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INTRODUCTION

Triple-S Salud, Inc. created this Manual for the providers that render services to the beneficiaries of the Government Health Plan. It constitutes a guide to be used in carrying out the Triple-S Salud, Inc. Managed Care Model.

Because of the updated and detailed information, it contains, and in accordance with the Managed Care Model, this Manual will become a valuable tool for the rendering of health services under the Government Health Plan, hereinafter GHP, through the Health Insurance Company, Triple-S Salud, Inc. The following topics are among the most important included herein:

1. Coverages
2. Risks Assumed
3. Administrative Aspects
4. Teleconsulta
5. Clinical Management and Support
6. Utilization Management
7. Billing
8. Legal Aspects

As previously said, this Manual sets up a guide and does not include, or pretends to include, all the situations a provider may face when rendering daily services. From time to time Triple-S Salud will add new topics relevant to the work of the providers or will update some of the information included in the manual. We hope that providers find the information included in the Manual to be useful when providing services to the beneficiaries.

BACKGROUND

Law No. 72 of September 7, 1993, as amended, created the Puerto Rico Health Insurance Administration (PRHIA, or ASES in Spanish) to manage, negotiate, contract health insurance plans to provide access to quality medical hospital services to the medical indigent population of the Island. Periodically, and as contracts reach their termination date, PRHIA invites the companies that are interested and are authorized by the Insurance Commissioner of Puerto Rico to submit service proposals and premium quotations.

The proposal application specifies that the objective is to guarantee the beneficiaries' right to choose the health care organizations, primary care physicians as well as other physicians and support providers within a managed care framework.¹

DESCRIPTION OF THE COMPANY

Triple-S Salud, Inc., a subsidiary of Triple-S Management Corporation, will manage the contract according guidelines agreed with PRHIA.

The administrative divisions that compose Triple-S Salud, Inc. are the following:

- Executive Division
- Medical and Dental Affairs
- Clinical Management
- Finances
- Claims
- Information Systems
- Provider Services
- Customer Services

EQUALITY AND CULTURAL SENSITIVITY POLICY

Triple-S Salud is aware of the diversity among our beneficiaries. It is important that our providers and participants are also aware of this fact and know how to deal with ethnical diversity, religion, language, race and beliefs of this population and that services are not denied only based on these criteria.

Triple-S has available for our plan members, sign language and language translation services and a line dedicated for the hearing impaired. As a provider, you can use these tools to ensure the quality of the services rendered to population under his care. If you need assistance with any of these services for GHP beneficiaries, you may contact Government Health Plan Call Center to coordinate them.

MANAGED CARE MODEL

The rendering of services for Government Health Plan is based on a Managed Care Model, which promotes access to primary care physician and preventive services through a network of Primary Medical Groups (PMGs), specialists and hospital services through the preferred network of Triple-S Salud. This model promotes the integration of physical and mental health and a disease management program for asthma, diabetes, congestive heart failure (CHF), hypertension, weight control, depression, care of the kidneys and health education.

Primary Medical Groups are composed of:

- family physicians
- general practitioners
- internists
- pediatricians
- gynecologists
These physicians can render services at their private offices, facilities or health center. The number of physicians per group will vary according to the number of beneficiaries subscribed to that group.

Physicians interested in joining a PMG must be participants’ providers of Triple-S Salud and the Government Health Plan (GHP), when requesting admission to the PMG. The enrollees will have available an enhance Preferred Provider Network (ePPN) that includes, but is not limited to, specialists, clinical laboratories, radiology services and hospitals. Beneficiaries can access the ePPN without referrals or paying copayments or coinsurances. Prescriptions written by physicians within the ePPN do not need the countersignature of PCP. In addition to the ePPN, beneficiaries will have a supplemental network of sub-specialist providers. In this case, the Primary Care Physician (PCP) will be responsible of delivering a Referral Form to the enrollee and the enrollee will be responsible of paying the applicable copayments or coinsurances. Prescriptions written by providers outside the ePPN require the countersignature of enrollee’s PCP.

During the beneficiaries’ enrollment process, the policyholder must choose a PMG and a PCP for each family member inside the same PMG, who will be responsible of providing and coordinating the services specified in the plan coverage. The policyholder would have the option to choose a pediatrician from the same PMG for his direct dependents under age 21. Female enrollees will have the right to select a second PCP, an obstetrician/gynecologist; could be from the same PMG or from Triple-S GHP network.

Beneficiaries may receive services from their primary care physicians, Monday to Saturday during regular business hours, 8:00 a.m. to 6:00 p.m. After regular business hours, beneficiaries may receive services on extended business hours until 9:00 p.m., Monday to Friday.

**PRIMARY MEDICAL GROUPS ADMINISTRATION DEPARTMENT (PMG)**

The purpose of this department is to serve as intermediary and centralize requests and individual needs of each Primary Medical Group (PMG). Among its goals there are to establish a PMG and PCP’s network that is adequate to the needs of our beneficiary population, facilitate the participation and satisfaction of participating providers and promote the financial success of the PMGs. Among its objectives, it also includes carrying out workshops on billing processes, reduce adjustment requests from providers with a greater difficulty, promote the use of the Electronic System, evaluate fulfillment of Plan Compliance, help them get acquainted with the correct billing and reconciliation processes and request for adjustment, among others.

