A Public Entity

INLAND EMPIRE HEALTH PLAN

To: Qualified Autism Service Providers (QASPs)

From: IEHP – Provider Relations

Date: July 26, 2016

Subject: **<u>CORRECTION:</u> Acceptable Means of QASPs Authorization Requests and Submission of Clinical Documentation**

Please disregard previous communications.

Inland Empire Health Plan's (IEHP) Behavioral Health Unit (BHU) is initiating a new outpatient authorization process to ensure that you will have timely responses to your requests.

Effective immediately, the Behavioral Health Department's Autism Team **<u>will no longer accept requests via emails, SFTP server or phone</u>** for the following:

- Requests for Additional Services
- Functional Behavioral Assessments (FBA)
- Psychological Assessments
- Clinical documentation (ie: progress reports or monthly reports)

Moving forward, to ensure that you are receiving a prompt response, **all authorization requests and clinical documentation, need to be directed through IEHP secure web portal at** *<u>www.iehp.org</u>* **or via fax at (909) 890-5763.** When utilizing the fax, please include the coversheet that is provided.

If you need training on how to submit forms using the IEHP web portal or have any questions in regards to claims, please contact the IEHP Provider Relations Team at (909) 890-2054. Please advise the Provider Relations Team if you need a Provider Services Representative (PSR) to schedule a training on our website, forms and policies.

As a reminder, all communications sent by IEHP can also be found on our Provider portal at the following address: https://ww3.iehp.org/en/providers/correspondence/.

Thank you for your continued support and partnership. If you have questions or experience technical difficulties, please contact the IEHP Provider Relations Team at (909) 890-2054.

Attachment: Autism Cover Sheet

INLAND EMPIRE HEALTH PLAN

Autism Cover Sheet

***** Indicates Required Information

***PROVIDER OF SERVICE INFORMATION:** *(Please Print Clearly)*

Name	**IEHP ID/NPI**	**Auth #**	**Report Date**

Address	**City, ST Zip**	**Phone**

***MEMBER INFORMATION:** *(Please Print Clearly)*

Name	**IEHP ID**	**Date Of Birth**	**Current Phone Number**

VISIT INFORMATION

Initial Visit Date:_____ **Concurrent Specialist (if applicable):**_____

Please select the type of form(s) attached to this coversheet;

1. Types of Forms

1) ☐ Clinical Review (For Dr. Cash Only)
2) ☐ Monthly ABA Progress Report
3) ☐ 6 Months (Request for Additional Services)
4) ☐ Functional Behavioral Analysis (FBA)
5) ☐ PDE – Psychological Diagnostic Evaluation
6) ☐ CDE – Comprehensive Diagnostic Evaluation (For ACE Use Only)
7) ☐ Autism Screening Test (For CPC Use Only)
8) ☐ Other Documents

Please Specify Clearly:_____