Provider Connection

FOURTH QUARTER 2019

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Physicians Health Plan

Working with PHP

General Training 101

The Provider Relations Team offers training sessions throughout the year to help you and your office staff work smoothly with PHP.

Learning opportunities include a review of the Provider manual, checking eligibility and benefits, claim status, authorizations/approvals, and much more. Attendees should include management and all office staff.

Jan. 14, 2020 | 8:30–10 a.m.
April 16, 2020 | noon to 1:30 p.m.
July 14, 2020 | 8:30–10 a.m.
Oct. 15, 2020 | noon to 1:30 p.m.

Please email your RSVP at least one week prior to the event. All trainings take place at PHP, are free of charge, and include a light meal.

Questions? Contact **PHPProviderRelations@phpmm.org**.

Changes to MyPHP!

PHP's Provider Portal, MyPHP, makes it very easy to verify eligibility, check claim status, view member benefits, access PHP's Medical, and Pharmacy Policies and much more! MyPHP is quick, easy and provides 24/7 access to information.

Effective January 1, 2020, users will no longer be able to change their username that was created at the time of initial registration. In addition, users that have not logged into MyPHP within 90 days will be disabled. If your access has been disabled due to inactivity, please email your PHP Provider Relations Team at **PHPProviderRelations@phpmm.org** to have your access reactivated.

PHP Medicare Advantage

Medicare Advantage plans are one of the fastest growing Medicare products on the market. PHP launched a new Medicare Advantage product to the market on October 15, 2019.

Provider marketing

» Provider Affiliation Letters: Letters to the PCP announcing affiliation with Sparrow Advantage/ Covenant Advantage were mailed October 1 and November 1

Annual enrollment period was October 15, 2019 and ended December 7, 2019

» 70-75% of total enrollment goal for 2019 is expected to be done during this time

Plan specifics

» 12 counties, 1 network (see service area below)