Any question or concerns can be address through your Provider Service Executives or the Financial Advisors of the PMG.
PROVIDER SERVICES DIVISION

The purpose of the Provider Services Division is to serve as intermediary and centralize the requests and particular needs of each provider. Among its goals is to support the network of providers whose adequacy to serve the needs of our beneficiary population is worked together with Triple-S Salud Network Management Division. It also orientates the Network of Providers on topics such as the managed care model and facilitates the participation and satisfaction of participants and providers. The Division has a Professional Relations Department, which specializes in attending to and satisfying the needs of our Network of Providers. Among its objectives are to carry out seminars on the billing process, to promote correct billing to decrease adjustment requests from providers, promote the use of the Electronic System and provide orientation on the correct billing, reconciliation and adjustment requests processes.

Any question or concern that the network providers may have, must be directed to our External and Internal Service Executives.

BENEFIT COVERAGE

The Health Insurance proposed will have broad coverage with minimal exclusions. There will not be exclusions, limitations, or waiting periods for preexisting conditions when granting coverage to the beneficiary. The beneficiary’s eligibility date will determine the coverage of benefits contracted, even when the required procedure or treatment has been medically recommended prior said date. The Health Insurance Administration will review, from time to time, the benefits it will includes in the Health Plan contracted. (See Attachment 1 – Puerto Rico Health Insurance Administration Government Health Plan (GHP) Coverage)

The Mental Health coverage for GHP beneficiaries will be provided through company contracted by Triple-S Salud, Inc.

For Plan beneficiaries who have Medicare Parts A and B and Medicare Part A only, the coverages will be:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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The table that follows describes the codes that will appear on the coverages:

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<td>MS</td>
<td>Medical – Hospital services</td>
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**THE GOVERNMENT HEALTH PLAN COVERAGE**

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**Medicare Coverage**

For subscribers that are also eligible to Part A and/or Parts A and B of the Medicare Federal Program, medical coverage will be as follows:

- **Subscribers with Medicare Part A**
  - They will be offered GHP regular coverage, excluding the Part A benefits. The GHP benefits will be activated once Medicare Part A benefits are used up.
- Part A deductible are not covered by GHP.
- The payment of the deductibles for GHP will be according to the table by payment capacity offered to all subscribers of the managed care health plan.

- **Subscribers with Medicare Parts A and B**
  - Will be offered the regular pharmacy and dental coverage of GHP
  - Includes the payment of Medicare Part B deductible and *coinsurance*
  - Does not include the payment of the Part A deductible.

**COORDINATION OF BENEFITS**

The participating provider in Triple-S Salud under GHP coverage is required to coordinate benefits with other health plans. These include, but do not limit to *Medicare*, other health insurance companies, or health maintenance organizations, non-profit associations organized under Law 152 of May 9, 1942, health plan sponsored by employee organizations, labor unions and any other entity that is responsible for the coverage of claims billed to Triple-S Salud for benefits rendered to subscribers.

For the beneficiaries of GHP through Medicaid, always this plan will be the secondary payer after any other entity or person held responsible of covering any claim for services rendered to a beneficiary. *(See Attachment 2 – Directives to Coordinate the Payment of Services / Coordination of Benefits Form).*

**DEDUCTIBLES**

Beneficiaries will pay copayments according to their level of medical indigence, distributed by Medicaid, from 0% to 200%. PRHIA will inform Triple-S Salud the levels of indigence. Subscribers with indigence level ranging from 0% to 50% will pay no deductibles. You may find the Deductibles Table in the attachment section. *(See Attachment 3 – Co-Pays & Co-Insurance – Effective on July 1st, 2013)*

**THE GOVERNMENT HEALTH PLAN CALL CENTER**

This is a health screening telephone service (Triage) to evaluate, provide orientation and inform on health topics. It is available to all Triple-S Salud plan members, through the toll-free number, 1-800-981-1352, and available 24 hours a day all year through.
The call center, located in the annex building, behind Triple-S Salud’s main building, has a staff of more than 30 nurses with a currently valid license to exercise the profession of nursing in Puerto Rico and an average of 7 years in intensive care as well as in emergency room in clinical experience. The main purpose of the Government Health Plan Call Center is to direct the person calling to the appropriate level of care, according to the symptoms the person presents when calling. Our experience with the service has been that approximately 75% of the persons that call, with the intention of visiting an emergency room, require a lower level of care, once the nurse evaluates the person according to the clinical criteria.

The evaluation is made through a computer tool called Personal Health Advisor. The tool is based on algorithms and was developed and validated by physicians of all specialties and supports consistency in the recommended service levels, increases the speed at which an answer is given and decreases the possibility of errors in the process. It is composed of more than 580 algorithms classified in five categories: pediatric, adult, elderly, woman health and mental health. These algorithms or series of questions are grouped in order of severity and their objective is to discard possibilities to perform a non-diagnostic evaluation and, identify which is the optimal level of care for the beneficiary, according to the symptoms the person presents. The different recommendations may be to call 911, go to an emergency room, call your primary care physician, make an appointment with your physician or recommend the use self-care techniques at home.

