meridian Behavioral Health Care Management Department: 888-222-8041 / Fax: 313-202-1268

Preferred Laboratories

Meridian Health Plan has entered into Preferred Provider Agreements with Quest Diagnostics and JVHL for laboratory services. Meridian has partnered with Quest Diagnostics and JVHL in this Preferred Provider relationship to capture laboratory results to support HEDIS and other quality initiatives.

Meridian Health Plan does not require prior authorization for routine laboratory tests for in or out-of-network providers.

Quest Diagnostics: 800-444-0106   JVHL: 800-445-4979

Diabetic Supplies

All Meridian members with diabetes will receive a new Advocate Redi-Code Meter through our exclusive diabetic supply company, Healthy Living Medical Supply (HLMS). HLMS is also the exclusive supplier of insulin pumps for Meridian members.

The Advocate Redi-Code meter offers:
  • Small blood sample size (0.6 microliter)
  • No Coding of test strips
  • 6 second test time, with a 450-test memory
  • Talking meter providing results in both English & Spanish
  • Alternate site testing

Healthy Living Medical Supply should be utilized for any Meridian member who is newly diagnosed or needs a new glucometer, insulin pump and supplies. Please contact HLMS at 866-779-8512 for coordination.

If a Meridian member has questions or needs assistance using their new supplies, please instruct the member to contact HLMS.

Meridian will not reimburse for any other glucometer, insulin pump or testing supplies from any other Durable Medical Equipment vendor.
### Diabetic Supply Prescription

**Start Date:**

<table>
<thead>
<tr>
<th>Referred by:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Date of Birth:</strong></td>
<td>Male □ Female □</td>
</tr>
<tr>
<td><strong>Address:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>City:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>State:</strong></td>
<td>MI</td>
</tr>
<tr>
<td><strong>Zip Code:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Phone #:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Phone #2:</strong></td>
<td></td>
</tr>
</tbody>
</table>

### Insurance

- **Meridian Health Plan ID:**
- **HMO Plan:**
- **Medicaid ID:**
- **Policy ID:**

### DURATION of need:

- **Duration of need:** □ Lifetime □ Other: ___________
  (The maximum allowed duration is 12 months. The duration will default to this unless specified otherwise.)
- □ Pre Existing □ New

### Diagnosis Code: (please circle)

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th>648._____</th>
<th>Due Date: __________</th>
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</thead>
<tbody>
<tr>
<td>250.00</td>
<td>250.01</td>
<td>250.02</td>
<td>250.03</td>
<td>Other: __________</td>
</tr>
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</table>

Is patient treated with insulin? □ Yes □ No

**On Insulin Pump?** □ Yes □ No

### Diabetes Testing Supplies: (please circle)

- Glucose Monitor
- Test Strips
- Lancets
- Alcohol Pads
- Control Solution
- Other: __________

### Recommended Testing Frequency:

- □ 1 time a day = up to 50 test strips/100 lancets
- □ 2 times a day = up to 100 test strips/100 lancets
- □ 3 times a day = up to 100 test strips/100 lancets
- □ 4 times a day = up to 150 test strips/200 lancets
- □ 5 times a day = up to 150 test strips/200 lancets
- □ 6 times a day = up to 200 test strips/200 lancets
- □ Other: __________ times a day

I have seen this patient within the last six (6) months to evaluate their diabetes control and have noted the reason(s) for a testing frequency of more than 6x a day: ____________________________________________________________________________.

**Physician Name:**

**Date:**

**Physician Signature:**

**DEA:**

**Address:**

**NPI:**

**Phone#:**

**Fax#:**

### HEDIS Data: Please fill in the result only within the Last 6 months for the following tests:

<table>
<thead>
<tr>
<th>Test (most recent)</th>
<th>Date of Test</th>
<th>Score/Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>LDL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HbA1c</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood Pressure</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Test (most recent)</th>
<th>Date of Test</th>
<th>Score/Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dilated Eye Exam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Micro albumin</td>
<td></td>
<td></td>
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<tr>
<td>BMI</td>
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</tbody>
</table>
Meridian Health Plan has contracted with MeridianRx to administer all pharmacy benefits. The formulary is available on our website (www.mhplan.com) and through Epocrates. We also have a relationship with Surescripts, giving our providers the opportunity to ePrescribe for Meridian members while integrating our policies and procedures.

In order to enjoy the benefits of ePrescribe, a provider must have an appropriate Electronic Medical Record System (EMR) or ePrescribing system.