» Teaming up with Covenant HealthCare in the Saginaw area

» $0 or $25 Monthly Premium for Advantage or Advantage Plus plans

» $5 PCP Copay

» No Deductible

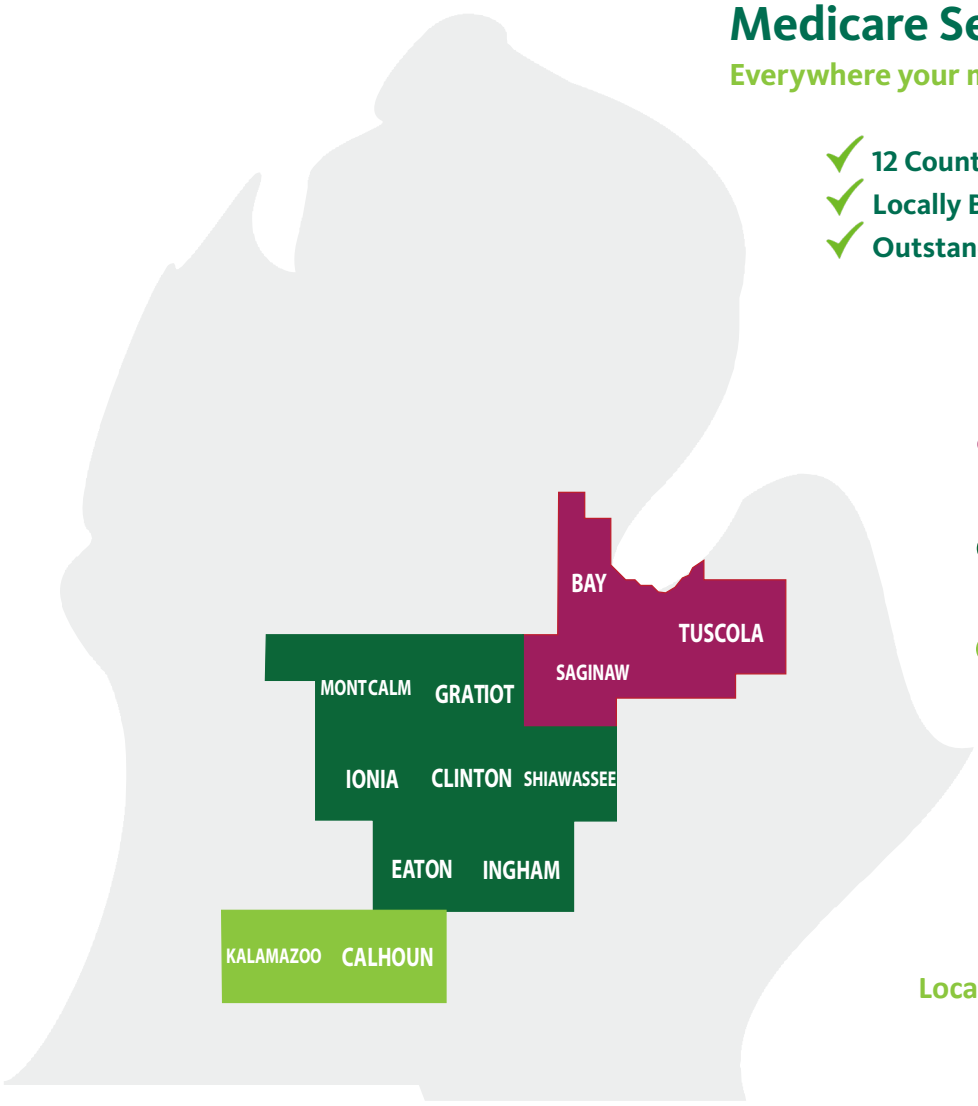
» $3,800 Out of Pocket Max

» Tier 1 and 2 meds $0 at an in-network pharmacy

Medicare Service Area

Everywhere your members are.

- ✓ 12 Counties
- ✓ Locally Branded
- ✓ Outstanding Benefits



Covenant ADVANTAGE A PHP Medicare Plan

Sparrow ADVANTAGE A PHP Medicare Plan

PHP ADVANTAGE

Local. Personal. Trusted.

Practitioner/Provider changes

All Network Providers must notify PHP in writing in advance of any demographic or status changes within the Practice/Facility. Failure to notify PHP can cause claim payment delays and/or denials. Changes includes:

- Tax ID number
- Telephone number
- Billing address
- Office address
- Office hours
- Open/closed status regarding accepting new Members
- After-hours availability for PCPs
- Physicians/Practitioners joining or leaving your Practice
- Member reassignment when a Physician leaves your practice

The "Demographic/Practice Information Update Form" should be used to notify us of demographic/practice information changes. The Demographic/Practice Information Update Form can be found on our website by going to **PHPMichigan.com** and selecting the Provider tab. Once you have reached the Provider page, you need to select Forms and the Demographic/Practice Information Update Form is located at the bottom of the forms page.

Utilization Management news and updates

4th Quarter 2019

A comprehensive list of procedures and services requiring prior approval is available on our website at **PHPMichigan.com/Providers**. Select "Notification and Prior Approval Table" to locate this list. This information is also available on the Provider portal, MyPHP.

If you have any questions about the prior approval process, please call the PHP Customer Service Department at **517.364.8500** or **800.832.9168** between the hours of 8:30 a.m. and 5:30 p.m., Monday through Friday.

Reminder: Prior Approval requests may be submitted via the Utilization Management fax at **517.364.8409** from 8 a.m. to 5 p.m., Monday through Friday.

New Policies
BCP 12 ABA Therapy for Autism Spectrum Disorders – effective 10/1/2019
BCP-27 Home Infusions – effective 10/1/19

Changes to Coverage for Services

Code(s)	Procedure or Service	Action	Implementation Date
A9275	Home glucose disposable monitor includes test strips	Change from prior approval required to not covered	10/1/2019
E2367	Power wheelchair accessory, battery charger, dual mode, for use with either battery type, sealed or non-sealed, each	Change from not covered to prior approval required	10/1/2019

*Any Provider or Member that was directly impacted by these changes recieved a direct mailer explaining the changes.

When is prior approval needed?

Certain health services require Prior Approval from PHP for coverage of services or products. Healthcare Providers must get Prior Approval from PHP before certain services can be provided. If Prior Approval is not obtained, benefits and/or reimbursement for a health service may be reduced or not covered at all. The Member may be responsible for non-covered charges.

To request Prior Approval, call the number on the Member's ID card for Customer Service. By calling PHP before a treatment or service is received, you can check to see if the service:

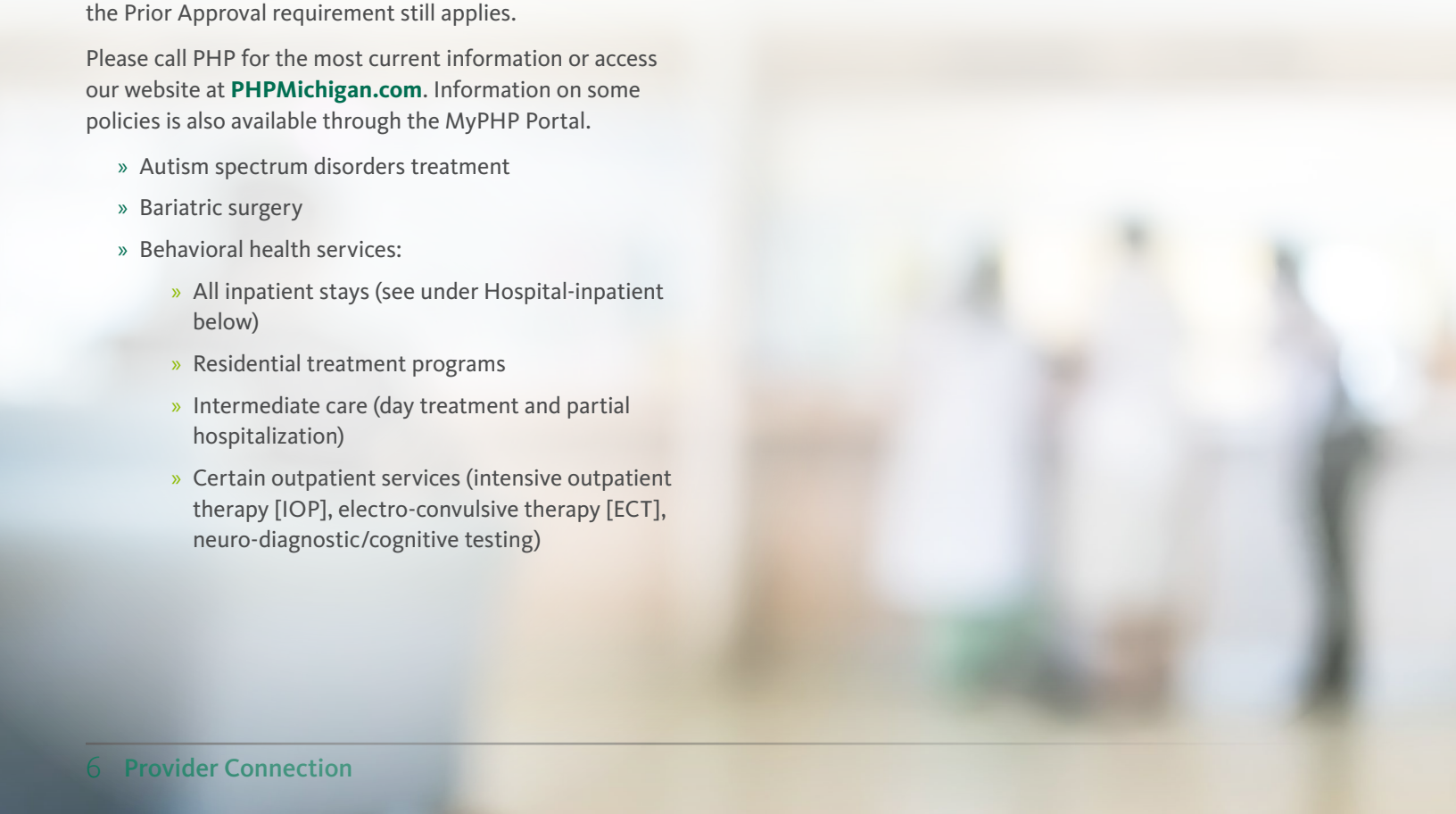
- Is a cosmetic procedure or service
- Has a benefit limit
- Is an experimental, investigation or unproven service
- Is specifically excluded under a benefit pan

Prior Approval is not a guarantee of benefits. Coverage depends on the services that are received, a Member's eligibility status at the time of service, and any benefit limitations or exclusions. In addition, a Prior Approval is not a guarantee of reimbursement. Correct coding, timely claim submission, review of supporting documentation and code edits may affect final reimbursement of otherwise approved services.

Below is a list of covered health services that require Prior Approval and is subject to change. This list is not all inclusive. If Medicare or other healthcare coverage pays before PHP, the Prior Approval requirement still applies.

Please call PHP for the most current information or access our website at **PHPMichigan.com**. Information on some policies is also available through the MyPHP Portal.

- Autism spectrum disorders treatment
- Bariatric surgery
- Behavioral health services:
  - All inpatient stays (see under Hospital-inpatient below)
  - Residential treatment programs
  - Intermediate care (day treatment and partial hospitalization)
  - Certain outpatient services (intensive outpatient therapy [IOP], electro-convulsive therapy [ECT], neuro-diagnostic/cognitive testing)
- Dental services – accidental (prior to follow-up care)
- Durable medical equipment – certain items only
- Gender reassignment surgery, procedures, and medications
- Genetic testing
- Home health care
- Home infusion therapy
- Hospice care
- Hospital – inpatient (including extended maternity stays, emergency admission for behavioral health and non-behavioral health conditions and long-term acute inpatient care)
- Procedures – inpatient or outpatient: capsule endoscopy, hyperbaric oxygen therapy, spinal cord stimulation, sacral nerve stimulation, facet injections and facet neurotomy, orthognathic surgery, varicose vein treatment, and femoro-acetabular hip impingement surgery
- Prosthetic and Orthotic devices over $1,000
- Reconstructive procedures
- Rehabilitation services – outpatient physical and occupational therapy
- Skilled Nursing Facility / Inpatient Rehabilitation Facility
- Specialty drugs
- Transplant services



JW Modifier

In accordance with CMS guidelines and requirements, PHP requires documentation of medication waste with the use of the JW modifier. For medications that come in single-use vials where the full amount is not used, please use the JW modifier when billing for discarded product. In addition, Providers must document the amount administered as well as wasted medication within the Patient's medical record.