Besides, our nurses handle general health information questions on topics such as chronic conditions, nutrition, prescription drugs, and diagnostic tests, among others. We also provide orientation service through our Health Telephone Library. The Health Telephone Library counts with a number of general health topics such as: diabetes, heart and circulatory problems, respiratory and lung disease, medications, first aid, children’s health men’s health, women’s health, elderly health, mental health, foot care, eye care, nutrition, exercise, cholesterol, stress, substance abuse, sleep disorders, infectious disease, safety, common disease and diagnostic procedures, among others.

When a physician is going to be absent for a determined period, we recommend that he/she programs his/her telephone answering machine to direct your Triple-S Salud plan members calls to the Government Health Plan telephone service. In this way, patients will always have access to orientation, evaluation and reliable health information.

Our staff is available to offer orientation to the physicians of your PMG on the multiple benefits of the Government Health Plan for the beneficiaries and your PMG. You may call (787) 775-1352 to coordinate an appointment.
ADDED VALUE OF THE GOVERNMENT HEALTH PLAN CALL CENTER TELEPHONE SERVICE

- You patients have access to health information, orientation and evaluation 24 hours a day, 365 days a year.
- It saves time to your patients, for they will not have to wait long hours at an emergency room unnecessarily, for situations that can be solved with a medical appointment or treated at home.
- The Government Health Plan Call Center nursing professionals support physicians by instructing the patients to comply with the medical treatment and help maintain the medical-patient relationship.
- Monthly or annual reports with statistical information are generated for the evaluation of the volume of calls and the impact of emergency room services utilization.
- We have strict service levels that have allow us to obtain quality accreditations for the Health Information Line Library (NCQA) as well as for the health call center Health Call Center (URAC). All this through McKesson Health Solutions, which is our service provider.
MANAGED CARE MODEL: HEALTH EDUCATION AND PREVENTION

It is Triple-S Salud, Inc. responsibility to offer its beneficiaries of GHP its Wellness Program, which includes health education and prevention services, known as Managed Care Program. The objective of this program is to keep the beneficiary informed on the risks related to the most prevalent conditions and promote lifestyles that result in an optimal health. Under this model, each PMG will be required to have a Health Educator and a Nutritionist as part of its multidisciplinary care team, thus the PMG will be responsible for the delivery of these services.

According to Puerto Rico vital statistics, in general, the principal causes of mortality and morbidity in Puerto Rico are heart diseases, diabetes, cancer, respiratory disease, HIV/AIDS and accidents, among others. There are other factors that can lead to the development of health problems and chronic conditions that can be prevented and it is very important to keep beneficiaries informed.

Through the development of group and individual educational activities conducted by health educators and other health professionals, they will offer beneficiaries education to promote prevention and modification lifestyles not conductive to a healthy life. An essential and important element of these activities is to motivate beneficiaries to make voluntary changes to their lifestyles in order to achieve better health. In the implementation of this program, they will also promote the availability and coverage of preventive services available according to each life stage.

The program workshops on prevention and health promotion will be offered at the PMGs, medical offices and in community activities. These educational activities are developed in response to the vital statistics of the Puerto Rico Department of Health, particular situations such as an outbreak of a disease or an epidemic, educational needs identified by the PMGs, physicians and according to the educational and wellness plan submitted by Triple-S Salud.

Part of the educational and Wellness plan will include collaborative agreements with the Puerto Rico Department of Health, the Puerto Rico Lung Association, Cancer American Society, Puerto Rican Diabetes Association and the Puerto Rican Heart Association, among others.

CARE MANAGEMENT DEPARTMENT

OBSTETRICS PROGRAM – TRIPLE-S PRENATAL

Triple-S Salud designed an Obstetrics Model and a Prenatal Education Program for female beneficiaries of the Government Health Plan subscribed by Triple-S Salud, certified as pregnant patients, to provide patients orientation on prenatal care and the care of infants.
The Education and the Disease Management Departments have developed the Triple-S Prenatal Program aimed to pregnant beneficiaries. For beneficiaries with high-risk pregnancies, the program offers telephone interventions as well as educational group activities. In which they offered information on the importance of prenatal care, the steps to follow for a healthy pregnancy and promote health changes in behavior the mother and the unborn child. The beneficiary may be referred to the Triple-S Prenatal Program via fax at (787) 706-2550.

The Primary Medical Group (PMG) does not assume the financial risk of the medical services under GHP coverage during pregnancy and post partum stages. Coverage extends up to 56 days after normal delivery or c-section delivery or 30 days after a miscarriage. The obstetrician must be a Triple-S Salud participating provider for GHP beneficiaries, but he does not have to be a physician of the Primary Medical Group (PMG).

The pregnant beneficiary will choose the obstetrician within the network of providers to provide the prenatal care. During the first prenatal evaluation, the obstetrician will inform the beneficiary if he can take charge of her prenatal care and the delivery. The obstetrician will determine if he has space and the capacity to include another pregnant woman under his care and management. If he is able to take charge of the patient’s care, the physician will register the patient by filling out the Registration Form for Obstetric cases and Referrals to the Educational Program (See Attachment 4 – Obstetric Registration Form) and will inform Triple-S, by fax at (787) 774-4835 or electronically through our webpage at www.ssspr./sesweb.