If you are currently using an EMR or ePrescribe software, chances are that your software is already currently certified by Surescripts. To find out if your software is certified, or to find out more about e-Prescribing, we invite you to view the Surescripts website at www.surescripts.com.

e-Prescribing allows providers to electronically send an accurate, error-free and understandable prescription directly to a pharmacy from the point of care. This is an important element in improving the quality of patient care. Electronic prescribing has been instrumental in reducing medication errors.

MeridianRx Support:
866-984-6462

MeridianRx Fax:
877-355-8070
**Request for Medication Prior Authorization**

Phone 866-984-6462 / Fax 877-355-8070

**Only one medication request per form**

All fields must be complete and legible for review

Prior Authorizations cannot be completed over the phone

---

**Patient Information**

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
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<tbody>
<tr>
<td>Patient Name:</td>
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</tr>
<tr>
<td>Member ID#:</td>
<td></td>
</tr>
<tr>
<td>Sex (circle): Male</td>
<td>Female</td>
</tr>
<tr>
<td>Date of Birth:</td>
<td></td>
</tr>
<tr>
<td>Patient Phone:</td>
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</table>

**Prescriber Information**

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<th>Field</th>
<th>Information</th>
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<tbody>
<tr>
<td>Prescriber Name and Specialty:</td>
<td></td>
</tr>
<tr>
<td>NPI#:</td>
<td></td>
</tr>
<tr>
<td>Office Phone:</td>
<td></td>
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<tr>
<td>Office Fax:</td>
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<tr>
<td>Contact Person:</td>
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**Diagnosis and Medical Information**

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<th>Field</th>
<th>Information</th>
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<tbody>
<tr>
<td>Medication:</td>
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</tr>
<tr>
<td>Strength and Route of Administration:</td>
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<tr>
<td>Frequency:</td>
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<tr>
<td>Height and Weight:</td>
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<td>Expected Length of Therapy:</td>
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<td>BMI:</td>
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<td>Date Calculated:</td>
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<tr>
<td>Diagnosis Related to Medication Request:</td>
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<tr>
<td>Blood Pressure:</td>
<td></td>
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<tr>
<td>Taken on:</td>
<td></td>
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<tr>
<td>Drug Allergies:</td>
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**Rationale for Prior Authorization**

History of a medical condition, allergies or other pertinent information requiring the use of this medication:

_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

Previous use of non-authorized and prior authorized medications tried and failed for this condition:

<table>
<thead>
<tr>
<th>Name of Medication:</th>
<th>Reason for Failure:</th>
<th>Date of failure:</th>
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Relevant laboratory tests or procedures. Please attach most recent info to ensure a complete PA review:

<table>
<thead>
<tr>
<th>Test:</th>
<th>Results:</th>
<th>Date of test:</th>
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</table>

**Prescriber’s Signature:**

Date: ______________________

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**Confidentiality Notice:** The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender (Via return FAX) immediately and arrange for the return or destruction of these documents. **Revised 12/19/2011**
Patient Centered Medical Home Incentive Program

Meridian Health Plan would like to offer Primary Care Providers contracted with us our Patient Center Medical Home (PCMH) Incentive Program. This incentive program not only rewards our providers that have already received designation as a PCMH, but also encourages providers to become a PCMH. To qualify for this program you must be a contracted Primary Care Provider, on a fee-for-service contract and open to and accepting new Meridian* enrollees. Please review the outline of the program below and contact your local Provider Network Development Representative for the full details of this incentive program.

Meridian PCP PCMH Bronze

Qualifications
- Contracted – Fee for Service
- Open to and accepting new Meridian members
- Meridian membership of 100+
- Level 1 NCQA recognition or score of 35-59 on the Baseline Self-Assessment Tool (Passing all Must Pass Elements)

Administrative Payment
- $1.00 PMPM
- Meridian HEDIS Bonus Program

Meridian PCP PCMH Silver

Qualifications
- Contracted – Fee for Service
- Open to and accepting new Meridian members
- Meridian membership of 100+
- Level 2 NCQA recognition or score of 60-84 on the Baseline Self-Assessment Tool (Passing all Must Pass Elements)

Administrative Payment
- $2.00 PMPM
- Meridian HEDIS Bonus Program

Meridian PCP PCMH Gold

Qualifications
- Contracted – Fee for Service
- Open to and accepting new Meridian members
- Meridian membership of 100+
- PCMH recognition by Joint Commission, URAC or AAAHC and/or level 3 NCQA recognition or score of 85-100 on the Baseline Self-Assessment Tool (Passing all Must Pass Elements)

Administrative Payment
- $3.00 PMPM
- Meridian HEDIS Bonus Program

*Excludes Healthy Michigan Plan enrollees. $10,000 annual cap per provider
Meridian Health Plan has a team of trained Medical Record Abstractors that may reach out to your office to conduct a record review. Meridian has exciting new technology that allows our staff to quickly and efficiently review your records to maximize your HEDIS incentives.