Criteria for billing with JW Modifier

- JW modifier must be applied to the amount of drug or biological that was discarded from a single-use vial/package
- Waste must be billed on a separate line from the administered units with the JW modifier for the units not administered
- JW modifier applied on all non-inpatient place of service claim lines
- Drug or biological is only available in a single-use vial/package
- Units of Service must be billed in multiples of the dosage specified in the CPT/HCPCS description
- When the amount administered is not a multiple of the CPT/HCPCS code, round to the next highest unit in the CPT/HCPCS description for that code
- Administered dose per documented wasted dose must not exceed the vial amount for single-use vials/packages
- Drug waste is not administered to another patient
- Multi-use vials are not subject to payment for discarded amounts of medication
- If the full amount of a single-use vial is administered to a patient, there is no need to use the JW modifier

Billing example using the JW Modifier

Trastuzumab is available in a single use, 150mg vial. The CPT/HCPCS code and description for Trastuzumab are J9355, Trastuzumab 10mg. If 550mg is administered to the patient, then four 150mg vials (total 600mg) should be utilized. When 600mg are utilized but only 550mg are administered, then 50mg is wasted and documented in the medical record. The correct billing is 55 units J9355 on one line of the claim, and 5 units J9355JW on another line.

Documentation requirements

Drug waste must be clearly documented in the medical record to support reimbursement. Documentation of drug waste should include the dose administered, the date and time of administration, the reason for waste, and the discarded amount. When billing with an unlisted drug/biological code the appropriate NDC number is required on the claim.

Please visit MyPHP under Providers at **PHPMichigan.com** for reimbursement policy PRP-11 Drugs and Biologicals for additional details.

Pharmacy news and updates

Newly Released Drugs to Market	
Drug Name	**Formulary Action**
Skyrizi (risakizumab) SQ injection	Tier 2, Prior Approval Required
Mayzent	Add to Preferred Tier (2)
Mavenclad	Add to Non-Preferred Tier (4). Prior Approval Required

Changes to Current Formulary Effective January 1, 2020

Formulary Changes

Removed

Therapeutic Category	Medication	Preferred Alternatives
Multiple Sclerosis	Glatopa, Glatiramer	Copaxone
IBD (Irritable Bowel)	Asacol HD, Delzicol (Brand), Lialda, Pentasa	Brand: Apriso Generic: Mesalamine
Prostate Cancer	Zytiga 250 mg	Generic available
PAH (Pulmonary arterial hypertension)	Letairis, Tracleer	Generic available
VEGF inhibitor (vascular endothelial growth factor receptor)	Avastin	Mvasi – preferred biosimilar
Antineoplastic (chemotherapy drug)	Herceptin	Kanjinti – preferred biosimilar
G-CSF Short-acting	Neupogen, Zarxio, Granix	Nivestym – preferred biosimilar
Fertility – FSH	Follistim AQ	Gonal-F

Tier Changes

Therapeutic Category	Medication	Tier Change	
PARP Inhibitors	Lynparza, Rubraca, Zejula	Down	2
Prostate Cancer	Erleada, Nubeqa, Yonsa, Xtandi	Down	2
Beta Blockers	Bystolic	Down	2
Osteoporosis	Forteo	Up	4
Rosacea Agents	Finacea Foam	Up	3

Tier Changes

Therapeutic Category	Medication	Quality Limits	Prior Auth
Insulin	U-100 Insulins (All)	Added	
Somatostatic Agents	Octreotide		Removed
Glucocorticosteroids	Uceris	Added	Removed
Sinus Node Inhibitors	Corlanor		Removed

*Any Provider or Member that was directly impacted by these changes recieved a direct mailer explaining the changes. Letters can be located on **PHPMichigan.com**.

ACA Changes

The U.S. Preventive Services Task Force (USPSTF) is an independent panel of national health experts that make evidence-based recommendations about preventive services and medications. PHP has adopted the following recommendations below.

Therapeutic Category	Medication	Change	Coverage
Cardiovascular Disease & Colorectal Cancer	Aspirin	Select age ranges will no longer be covered at $0 copay	**Continued coverage at $0 copay for:** **Ages 50-59** to prevent cardiovascular disease and colorectal cancer **Pregnant women** who are at high risk for preeclampsia using aspirin as a preventive medication
Vitamins	Vitamin D Ferrous Sulfate	No longer be covered at $0	**Available over-the-counter**
Prenatal	Prenatal Vitamins Folic Acid	Prenatal Vitamins – no longer covered at $0	**Prenatal vitamins** will be covered at the applicable copay based on the benefit coverage **Folic Acid** – a component of prenatal vitamins will continue to be covered at $0 copay (0.4 – 0.8 mg)

Changes to Current Formulary Effective January 1, 2020

Formulary Changes

Medications – Removed

Therapeutic Category	Medication	Tier Change
Growth Hormone	Humatrope, Nutropin AQ, Omnitrope, Saizen, Zomacton	Genotropin, Norditropin

Tier Changes

Therapeutic Category	Medication	Tier Change	
Growth Hormone	Genotropin, Norditropin	Down	2

*Any Provider or Member that was directly impacted by these changes recieved a direct mailer explaining the changes. Letters can be located on **PHPMichigan.com**.