Registration requests sent by fax to the Special Coverage Registration Unit will be processed and registration evidence will be mailed to the beneficiary. If the obstetrician registers the patient through our webpage, he will be able to give the beneficiary the obstetrics registration letter on the beneficiary’s first visit to his office. This will allow the beneficiary to go to the laboratory to make her the test prescribed by the obstetrician and get her prescription drugs without having to obtain the authorization or a referral from the primary care physician. Registration cannot be performed unless the physician completes the 4P+ Questionnaire.

Certified pregnant beneficiaries will have free access to the necessary obstetrics services to guarantee adequacy and quality of prenatal care.

The Disease Management Department has available a nursing staff to coordinate the necessary medical services for beneficiaries with high risk pregnancies. Among these services there are:

- Coordination to give glucometers and strips to diabetic pregnant beneficiaries
- Coordination of appointments at high-risk pregnancy clinics.
- Identification of cases at risk of preterm births and coordination for treatment with progesterone in case it is ordered the obstetrician.
Some obstetrics procedures performed at the obstetrician office, require Triple-S precertification through its Precertification Department. These are:

- Biophysical profile
- Non-Stress Test/NST

To request a payment precertification for these services, the obstetrician must fill out the Precertification Request Form of the Obstetrics Program and fax Triple-S Salud/GHP at (787) 749-9980 or contact the Precertification’s Call Center at 1-866-365-9024. (See Attachment 4 – Obstetric Registration Form)

DISEASE MANAGEMENT PROGRAM

Triple-S Salud offers GHP beneficiaries the Disease Management Program. This program is designed to address the chronic conditions that most affect the country’s public health: diabetes, asthma, hypertension, congestive heart failure (CHF), obesity, depression, and stage I and II renal disease. This program includes services such as support to the treatment offered by your primary care physician, follow-up by nurses and health educators and instructions on how to know and control your condition.

The objective of the Disease Management Program is to help physicians in the tasks of caring for their patients through different strategies such as telephone calls, written communication, printed materials, educational workshops, among others, in order to reinforce recommendations and motivate the patient to comply with said recommendations.

The primary source of contact of the Program is by telephone and is available in a schedule convenient for the beneficiary. Part of the strategies aim to inform primary care physicians on the health progress of the beneficiaries and review the guidelines to treat the conditions previously mentioned.

Another essential component for the development of this program is Health Education. A team of professionals is available to provide group or individual direct education to the beneficiaries under the Program. The staff provides disease self-control techniques such as the use of the glucometer, the use of the maximum exhalation meter, among others. Beneficiaries identified as eligible to the Program are invited to participate in educational activities by mail or telephone call. The Program also mails them information brochures and invites them to participate in community activities such as health fairs and special clinics.

The educational program on the management of chronic conditions offers different workshops for each of the conditions included in the Disease Management Program:

- **Heart Failure** (for beneficiaries with heart failure who are over age 18)
- **Asthma** (for beneficiaries with asthma aged 5 to 56)
- **Diabetes** (for beneficiaries with diabetes who are over age 18)
▪ **Hypertension** (for beneficiaries with hypertension who are over age 18)
▪ **Weight control** (for beneficiaries with overweight or obesity problems who are over age 18)
▪ **Depression** (for beneficiaries with depression who are over age 18)
▪ **Care of the Kidneys** (for beneficiaries with stage I and II renal disease who are over age 18)

The primary care physician may refer any patient he understands that can benefit from the Program. The beneficiary identified or referred by the primary care physician will be evaluated according to the utilization claim history, pharmacy utilization, comorbidities and complications to determine his enrollment in the Program. Every primary care physician must fill out the referral sheet (See Attachment 5 – Referral for Disease Management Program) and send it to the Disease Management Program via fax at (787) 625-8722 or via email: manejodeenfermedades@ssspr.com. After the evaluation, they will inform the determination to the physician and the action plan for the referred case. Triple-S Salud will provide the primary care physician a report on the health status of all the beneficiaries participating in the Program.

**CARE MANAGEMENT PROGRAM**

Triple-S Salud Case Management Program offers beneficiaries the opportunity that a qualify staff can serve as guide and support, and help them coordinate medically necessary services or procedures included in their benefit coverage, as applicable.

Triple-S Salud is committed to provide the best care to individuals and organizations that acquire its services. Thus, the Case Management Program has been established with the goal of implementing a patient-centered program that follows the case management process to promote quality effective outcomes in compliance with local and federal regulations. The mission of this program is to facilitate communication, coordination and integration of services to beneficiaries with complex health condition among all the members of the health team, to promote adequate use of the health resources in order to improve quality of services and promote cost-effectiveness. Through the case management process, we can help to identify care options when the requested service is not covered or the patient has used up the benefit. The nursing staff will identify options to help the beneficiary/representative or provider to find another level of care that fulfills the need, with the purpose of improving its quality.