## HEDIS® Bonus Program

Meridian Health Plan will continue the HEDIS Bonus Program for all contracted Primary Care Providers in 2015. The yearly bonus period will cover all HEDIS services provided between dates of service January 1, 2015 and December 31, 2015. These services must be reported to Meridian on a claim form or via fax by February 28, 2016 in order to be eligible for a bonus payment. Providers may also submit HEDIS service information through Meridian’s secure web portal.

To qualify for a bonus payment, the service must be delivered in strict accordance with HEDIS guidelines. Services which are delivered, but do not meet strict HEDIS guidelines will not be eligible for a bonus. HEDIS guidelines are attached for the bonus measures. Timeframes and enrollment criteria for each measure must be met.

Bonuses will be paid in four installments. The first payment will be made at the end of April 2015, followed by a payment at the end of July 2015, the end of October 2015 with the final payment during March 2016.

Meridian will provide each PCP with a monthly HEDIS report either electronically through the Meridian Provider Portal or in a hard copy. The report will list all members who require HEDIS services. Specifically, a child member needing immunizations will remain on the list until all immunizations are received, or the second birthday passes. Childhood members requiring well-child visits will remain on the list until all 6 visits are received, or until the 15-month birthday passes. If members change PCPs but are still enrolled with Meridian, they will show on the new PCP lists.

In addition, Provider Network Development Representatives will meet with each practice to answer questions and assist in developing a plan to ensure Meridian members receive these very important services.

Meridian is committed to ensuring that our members receive quality preventive health care.
Meridian Outreach

Meridian Health Plan wants to make sure that all of our members receive the preventive care they need. In order to demonstrate our commitment, Meridian has dedicated significant resources to its member outreach programs.

All of these efforts result in higher HEDIS scores and help our providers obtain their incentive bonuses. This summary of Meridian’s outreach efforts for 2013 demonstrates our commitment to quality:

- Meridian’s Member Outreach Team made over 540,580 phone calls to Meridian households to remind them of important preventive services, including:
  - Well-Child and Adolescent Visits
  - Child and Adolescent Immunizations
  - Blood Lead Testing
  - Breast and Cervical Cancer Screenings
  - Diabetes Testing (HbA1c, LDL, Eye Exams)

- All of these outreach phone calls were provided by a live person, not a pre-recorded voice message. On every call, the member outreach specialist verifies the member’s demographic information and PCP selection, in addition to providing outreach reminders
- Over 75,700 members had a HEDIS hit with a date of service after receiving an Meridian outreach call
- Meridian mailed over 730,000 outreach educational mailings to its members to remind them of important preventive services
- Over 13,450 hours of staff time were utilized to make outreach calls
- Over 190 incentives were distributed to our members for obtaining preventive health services, including gift cards, Apple iPads, Xbox Kinect Bundles and Fisher Price Smart Cycles
- Meridian sponsored or participated in over 62 community events, including health fairs and lead screening fairs

The Meridian Provider Services department can work with PCP offices to design a targeted mail outreach program especially for your patients. Over 114,115 postcard reminders were sent to patients by Meridian on behalf of PCP offices in 2013.

Charitable Activities
Meridian Health Plan is committed to and engaged with our local communities and the entire State of Michigan. Our donations of time and dollars demonstrate the commitment of Meridian Health Plan and our employees to fostering programs that improve the quality of care in a low resource environment.
Avoid Missed Opportunities

According to the National Committee for Quality Assurance and HEDIS specifications, infants need at least six well-child visits between the ages of 0 and 15 months. Children between the ages of 3-6 years and adolescents between the ages of 12-21 years need one well-child visit every year. A well-child visit includes:

- Health and developmental history (physical and mental)
- Physical exam
- Health education/anticipatory guidance

What is a Missed Opportunity?
Meridian Health Plan wants providers to avoid missed opportunities. Take advantage of every office visit to provide the preventive health services our members need, including well-child visits, immunizations and lead testing. Here are some tips to maximize those visits:

Turn a Sick Visit into a Well-Child Visit
Meridian Health Plan will reimburse providers for a well-child visit and a sick visit performed on the same day. Simply add a modifier 25 to the sick visit and bill for the appropriate well visit.

Turn a Sports Physical into a Well-Child Visit
Many children request sports physical annually to participate in school and community activities. Just add anticipatory guidance to the sports physical's medical history and physical exam, and you can turn it into a well-child visit.