For up-to-date information on drug recalls please visit **PHPMichigan.com/providers**. A link to the FDA's drug recall website is available under the Pharmacy Services tab.

Outstanding overpayment balances

Overpayments can happen and Physicians Health Plan (PHP) makes every attempt to recover via auto-recovery. In the event that you realize PHP has made an overpayment, you must report this with a claim adjustment form and a corrected claim, if needed. Claim adjustment forms can be found on PHP's website at PHPMichigan.com. Once your adjustment is processed, PHP initiates the adjustment/take back on future claims payments which is evidenced on an Explanation of Payment (EOP). Specific overpayment detail(s) are indicated in the recovery detail portions of your EOP.

See the example below:

Amount Billed	Allowed	Financial Allowance	Prov. Adjust	Patient Ineligible	Deductible	Copay/Co-Ins	Other Ins	Net Paid
120.00	100.00	0.00	20.00	0.00	0.00	0.00	0.00	100.00

Interest Amount:	0.00
Refund Requested:	0.00
Auto-Recovered Amount:	-85.06
Prior Overpayment Balance:	0.00
Check Amount:	14.94

Overpayment Recovery Detail (adjustment - Retractions could be applied to the net payment)

Claim#/ Ref#	Member Name	Patient Acct #	Recovery Type	Adjusted Date	Original Amt Paid	Original Overpay	Previously Recovered	Recovered This Check	Remaining Balance	Orig. Date Paid	Orig. Check Number
19000E000XXX	John Smith	1234567	B	12/14/2019	85.06	85.06	0.00	85.06	0.00	5/29/2018	654321

In certain situations, PHP may determine that a refund check is the only way to resolve an overpayment, such as a change in a tax identification number, a physician who is no longer practicing or has made changes to payee information. In these situations, money cannot be recovered automatically. You will notice that an outstanding overpayment amount will remain as a "Remaining Balance" on your EOP. It is important to pay attention to the Prior Overpayment Balance, or Remaining Balance noted in the example (right); it may be necessary to send a refund check to PHP for an outstanding remaining balance.

Paid To: Michigan State Hospital
Tax #: 123456789
Reference #: 201611221023456
Check Amount #: 123456
Check Amount: $250.00
Prior Overpayment Balance: $575.00
Auto-Recovered this Check: $250.00
Current Overpayment Balance: $325.00
Year To Date Financial Allowance: $0.00

See the example below:

Overpayment Recovery Detail (adjustment - Retractions could be applied to the net payment)

Claim#/ Ref#	Member Name	Patient Acct #	Recovery Type	Adjusted Date	Original Amt Paid	Original Overpay	Previously Recovered	Recovered This Check	Remaining Balance	Orig. Date Paid	Orig. Check Number
19000E000XXX	John Smith	1234567	B	12/14/2019	700.00	700.00	125.00	250.00	325.00	5/29/2018	654321

If a balance is unable to be recouped by PHP within three months of the Explanation of Payment (EOP) mail date, you may then receive letters and/or phone calls related to the overpayment collection process. Additional information is available to assist you in the resolution of overpayment balances via the Provider Portal, MyPHP.

If you have questions about your EOP or the overpayment recovery process, please contact Customer Service at **517.364.8500**.

Importance of "Place of Service" codes

A Place of Service (POS) code is a required data element of a professional medical claim submission. Place of Service codes are two-digit numeric codes reported on health care professional claims to indicate the setting in which a service was provided. It is critical that claims identify the POS. The Place of Service code must be entered in box 24b of your HCFA 1500 claim form or electronic equivalent. CMS develops and maintains the Place of Service Codes within the health care industry. Place of Services Codes are essential in ensuring that any Provider submits a clean claim. Each code is reviewed to determine whether the place of service (POS), type of service (TOS), age and provider specialty are appropriate for the service billed. This is essential in ensuring that all medical services provided to our members are valid and legitimate.

Antibiotic awareness

Antibiotic resistance is one of the most serious public health problems in the United States and threatens to return us to the time when simple infections were often fatal. When we optimize how we use and prescribe antibiotics, we protect patients from harm and combat antibiotic resistance.

Educating our patients is key. Common infections, whether caused by bacteria or viruses, are often painful and can get in the way of our well-being and everyday lives. Many infections do not require antibiotics and there are other actions that can be taken to lessen symptoms until the illness runs its course.

Thank you for discussing this important information with your patients.