Participation in our Case Management Program is voluntary. Services offered by the Case Management Program target policyholders of Commercial line of business and beneficiaries of the Government Health Plan. The Case Management Program focuses on enrollees with special health needs that require individual attention for quality of care. Interventions include communication, coordination, support and resource management. Case manager interventions may include but are not limited to: telephonic, home visits/security risk assessment, email, and letters.

Triple-S Salud Case Management Program offers enrollees the opportunity to receive needed care in a coordinated and effective way and following best existing evidence based clinical practice.
Some of the home care alternatives that may be coordinated are:

- Intravenous antibiotic and other intravenous prescription drug therapy
- Pain management
- Chemotherapy
- Hydration
- Physical, speech and occupational therapy
- Wound or ulcers care

Note: To refer other potential conditions to the Case Management Program, the person issuing the referral must use Potential Referral Form and sent via fax at (787) 774-4837. (See Attachment 6 – Potential Patient Referral – Case Management Department)

**PRECERTIFICATION**

Triple-S Salud recognizes the need of precertifications or prospective review of high cost services or with a high utilization potential to ensure cost-effectiveness and quality of the services rendered to the beneficiaries. It also recognizes the need to use clinical guidelines to ensure consistency and uniformity when making decisions.

The precertification of certain services and procedures has been assigned to **McKesson Health Solutions PR, Inc.** The nurses work at a call center available 7 days a week and use the InterQual® Guidelines to be consistent in their decision-making. When the precertification does not comply with the criteria set by these guidelines, it is referred to a medical advisor for the final determination. The process of denial, reconsideration and appeal of a determination on a precertification is always assigned to independent medical advisors contracted by Triple-S Salud. A preauthorization may be requested by calling the Precertification Call Center at 1-866-365-9024 or by fax at (787) 749-9980. To know which are the procedures, and their codes, that require precertification, please check the table that details them. (See Attachment 7 – Codes that Require a Precertification through Triple-S Salud Call Center and See Attachment 8 – Request Form for Nuclear Studies).

The nurses, pharmacy assistants and licensed medical specialists from the Utilization Review Unit of Clinical Management Division make the determinations on precertifications for special coverage, non-emergency transportation, ambulance services or procedures and services not covered or limited by the policy. To be consistent in making clinical decisions, they use the criteria, guidelines, protocols and policies developed by PRHIA, Triple-S Salud, the FDA and well-known Medical Organizations.

**SPECIAL COVERAGE**

The special coverage is a registry provided to beneficiaries with high cost, complex medical conditions to facilitate access to the services of the specialist in charge of treating the condition without affecting the financial soundness of the Primary Medical Group.
To grant a special coverage registry, it is necessary to the primary care physician or the specialist in charge of treating the beneficiary requests it. The physician requesting the registry must request must send all the documents required for the registry, as set for each condition in the Special Coverage Registry Form (See Attachment 9 – Special Coverage Registration Form, Oncology Initial Registration Form, Children with Special Needs Form, Obstetrics Registration Form). The physician may fax the documents to (787) 774-4835 or send them via e-mail to cubiertasespeciales@ssspr.com.

Conditions that require the Special Coverage Registry are the following:
- Aplastic anemia
- Rheumatoid arthritis
- Autism
- Cancer
- End-stage Renal Disease (stages 3, 4 and 5)
- Scleroderma
- Multiple Sclerosis and Lateral Sclerosis
- Cystic Fibrosis
- Hemophilia
- Children with special needs
- Obstetrics
- Post Organ Transplants
- Lupus erythematosus and systemic lupus
- Tuberculosis
- HIV/ AIDS
- Leprosy

**PRESCRIPTION DRUGS**

Our pharmacy coverage is governed by a formulary established by PRHIA, the Medullar Formulary and a Preferred Drug List (PDL). The PDL will be distributed to the Primary Medical Group (PMG) primary care physicians, specialists, emergency rooms and hospitals. The PDL details prescription drugs covered, as established by PRHIA, the prescription drugs that need preauthorization for payment (PA) (See Attachment 10 – Request for Medical Information Pharmacy Department) those that need step therapy or the plan limits the amount to be dispensed (AL) and contracted drugs with federal legend.

The PDL has seven lists of preferred drugs:
- Physical Health
- Dental – For the use of dentists, do not require the countersignature of the primary care physician.
- Emergency – For the use of the emergency room physician without requiring the countersignature of the primary physician. The quantities of the medication are limited.
✓ Nephrology – For the use of nephrologists with beneficiaries registered in the nephrology special coverage.
✓ OBGYN – For the use of obstetricians with female beneficiaries registered in the obstetrics special coverage.
✓ Oncology – For the use of oncologists with beneficiaries registered in the cancer special coverage.
✓ HIV/AIDS – For the use of physicians with beneficiaries registered in the HIV/AIDS special coverage.

Except those prescription drugs in the Physical Health Category, the prescription drugs in the other formularies do not require the countersignature of the primary care physician if they are prescribed by the physician in charge of rendering the services or of treating the condition. Prescription drugs prescribed by physician within the preferred network of the Primary Medical Group do not require the countersignature of the primary care physician.

The pharmacy coverage makes mandatory the use of generic bioequivalent drugs classified as “AB” by the Food and Drugs Administration (FDA) as first option. These drugs can be identified in the PDL because they are written in bold. The brand name is only used for reference. The physician must always use the drugs included in the PDL as the first option to treat a condition. Some prescription drugs included in the PDL are subject to preauthorization for payment.