Make Every New Patient Visit a Well-Child Visit
New patients usually require a health and developmental history and a physical exam. Add some health education, and you have provided a well-child visit. Include the V20.2 diagnosis code to your claim, along with the appropriate CPT code for the new patient visit.

Don’t Wait a Year for the Next Well-Child Visit
Meridian pays for one well-child visit per calendar year - the visits do not have to be 12 months apart, or coincide with the child’s birthday. For example, if you provided a well-child visit in October 2013 and the child is back in your office in May 2014, you can provide a well-child visit and Meridian will reimburse you.

Meridian Offers a Quality Incentive Bonus for Well-Child Visits
For every well-child visit performed on an assigned member in accordance with HEDIS specifications, providers will receive a bonus payment between $25 and $100.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>CPT Codes</th>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-15 Months</td>
<td>99381, 99382, 99391, 99392, 99432</td>
<td>V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9</td>
</tr>
<tr>
<td>3-6 Years</td>
<td>99382, 99383, 99392, 99393</td>
<td>V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9</td>
</tr>
<tr>
<td>12-21 Years</td>
<td>99383, 99384, 99385, 99393, 99394, 99395</td>
<td>V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9</td>
</tr>
</tbody>
</table>
The Meridian Health Plan website has been updated with the following features:

- Provider manual
- Provider directory
- Formulary
- Bulletins
- Forms
- Useful links and information
- Live online chat services
- Plus much more

Meridian Provider Portal

The Meridian Provider Portal is available FREE for contracted providers with the following features:

- Verify eligibility for ANY Meridian member
- Authorizations
- Claims status and submission/correction
- Meridian member information & reports
- Enrollment lists
- HEDIS Bonus information
- HEDIS self-reporting
- Request HEDIS postcards
- Plus much more

A Meridian-supplied user name is required for access. To sign up, please visit our website at www.mhplan.com/mi/mcs. If you have any questions, please contact your Provider Network Development Representative.
Referrals
Referral processing is the primary activity performed by our Utilization Management Specialist staff. The Specialists are assigned in teams by provider group and region. If you have a referral request or question, please contact a member of your team. They will be glad to help you.

Meridian offers three easy ways to submit referrals:

1. Electronically through Meridian’s secure Provider Portal

2. By fax to the Utilization Management regional team fax numbers. Please include pertinent clinical documentation with the request if indicated.

3. By phone for urgent requests. These must always be submitted by calling your regional team. Make sure you identify the request as “urgent” to expedite the pre-service review process. Please refer to page 28 for the contact and fax numbers of your regional team.

Pre-Service Clinical Review Program
Meridian clinical staff must review select services before they are provided. Clinical review assists in determining whether the service is clinically appropriate, is performed in the appropriate setting, and is a covered benefit. Please forward the pertinent clinical information with your request via fax or the secure Meridian Provider Portal services to expedite a response.

Refer to the next page for the services that require clinical review.

Utilization Management clinical staff use plan documents for benefit determination and Medical Necessity Coverage Guidelines to support Utilization Management decision-making. All Utilization Review decisions to deny coverage are made by Meridian’s Medical Directors. In certain circumstances, external reviews of service requests are conducted by qualified, licensed physicians with the appropriate clinical expertise.

Provider Appeal
Providers may appeal a denial either before or after a service is rendered. In the instance of a pre-service denial, Meridian’s nurse reviewer contacts the provider office by phone to inform them of the denial decision and the reason for the denial. The nurse reviewer also provides contact information to discuss the denial with an Meridian Medical Director.

Written denial notification is sent via fax and mailed to the member. Treating providers who would like to discuss a utilization review determination with the decision-making Medical Director may contact the Utilization Management department at 888-322-8843. The written denial notification will include the reason for the denial, the reference to the benefit provision and/or clinical guideline on which the denial decision was based, and directions on how to obtain a copy of the reference. You may contact the Utilization Management department at 888-322-8843 to request a copy of Meridian’s medical necessity guidelines.
Authorization Overview

MEDICAID PRIOR AUTHORIZATION PROCEDURES OVERVIEW

You may forward your request to Meridian via fax: 313-463-5254 or contact Meridian by Phone: 888-322-8844.

Most outpatient services are auto approved via the secure Meridian Provider Portal at www.mhplan.com/mi/mcs.