Quality corner

PHP strives to improve the health of individuals, families, and communities. We can't do it without you. The Quality Department collects and evaluates member health information to identify opportunities to assist Providers in helping our Members reach and maintain their optimum health. One of the data sources we utilize is the Healthcare Effectiveness Data and Information Set (HEDIS®). HEDIS® is a standardized set of performance measurement criteria that is used by the managed care industry to compare health plan performance across plans and against national benchmarks. The National Committee for Quality Assurance (NCQA) develops and coordinates the HEDIS® process and scoring. Performance scores provide comparative data that is used to focus on quality improvement efforts and allows consumers to compare the performance of health plans.

The HEDIS® 2020 audit process begins soon

What does this mean for providers?

The majority of the record review is conducted February through May. Your office or facility will be contacted directly by a PHP HEDIS® Nurse Reviewer. If we require less than five records, this contact and request comes in the form of a fax. If more than five records are needed, the Nurse will call to make arrangements with you for obtaining the necessary portions of the medical record. The Nurse can come to your location at a convenient time for you and review the medical records. We will provide a list of all records required for review. The Nurse will need to print, copy, or download to an encrypted flash drive or disk the records identifying the specific medical information being audited. This may include vital signs, problem lists, diagnoses, medication lists, office visit notes, lab results, education, growth charts, etc. We can bring the paper and flash drive at your request.

Frequently asked questions:

Does the Health Information Portability and Accountability Act (HIPAA) permit me to release records to a PHP representative?

Yes. Under HIPAA requirements, HEDIS® data collection is a quality assessment and improvement activity and is therefore included in the definition of healthcare operations and may be provided to PHP without member consent.

Is my participation in HEDIS® mandatory?

Yes. Contracted providers are required to participate in PHP's Quality Improvement activities. This includes participation in office reviews, chart access, and audits.

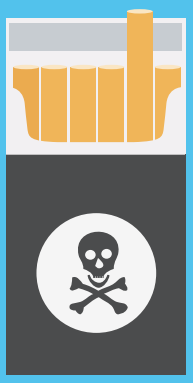
We submit claims, why does PHP need medical records?

Not all services rendered are captured through claims and encounter data. Therefore, NCQA allows us the opportunity to collect medical record data in addition to claims, in order to accurately capture the quality of care being provided to our members. The Nurses are looking for documentation of preventive care, screenings, lab reports, and other information that was not billed or coded for the service rendered. While record review cannot be eliminated completely, it can be reduced through correct and complete billing and coding.

We look forward to working with you in this process. Please feel free to contact the Quality Department if you have further questions at **PHPQualityDepartment@phpmm.org**. The Nurse Reviewer is also able to answer questions during their contact.

Future HEDIS® Corner topics will discuss review measures in more detail.

QUIT SMOKING



5 TRILLION

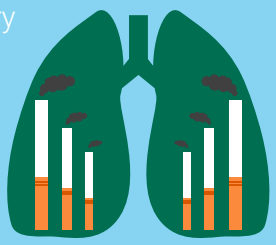
cigarettes are sold each year to the

1,350,000,000

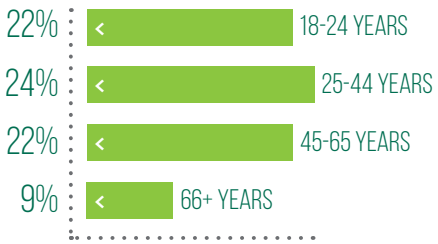
people who smoke worldwide.

COPD Chronic obstructive pulmonary disease

is a chronic inflammatory lung disease caused by long-term exposure to irritating gasses, most often **cigarette smoke**. It is the **4th** leader in deaths in the US.



SMOKING BY AGE IN U.S.

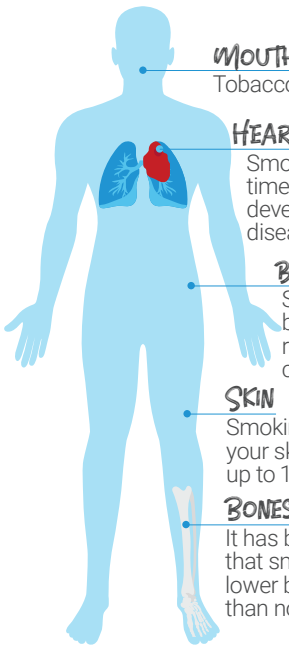


LUNG CANCER

is the leading cause of cancer deaths in the United States. It is one of the easiest to prevent.

4 OUT OF 5 cases are caused by smoking.

REASONS TO QUIT SMOKING



MOUTH
Tobacco stains teeth.

HEART
Smokers are 2-4 times more likely to develop coronary disease.

BLOOD
Smoking damages blood vessels, resulting in poor circulation.

SKIN
Smoking ages your skin by up to 19 years.

BONES
It has been found that smokers have a lower bone density than non-smokers.

LIFE EXPECTANCY
Within a year of quitting, your risk of heart attack declines by 50 percent. Within 10 years, your risk of lung cancer will be about the same as if you'd never smoked at all.