✓ Some of the prescription drugs included in the Formularies are subject to a preauthorization for payment.

To preauthorize prescription drugs for payment, the provider or the facility must send by fax to (787) 625-8698 the Request for Medical Information Pharmacy Department (See Attachment 10 - Request for Medical Information Pharmacy Department) together with the following documents:

- Prescription and the diagnosis, including the physician’s NPI.
- Patient’s name and contract number.
- Clinical instructions and laboratory tests or studies justifying the use of the drug prescribed.

PRHIA has established an exception process for prescription drugs that are not available in the PDL.

**Exception Process established by PRHIA for the approval of prescription drugs not included in the Formularies**

The information that follows describes the criteria to use for the approval of a prescription drug through the exception process.

1. Any prescription drug prescribed and approved, through this process must have the approval of the Food and Drug Administration (FDA).
2. The pharmacy coverage does not apply to drugs in their experimental stage or for experimental purposes not approved by the FDA.

3. Physicians must check that the drug to be prescribed is included in PRHIA’s PDL.

4. If the prescription drug is not included in the PDL, the physician must contact Triple-S Salud to ensure the following:

   a. The prescription drug does not have a generic bioequivalent available in market.
   b. Any drug prescribed must be clinically indicated for the condition to be treated.
   c. The prescribing physician must justify and provide evidence that he is prescribing the drug for any of the following reasons:

      1) There are contra-indications for some of the prescription drugs included in the PDL.
      2) Patient’s history of adverse reactions to some prescription drugs included in the PDL.
      3) Therapeutic failure of all the options available in the PDL.
      4) There is not a therapeutic option in the PDL.
      5) The patient is epileptic and has been taking a prescription drug approved by the FDA that is not included in the PDL, and the disease is under control with said drug.
      6) In cases in which the patient has been diagnosed epilepsy for the first time, treatment must begin by prescribing the generic drugs available in PRHIA’s PDL. Brand-name drugs will only be prescribed if the patient’s condition cannot be stabilized with the generic drug or vice versa.
      7) Once the drug is clinically validated, the physician will proceed to issue the prescription to substitute the drug being used for the one requested as an exception or by a prescription drug included in the PDL.

If for clinical reasons, they must authorize the prescription drug not included in the PDL, the drug must not be in its experimental stage and the FDA must have approved it to treat the condition for which it is prescribed. The drug will be authorized, even if it is not included in the Medullar Formulary, without delay, through a dispensing exception.

A detailed explanation on the policies and procedures for pharmacy processes and the PDL is available in **Attachment 11 – Policy and Procedure of Drugs Preauthorization of the Health Plan of the Government and Policy and Procedure for the Process of Exceptions of Drugs of the Government Health Plan.**
AMBULANCE SERVICE

Transportation in emergencies such as the ones mentioned below, do not need precertification:

- from the beneficiary’s home to an emergency room or a hospital
- from hospital to hospital
- from emergency room to hospital

Non-emergency ambulance transportation services require preauthorization. To request said preauthorization they must fill out the Certificate of Medical Necessity for Ambulance. (See Attachment 12 – General Guidelines Use of Ground Ambulance Service, Certificate of Medical Necessity for Ambulance). Example of cases in which the service is authorized: transportation of beneficiaries to dialysis facilities, bedridden beneficiaries or beneficiaries that need mechanical ventilation.

Air Ambulance

Aerial emergency transportation services are provided and paid for ASES under a separate contract. Triple-S shall coordinate the provision of aerial emergency transportation on behalf of its enrollees when medically necessary utilizing the providers designated by ASES.

CLINICAL UTILIZATION REVIEW

Triple-S Salud performs prospective, concurrent, and retrospective reviews in order to keep health services cost effective without influencing the medical care decisions of the patient. The InterQual® Guidelines are the guidelines used to carry out this evaluation and maintain uniformity in decision-making. The staff that carries out the evaluation is licensed nursing professionals, certified in the use of the guidelines and with broad hospital experience. Denial determinations are always made by medical specialists. The processes carried out by the department include hospital admission registry, concurrent review, and retrospective review, review of emergency room services, appeals process and arbitration process. The information that follows explains all these processes in detail.

HOSPITAL ADMISSION REGISTRY

It is required for the payment of the services, that admissions are registered electronically through SES Web or through the McKesson Call Center at 1-800-981-1352, within a term of 24 hours from the date the person was admitted. This does not apply to admissions for deliveries, c-sections or to elective or ambulatory surgeries. Elective or ambulatory surgeries require for payment a referral from the Primary Medical Group (PMG). There must be one registration per admission. The registration number must be included in the claim for the payment process to be fast and effective. This registration number must be the same number the review analyst documents in his evaluation.
CONCURRENT EVALUATION

It is required that the medical files of all Triple-S Salud admitted at the hospital are submitted on the next business day for the analysts assigned to each hospital can proceed with the concurrent evaluation. If the beneficiary is discharged from the hospital over the weekend, on a holiday or after the analyst has completed his work schedule, it is preferable to keep the file on the floor where the patient was hospitalized and be handed to the analyst to complete and close its evaluation.