<table>
<thead>
<tr>
<th>No Prior Authorization</th>
<th>Primary Care Provider (PCP)/Specialist Notification to Meridian (in or out of network)</th>
<th>Corporate Prior Authorization (may require clinical information)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy Testing</td>
<td>Complex Outpatient Treatment • Dialysis</td>
<td>Ambulance Transportation (non-emergent)</td>
</tr>
<tr>
<td>Audiology Services and Testing (excluding hearing aids)</td>
<td>• Outpatient Radiation Therapy</td>
<td>Anesthesia (when performed with radiology testing)</td>
</tr>
<tr>
<td>Barium Enema</td>
<td>Maternity Care/Delivery Notification is needed for OB referrals and for OB delivery.</td>
<td>Any Out-of-State Service Request (physician or facility)</td>
</tr>
<tr>
<td>Bone Densitometry Studies</td>
<td></td>
<td>Bariatric Surgery</td>
</tr>
<tr>
<td>Brain Surgery*</td>
<td>Specialist Office Visits/Consults Meridian Health Plan requests notification to communicate services with all providers involved, provide additional reporting services and support Case and Disease Management efforts.</td>
<td>Cardiac and Pulmonary Rehab</td>
</tr>
<tr>
<td>Bronchoscopy</td>
<td>PCP/Specialist Notification is not Necessary for Claims Payment. In-network or out-of-network practitioners will be reimbursed for consultations, evaluations and treatments provided within their offices, when the member is eligible and the service provided is a covered benefit under Michigan Medicaid and the Medicaid MCO Contract.</td>
<td>Chemotherapy and Specialty Drugs • May require review under the medical or pharmacy benefit</td>
</tr>
<tr>
<td>Cardiac Procedures*</td>
<td>Speciality Network Access Form (SNAF) All referrals for Specialty Care at Hurley Hospital and Michigan State University must follow the SNAF process. Please contact the Meridian Care Management Department directly for referrals to specialists at these entities. Meridian is required to complete a specific referral form on behalf of the PCP.</td>
<td>DME/Prosthetics and Orthotics &gt; $1000 (faxed requests only)</td>
</tr>
<tr>
<td>Cardiac Stress Test</td>
<td>MeridianRx is the Meridian Pharmacy Benefit Manager. If you have questions about the formulary or prior authorizations, please call 866-984-6462.</td>
<td>Elective Inpatient/Surgeries and SNF Admissions</td>
</tr>
<tr>
<td>Cardiograph</td>
<td></td>
<td>Elective Hospital Outpatient Surgery • See Bulletin on Reduction of Auth Requirements</td>
</tr>
<tr>
<td>Chemotherapy/Infusions*</td>
<td></td>
<td>Genetic Testing</td>
</tr>
<tr>
<td>Chiropractic Services (in-network only)</td>
<td></td>
<td>Hearing Aids</td>
</tr>
<tr>
<td>Cleft Lip Repair*</td>
<td></td>
<td>Hereditary Blood Testing (e.g., BRCA for breast and ovarian cancer)</td>
</tr>
<tr>
<td>Colposcopy after an Abnormal Pap</td>
<td></td>
<td>Home Health Care</td>
</tr>
<tr>
<td>DME/Prosthetics and Orthotics ≤ $1000 (in-network only)*</td>
<td></td>
<td>Hospice and Infusion Therapy</td>
</tr>
<tr>
<td>Electrocardiography</td>
<td></td>
<td>Infusions</td>
</tr>
<tr>
<td>Endoscopy</td>
<td></td>
<td>Specialty Drugs (covered under the medical benefit)</td>
</tr>
<tr>
<td>Gastroenterology Diagnostics</td>
<td></td>
<td>• e.g. Rituxin and Remicade</td>
</tr>
<tr>
<td>GI Procedures*</td>
<td></td>
<td>• View a complete list at <a href="http://www.mhplan.com">www.mhplan.com</a></td>
</tr>
<tr>
<td>Habilitative Therapy Services (21 and under)</td>
<td></td>
<td>Weight Management (prior to bariatric surgery)</td>
</tr>
<tr>
<td>Hernia Repair*</td>
<td></td>
<td>All emergency inpatient admissions, surgeries and out-of-network 23-hour observations require corporate authorization. For emergency authorizations, Meridian must be notified within the first 24 hours or the following business day.</td>
</tr>
<tr>
<td>Intravenous Pyelography (IVP)</td>
<td></td>
<td>Out-of-network hospitals must notify Meridian at the time of stabilization and request authorization for all post-stabilization services.</td>
</tr>
<tr>
<td>Life-Threatening Emergencies (ER Screening)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lymph Node Surgery*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mammogram and Pap Test</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Myoview Stress Test</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nerve/Tendon Surgery*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurology and Neuromuscular Diagnostic Testing (EEGs, 24-Hour EEGs and EMGs)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Invasive Vascular Diagnostic Studies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obstetrical Observations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orbital Procedure*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthopedic Replacement/Revision*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical, Occupational, and Speech Therapy (evaluations only)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PT/OT/ST for 1st 24 visits age 21+*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulmonary/Vascular Procedures*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Lab</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine X-Ray (CT Scan, MRI, MRA, PET Scan, DEXA, HIDA Scans)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sigmoidoscopy or Colonoscopy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin Graft*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sleep Studies (Facility only)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SPECT Pulmonary Diagnostic Testing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spleen/Liver Procedure*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ultrasounds</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Video EEG*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision/Glasses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Voiding Cysto-Urethrogram</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23-Hour Observation for In-Network Facilities Only</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*These outpatient surgeries do not require authorization when performed at in-network facility. OON facilities require prior authorizations.