TASTE
Without smoke to interfere with your taste buds and sense of smell, food will taste better.

ENERGY LEVELS
An increased amount of oxygen to the bloodstream results in higher energy levels.

CHOLESTEROL
Smoking reduces HDL ("good") cholesterol and may alter LDL ("bad") cholesterol, leaving plaque in arteries.

Sources:

American Cancer Society | Cancer.org
American Heart Association | AmericanHeart.org
American Lung Cancer Association | Lung.org
Center for Disease Control and Prevention | CDC.gov
Healthline Networks | HealthLine.com
Health Watch Center | HealthWatchCenter.com
Mayo Clinic | MayoClinic.org
National Cancer Institute | Cancer.gov
The National Center for Biotechnology Information | NCBI.nlm.nih.gov
Quit | Quit.org

Physicians Health Plan

Local. Personal. Flexible.

Tobacco Cessation Program

Eligibility

All current members, age 18 and older, of Physicians Health Plan, PHP Insurance Company, and PHP Service Company are eligible to enroll in the program managed by Healthyroads®. There is no cost to the member to participate.

Enrollment and Phone Support

To get started, members can enroll online at **Healthyroads.com** or call Healthyroads® at **877.330.2746** to speak with a customer service representative about the Healthyroads® program.

What members will learn

- how to deal with triggers
- how to use new strategies
- how to cope with cravings
- how to plan for success
- how to develop a new self-image

Coaching session topics

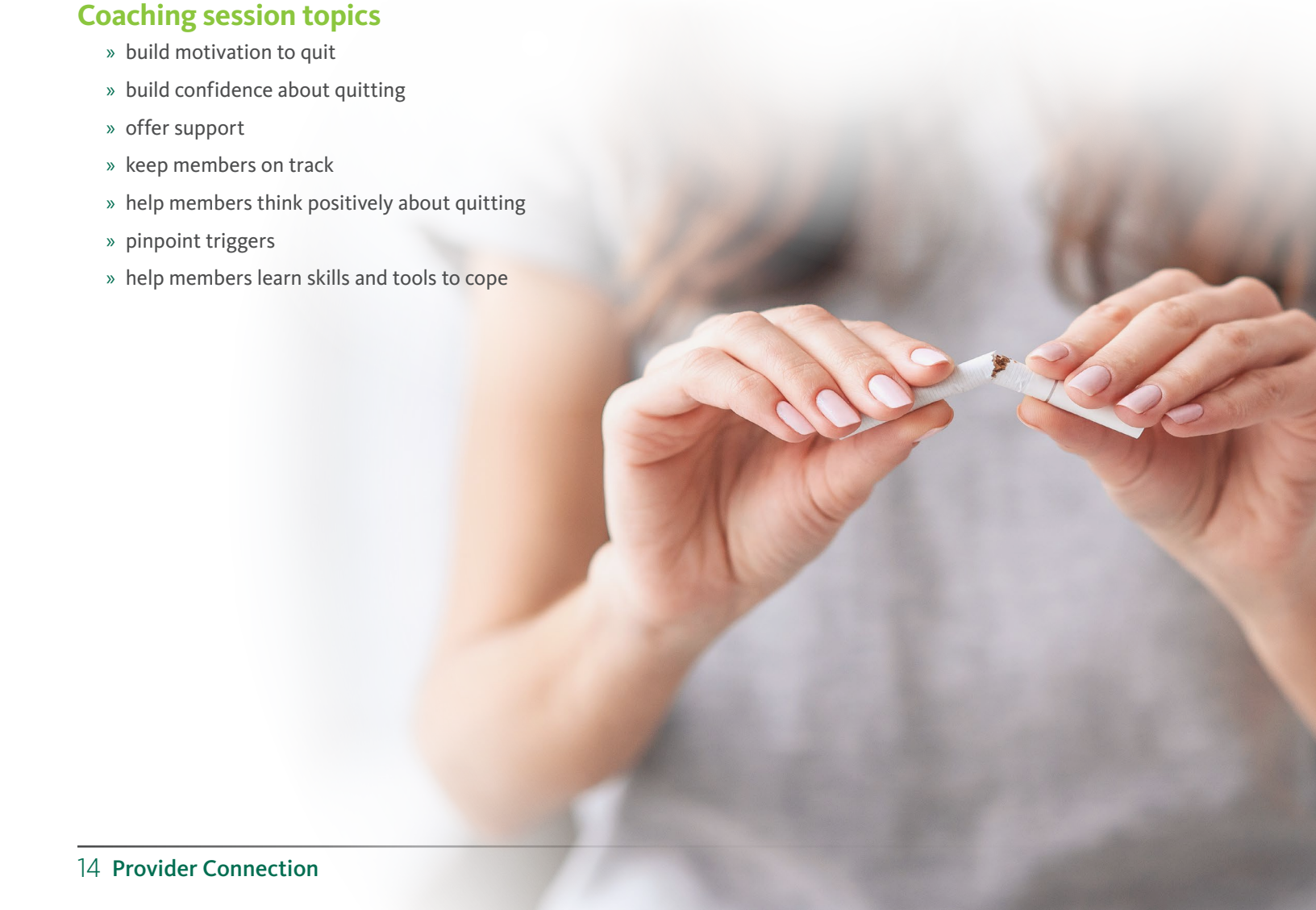
- build motivation to quit
- build confidence about quitting
- offer support
- keep members on track
- help members think positively about quitting
- pinpoint triggers
- help members learn skills and tools to cope