RETROSPECTIVE EVALUATION

For retrospective evaluations, it is required that the medical record is complete. The medical record must be submitted within a term that does not exceed 15 days from the date the person was released from the hospital.

EMERGENCY ROOM EVALUATION

The emergency room evaluation is only carried out for those beneficiaries that have begun the benefits eligibility process and the process was not completed. They also evaluate mental health diagnostics which have been billed to us, to determine if they have received physical health services and Triple-S Salud is responsible for their payment.

APPEALS PROCESS

The appeals process is a process to which the beneficiary is entitled, which allows the person to request a reevaluation of a determination Triple-S Salud made and with which the person does not agree. It is requested for denials for the payment of procedures and admissions. The appeals process may be initiated by the beneficiary, the provider, the facility or by a representative appointed by the beneficiary. The term to request an appeal is 45 days from the date the determination was notified. When the beneficiary’s health condition requires an expedite determination, the appeal process can be begun as soon as he receives the determination notice.

The person requesting the appeal must submit comments, written documents or any other information related to the appeal. It must include the patient’s name, the contract number, date of service, the place where the service will be rendered, copy of the medical file or a document justifying the medical need or any other information relevant to the medical condition of the patient that justifies the service.

To request an appeal, the person requesting it must clearly specify that he is requesting an Appeal to the prior decision. The information may be faxed to (787) 774-4839 or sent by mail addressed to

CLINICAL REVIEW MEDICAL DIRECTOR
TRIPLE-S SALUD, INC.
PO BOX 363628
SAN JUAN, PR 00936-3628
Re-appeal – If the beneficiary, his representative or a provider do not agree with the determination on the appeal, they may initiate re-appeal within a term of up to 15 days from the date appeal determination was notified.

**ARBITRATION PROCESS**

This is a mechanism established in the provider’s contract to clarify any controversy regarding the denial of days or of a service, after exhausting all the administrative processes established: appeal and re-appeal.

**INCORPORATING NEW TECHNOLOGY**

New technology refers to any new procedure or medical device for diagnosis or treatment that is available on market, which has the due approval of the Food and Drug Administration (FDA).

Triple-S Salud, through its Medical Policy Department, performs an ongoing evaluation of emerging technology on the market. The purpose of this ongoing evaluation is to recommend or not the inclusion of said technology in the Plan different benefit coverages. As part of this evaluation, Triple-S Salud will consider the determination the Blue Cross Blue Shield, as well as CMS determination and those made by well-known medical associations. To consider the inclusion of the new technology evaluated, it must comply with corporate criteria and must also be in tune with a payment policy that tempers quality and cost effectiveness.

**CLINICAL QUALITY PROGRAM**

**DESCRIPTION OF THE PROGRAM**

The Clinical Quality Program is in operation since April 1, 1995. It is supervised by a duly licensed physician, in accordance with of Puerto Rico law. The clinical nursing staff, who have a bachelor's degree or a master's degree, carry out the evaluations of the clinical practice guidelines, as determined by recognized sources among which there are the Puerto Rico Health Department, CMS and well--known professional practice Associations.

The Clinical Quality Program directs its attention and effort to the monitoring, measurement, analysis and evaluation of those processes or activities that have the greatest impact on the quality of services rendered to the membership. The program has developed a system of quality assessment, addressed to the primary physician, participating providers and the medical team, which measure compliance with established standards.
The work of the Quality Review Specialist is strategically divided by municipalities. Every specialist has about 100 primary care physicians under her supervision, and she is responsible to check for the implementation of quality assessment, discussion of the results of the measures "Healthcare Effectiveness Data and Information Set" (HEDIS) and serve as a support agent in the implementation of corrective measures. The Quality Program develops a comparative quality profile of each primary care physician, by specialty and a profile for each Primary Medical Group (PMG). This profile allows us to identify areas for improvement, so we are more efficient in the interventions that we do.

QUALITY EVALUATIONS TO THE PRIMARY CARE PHYSICIAN

1. **Documentation of the Medical Record** – The medical record is a medical-legal document that gathers the health and illnesses history of the patient. In the record information regarding medical visits, consultations and/or services rendered must also be documented. To ensure this happens, we have developed indicators to measure the confidentiality of information, the availability and adequacy, continuity and coordination of medical care. The indicators have been developed in accordance with the requirement of regulatory agencies, Law 101 of June 26, 1965, related literature and quality indicators accepted as established by the National Committee of Quality Assurance (NCQA). The parameters evaluated are:

   a. Availability
   b. Security
   c. Organization
   d. Confidentiality
   e. Documentation:
      - Demographic data
      - Habits
      - History and physical examination
      - Medical problems
      - Medications
      - Progress Notes
      - Diagnostic
      - Consultation
      - Education
      - Ancillary services
This evaluation is made to primary care physicians and participating providers.