' All DME supplies and chiropractic services should be provided by an in-network provider.

Outpatient Mental Health Services: No prior authorization is required for the first 3 visits, but notification using the Continued Outpatient Treatment Notification Form (COTNF) from the Behavioral Health Provider to Meridian is required for the remaining 17 visits. The COTNF form is located at www.mhplan.com. The Medicaid benefit is 20 outpatient mental health visits per calendar year. Please contact the Meridian Behavioral Health department for assistance at 888-222-8041.

Non-Covered Benefits: The following services are not covered benefits under Medicaid and will not be reimbursed by Meridian: Aqua Therapy, Children’s Speech, Physical and Occupational Therapy covered under School Based Services, Community mental health services, Convenience Items, Cosmetic Services, Functional Capacity, Infertility Services and any other service otherwise not covered by Medicaid.

Note: Prior Authorization Procedures refer to Medicaid covered services ONLY.
Claims Payments & Status
Meridian Health Plan is dedicated to processing your claims in under 10 days. You may status your claims several ways:

- Meridian’s secure Provider Portal:
  www.mhplan.com/mi/mcs
- By Phone:
  800-203-8206
- By Fax:
  313-324-3642
- By Mail
  Meridian Health Plan Claims Department
  1001 Woodward Ave, Suite 510
  Detroit, MI 48226

Claims Appeal Process
Meridian Health Plan makes every reasonable effort to partner with our providers. In cases where a claim has been denied, providers may submit an appeal in writing within 30 days of the denial. Please include the following:

- Patient name and ID#
- Reason for appeal
- Any relevant clinical information to support your appeal

The Health Plan Appeals Committee meets regularly to review these appeals. You will receive a response within 30 days.

Meridian is continually making efforts to improve the efficiency of its claims payment by increasing automation of its processes. The two measures of claims efficiency are electronic claims submission and auto-adjudication. These automated processes support timely claims payment. The following chart demonstrates the level of automation of Meridian’s claims processing.

<table>
<thead>
<tr>
<th>Efficiency of Claims Processing</th>
<th>Automated</th>
<th>Manual</th>
</tr>
</thead>
<tbody>
<tr>
<td>EDI Submission</td>
<td>89%</td>
<td>11%</td>
</tr>
<tr>
<td>Auto Adjudication</td>
<td>77%</td>
<td>23%</td>
</tr>
</tbody>
</table>

Meridian consistently meets the State of Michigan performance requirements for timely claims payment.

- Total Claims Processed in 2013 = 4,615,510
- Average Monthly Claims Volume = 384,626
- Average Claims Payment Time = 1.90 Days
- Claims Payment Accuracy Level = 98.79%
- % of Calls Answered within 30 Seconds = 99.9%
Billing Information

Meridian Health Plan follows the State of Michigan Medicaid billing guidelines unless otherwise noted.

• By Mail
  Meridian Health Plan
  1001 Woodward Avenue, Suite 510
  Detroit, MI 48226

Meridian Electronic Claim Submission (EDI) Vendors

<table>
<thead>
<tr>
<th>Vendor</th>
<th>Customer Support</th>
<th>Claim Types</th>
<th>Payer ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availity</td>
<td>800-Availity</td>
<td>Professional/Facility</td>
<td>52563</td>
</tr>
<tr>
<td>Blue Cross Blue Shield of MI</td>
<td>800-542-0945</td>
<td>Professional</td>
<td>98999</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2936</td>
</tr>
<tr>
<td>Emdeon (WebMD)</td>
<td>800-845-6592</td>
<td>Professional/Facility</td>
<td>83253</td>
</tr>
<tr>
<td>NDC</td>
<td>800-942-3022</td>
<td>Facility</td>
<td>52563</td>
</tr>
<tr>
<td>Netwerkes</td>
<td>866-521-8547</td>
<td>Professional/Facility</td>
<td>A0915</td>
</tr>
<tr>
<td>PayerPath</td>
<td>877-623-5706</td>
<td>Professional</td>
<td>52563</td>
</tr>
<tr>
<td>Per-Se</td>
<td>877-737-3773</td>
<td>Professional/Facility</td>
<td>52563</td>
</tr>
<tr>
<td>Relay Health</td>
<td>800-527-8133</td>
<td>Professional/Facility</td>
<td>52563</td>
</tr>
<tr>
<td>SSI Group</td>
<td>800-880-3032</td>
<td>Professional/Facility</td>
<td>52563</td>
</tr>
<tr>
<td>ZirMed</td>
<td>877-494-7633</td>
<td>Professional/Facility</td>
<td>Z1054</td>
</tr>
</tbody>
</table>