Program benefits

- Tobacco cessation educational materials
- Online tools and resources available at healthyroads.com
- Contact with a Healthyroads Coach® to help you stay motivated to quit

Tobacco cessation products

Members with outpatient prescription drug coverage may receive 24 consecutive weeks of Preferred Tobacco Cessation Products without program participation. The member must participate in telephonic and/or online program for an authorization to be entered by the pharmacy department for continuation of therapy beyond 24 weeks.



Compliance corner: billing for smoking and tobacco use cessation counseling

Smoking and tobacco use cessation counseling visits

The provider counsels the patient on steps to stop use of tobacco products. The provider uses the discussion to discover the specific barriers to cessation the patient faces and possible relapse triggers. The provider and patient then discuss practical methods for coping with those issues. The provider may write a prescription for a pharmacologic intervention. The provider also may refer the patient to a support group that matches the patient's needs. The provider documents the discussion as well as the amount of time spent counseling the patient.

Coding

99406 – Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes

99407 – Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes

*Modifier -25 may be appropriate to append to the primary E/M visit code to identify separate procedure when billed with 99406 or 99407

Documentation requirements

To receive separate reimbursement for smoking and tobacco use cessation counseling, the documentation in the medical record must support the billing of the cessation code. The documentation needs to record what was discussed during counseling and should show a significant and separately identifiable service.

Appropriately documented counseling visit should include the following elements:

- The patient's tobacco use (duration, frequency)
- Counseling on steps to quit the use of tobacco products
- Impact of smoking
- Assessed willingness to attempt to quit
- Documented barriers/strategies
- Providing methods and skills for cessation
- Medication management of smoking cessation drugs (documentation of prescriptions)
- Resources provided (referrals to programs or support groups)
- Setting quit date
- Follow-up arranged
- Amount of time spent counseling patient

An entry in the patient's health record stating only "use of tobacco" under patient health history or "time spent counseling patient on tobacco use" without any additional detail is not sufficient documentation.

If PHP patients inquire about Smoking Cessation programs, please refer members to PHPMichigan.com, Take Charge of my Health, Disease Management, Tobacco Cessation for additional information. Members can call Healthyroads® at **877.330.2746** to enroll or go on online at **Healthyroads.com**.

Physicians Health Plan

1400 E. Michigan Avenue
P.O. Box 30377
Lansing, MI 48909-7877

Contact us

Department	Contact Purpose	Contact Number	Email Address
Customer Service	» To verify a covered person's eligibility, benefits, or to check claim status » To report suspected Member fraud and abuse » To obtain claims mailing address	517.364.8500 800.832.9186 (toll free) 517.364.8411 (fax)	
Medical Resource Management	» Prior authorization of procedures and services outlined in the Notification/Authorization Table » To request benefit determinations and clinical information » To obtain clinical decision-making criteria » Behavioral Health/Substance Use Disorders Services, for information on mental health and/or substance use disorders services including prior authorizations, case management, discharge planning, and referral assistance	517.364.8560 866.203.0618 (toll free) 517.364.8409 (fax)	
Network Services	» Credentialing - report changes in practice demographic information » Coding » Provider/Practitioner education » To report suspected Provider/Practitioner fraud and abuse » EDI claims questions » Initiate electronic claims submission	517.364.8312 800.562.6197 (toll free) 517.364.8412 (fax)	**Credentialing** PHP.Credentialing@phpmm.org **Provider Relations Team** PHPProviderRelations@phpmm.org
Pharmacy Services	» Request a copy of our Preferred Drug List » Request drug coverage » Fax medication prior authorization forms » Medication Therapy Management	517.364.8545 877.205.2300 (toll free) 517.364.8413 (fax)	**Pharmacy** PHPPharmacy@phpmm.org
Quality Management	» Quality Improvement programs » HEDIS » CAHPS » URAC	517.364.8000 877.803.2551 (toll free) 517.364.8408 (fax)	**Quality** PHPQualityDepartment@phpmm.org
External Vendor	**Contact Purpose**	**Contact Number**	**Email Address**
Change Healthcare (TC3)	» When medical records are requested	**Mail To:** Change Healthcare 5755 Wayzata Blvd, St. Louis Park, MN 55416 952.949.3713 949.234.7603 (fax)	MedicalRecords@changehealthcare.com