Per the MDCH Provider Manual, Section 11 – Billing Beneficiaries: When a provider accepts a patient as a Medicaid beneficiary, the beneficiary cannot be billed for the difference between the provider’s charge and the Medicaid payment for service. Members will not be balanced billed by a provider for the cost of any covered service, which includes any coinsurance, deductibles, financial penalties, or any other amount in full or in part.
Health care fraud, waste and abuse affects every one of us. It is estimated to account for between 3% and 10% of the annual expenditures for health care in the U.S. Health Care fraud is both a state and federal offense. Based on the HIPAA regulations of 1996, a dishonest provider or member may be subject to fines or imprisonment of not more than 10 years, or both (18USC, Ch. 63, Sec 1347).

The following are the official definitions of Fraud, Waste and Abuse: 42 CFR §455.2 Definitions.

**Fraud** means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

**Waste** involves the taxpayers not receiving reasonable value for money in connection with any government funded activities due to an inappropriate act or omission by players with control over or access to government resources (e.g. executive, judicial or legislative branch employees, grantees or other recipients). Waste goes beyond fraud and abuse and most waste does not involve a violation of law. Waste relates primarily to mismanagement, inappropriate actions and inadequate oversight-from the Inspector General.

**Abuse** means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.

Here are some examples of Fraud, Waste and Abuse:

**Fraud**

- Providers billing for services not provided.
- Providers billing for the same service more than once (i.e., double billing).
- Providers performing inappropriate or unnecessary services.
- The misuse of a Medicaid card to receive medical or pharmacy services.
- Altering a prescription written by a doctor.
- Making false statements to receive medical or pharmacy services.

**Waste & Abuse**

- Going to the Emergency Department for non-emergent medical services.
- Threatening or abusive behavior in a doctor's office, hospital or pharmacy.
Fraud, Waste & Abuse

Meridian encourages members, providers and employees to report all cases of fraud, waste and abuse. If you know of any Medicaid members or providers, including doctors, hospitals and pharmacies, who have committed actions of fraud, waste or abuse, you can report them using the process described below. You may report them anonymously if you choose.

To Report Potential Fraud, Waste and Abuse:

Meridian members, providers or employees can also report potential instances of fraud, waste and abuse directly to the State of Michigan at the following address. You can report anonymously if you choose.

Office of Inspector General
PO Box 30479
Lansing, MI 48909
Phone: 855-MI-FRAUD

Meridian members, providers or employees can also report potential fraud, waste or abuse anonymously in writing to Meridian Health Plan at the following address:

Compliance Officer
Meridian Health Plan
777 Woodward Avenue, Suite 600
Detroit, MI 48226
Phone: 877-218-7949
Fax: 313-202-0009

The False Claims Act
The False Claims Act is aimed at establishing a law enforcement partnership between federal law enforcement officials and private citizens who learn of fraud against the Government. Under the False Claims Act, those who knowingly submit, or cause another person or entity to submit, false claims for payment of government funds are liable for up to three times the government’s damages plus civil monetary penalties. The False Claims Act explicitly excludes tax fraud.

The Act permits a person with knowledge of fraud against the United States Government to file a lawsuit on behalf of the Government against the person or business that committed the fraud. The lawsuit is known as a "qui tam" case, but it is more commonly referred to as a “whistleblower” case. If the lawsuit is successful, the qui tam plaintiff is rewarded with a percentage of the recovery, typically between 15 and 25%. Any person who files a qui tam lawsuit in good faith is protected by law from any threats, harassment, abuse, intimidation or coercion by his or her employer. For more information on the False Claims Act, please contact the Meridian Corporate Compliance Officer at 877-218-7949.
In order to accommodate the needs of diverse populations, it is important for providers and their staff to annually participate in ongoing training and education efforts that encompass a range of activities from self-study education materials to interactive group learning sessions. The Meridian Provider Services department supports these efforts by collaborating with providers and their staff to offer up-to-date training resources and programs. Training available includes, but is not limited to:

- Provider Orientation
- HIPAA Privacy and Security
- Fraud, Waste and Abuse
- Recipient Rights and Reporting Abuse and Neglect and Critical Incidents
- Person-centered planning
- Cultural Competency
- Americans with Disabilities Act (ADA)
- Independent living and recovery
- Wellness principles
- Delivering services to LTSS and HCBS populations
- Self-determination
- Disability literacy training
- Care Coordination
- Interdisciplinary care team (ICT) training, including:
  - Roles and responsibilities of the ICT
  - Communication between providers and the ICT
  - Care plan development
  - Consumer direction
  - Any HIT necessary to support care coordination

If you would like to request a training session, please call your Provider Network Development Representative, or the Provider Services department at 888-773-2647.
Manager of Network Development
Jacqueline DuPuy: 313-720-2335

Director of Network Development
Kellie Rice: 313-820-1683

Manager of Network Development
Michael Dieterich: 216-912-0049

OHIO

Director of Network Development
Michael Dieterich: 216-912-0049

Provider Network Development Representatives

Lauren Arnold 313-407-7368  
Erica D’Ambrosio 248-508-0009  
Amanda Dubyk 313-410-2141  
Laura Godzwon 313-402-2209  
Melissa Kuiper 616-915-1005  
Sarah Lamphere 989-802-1710  
Alexandra Leas 313-400-1788  
Kelly Leng 989-450-7985  
Denal Nelson 231-557-7725  
Jennifer Peyerker 313-720-9233  
Anne Marie Salliotte 616-915-8777

*Please contact Jacqueline DuPuy at 313-720-2335
Meridian Contact Information

Meridian Care Management

• Process referrals
• Perform corporate pre-service review of select services
• Collect supporting clinical information for select services
• Conduct inpatient review and discharge planning activities
• Care Coordination

TEAM 1 Phone: 888-322-8843         Fax: 313-463-5254
Allegan, Alcona, Alpena, Antrim, Arenac, Barry, Bay, Benzie, Berrien, Calhoun, Cass, Clare, Kalamazoo,
Kalkaska, Lapeer, Livingston, Manistee, Missaukee, Montcalm, Montmorency, Ottawa, Presque Isle,
Roscommon, Saginaw, St. Joseph, Van Buren, Washtenaw, Wexford

TEAM 2 Phone: 800-845-8959         Fax: 313-463-5256
Branch, Clinton, Crawford, Eaton, Grand Traverse, Gratiot, Hillsdale, Ingham, Ionia, Iosco, Isabella,
Jackson, Lake, Lenawee, Mason, Mecosta, Monroe, Osceola, Otsego, Shiawassee, Wayne

TEAM 3 Phone: 888-322-8844         Fax: 313-463-5258
Charlevoix, Cheboygan, Emmet, Genesee, Gladwin, Huron, Kent, Macomb, Midland, Muskegon,
Newaygo, Oakland, Oceana, Ogemaw, Oscoda, Sanilac, St. Clair, Tuscola

Meridian Member Services

- Verify member eligibility
- Obtain member schedule of benefits
- Obtain general information and assistance
- Determine claims status
- Encounter inquiry

Phone: 888-437-0606         Fax: 313-202-0007
• Record member personal data change
• Obtain member benefit interpretation
• File complaints and grievances
• Verify / record newborn coverage
• Coordination of Benefit questions

Provider Services

- Fee schedule assistance
- Contractual issues
- Primary care administration

Phone: 888-773-2647         Fax: 313-202-0008
• Discuss recurring problems and concerns
• Provider education assistance
• Initiate physician affiliation, disaffiliation & transfer

Quality Management

- Requests and questions about Clinical Practice Guidelines
- Requests and questions about Preventive Healthcare Guidelines

Phone: 888-437-0606         Fax: 313-202-0006
• Questions about Quality Initiatives
• Questions about QI Regulatory requirements
• Questions about Disease Management Programs

Other Important Phone and Fax Numbers

<table>
<thead>
<tr>
<th>Service</th>
<th>Phone Number</th>
<th>Fax Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy Benefit Manager</td>
<td>866-984-6462</td>
<td></td>
</tr>
<tr>
<td>Non-Emergent Transportation</td>
<td>800-821-9369</td>
<td>Main Fax Number</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>888-222-8041</td>
<td>Behavioral Health Fax</td>
</tr>
<tr>
<td>Claims</td>
<td>800-203-8206</td>
<td>Women &amp; Children's Fax</td>
</tr>
</tbody>
</table>