2. **Documentation of Preventive Services** – When reviewing the medical record, they will verify that preventive services for certain health condition and by life cycle are adequately documented and are managed according to the set quality standards such as the guidelines for Early and Periodic Screening, Diagnostic and Treatment (EPSDT), Community and Migrant Health Centers (CMHC) y NCQA. Preventive services cover the following conditions:

   a. Chronic conditions:
      - Diabetes Mellitus
      - Asthma
      - Hypertension
      - Congestive Heart Failure

   b. Life cycle:
      - Prenatal care
      - Childhood (infancy, early and late childhood)
      - Adolescence
      - Adult (feminine cancer, masculine cancer and cardiovascular risks)
      - Geriatrics

   c. Prenatal care:
      - Laboratory protocol
      - Prenatal care visits
      - Education
      - Biometric profile

   d. Gynecological services:
      - Breast cancer screening
      - Cervical cancer screening
      - Physical exam
      - Immunizations
      - Education
      - Mental health screening

This evaluation is performed annually to primary care physicians.
3. **Inspection of physical facilities** - To ensure accessibility, privacy and safety of physical facilities where health services are rendered to our plan members, we developed the inspection of the physical facilities. The parameters evaluated are the following:

   1. Physical appearance
   2. Safety
   3. Privacy and confidentiality
   4. Accessibility
   5. Medical emergencies
   6. Control of infections
   7. Storage of samples

   The inspections of primary care physicians and participating providers is carried out annually.

4. **Compliance with the physical health and mental health integrated model** - One of the major changes incorporated as part of GHP Model is the integration of physical health with mental health. Audits of compliance with the integration model are addressed in two areas:

   i. **Compliance with the collaboration phase**: It consists mainly of assessing compliance with screening guidelines including but not limited to ASQ-9 (Ages and Stages Questionnaire) and TWEAK. It also measures the communication process between mental health and physical health professionals.

   ii. **Compliance with the collocation phase**: It consists mainly of assessing compliance with the process of early treatment of population at risk.

5. **Standards for care availability and accessibility** - GHP Model incorporates additional standards on the availability and accessibility to care. Standards of the medical appointment systems will be considered with special emphasis.

6. **Quality standard of medical record documentation, preventive services and facilities** - A minimum standard of 80 percent of compliance is required. A corrective action plan will be required if a percentage less than eighty is obtained. It is expected, at least 20 perceptual points increase per year until the goal of 80 percent of compliance is obtained. If this is not achieved, sanctions are going to be applied as per contractual requirements.

7. **Autism Screening Standards** - It is required that each primary care physician performs a screening on autism or its related syndromes screening mainly using objective screening instruments such as the M-CHAT.
QUALITY EVALUATIONS TO THE PMGS

1. **PMGS encounter submission** - A bidirectional encounter submission auditing process in place. This process measures (a) That every encounter documented on the medical record appears as a processed encounter claim in Triple-S claims system and, (b) That every encounter processed on Triple-S claims system have an associated documentation on the medical record and that the documentation is appropriate.

2. **Management of Vaccination Centers** - The Quality Program promotes vaccination of the population at risk. This is a very important preventive indicator, for it represents a decrease in the risk of contracting contagious diseases. The evaluation of Vaccination Centers is an initiative that supports quality evaluation of the Health Department, Vaccination Department. Both availability and accessibility of services are evaluated annually.

3. **Integration of Mental Health and Physical Health** - The primary medical Group must promote the integration of physical health with mental health, as required by GHP Model, including but not limiting to contracting a mental health professional for the facilities of the Primary Care Group, who should work at least twice a week. In addition, the medical group must ensure that the mental health professional performs the appropriate screening for mental health conditions, as recommended by the clinical evidence guidelines. To this purpose, we have designed a series of audits intended to measure compliance with this requirement.

4. **Compliance with preventive evaluations** - PMG’s will be evaluated to assure compliance with preventive services recommendations according to established guidelines. PMG’s will be profiled based on its PCP’s medical record review audits, administrative preventive data and utilization of Preventive Centers.

**HEDIS MEASURES**

HEDIS is a set of standards used to measure the performance of health plans. It consists of measures whose selection criteria are relevance, scientific validity and viability. The categories are:

- Effectiveness of care
- Accessibility and availability of care
- Satisfaction with care
- Utilization of care
- Cost of care
To calculate HEDIS measurements, one can choose two methods: administrative, which gathers claims data or hybrid, which gathers data from medical records reviews. In addition, the development and improvement of HEDIS measures is a requirement of the Health Insurance Administration (ASES, for its acronym in Spanish).

Among other initiatives, every year the Quality Program will inform the PMG’s and the primary care physicians, the results they obtained compared to their Region and the Mean, the NCQA national average. The purpose is to work collaboratively to develop improvement strategies.

INFORMATION CONFIDENTIALITY POLICY

The PMG and Triple-S Salud have the responsibility to protect the confidentiality of the beneficiaries’ clinical information, as required by state and federal laws (Bill of Rights of the Constitution of the Commonwealth of PR; 1979 PR Evidence Rules; Law 101 of June 26, 1965; Regulation #52 of the Department of Health; and the 1974 Privacy Act (P.L. 93579) federal law.

There are special cases in which the confidentiality of information must be protected to a greater extent, for they are regulated by special laws (Mental Health Code of PR and Regulation #51 of the Department of Health). These cases include beneficiaries that are HIV positive, have mental problems and prisoners. Triple-S Salud will use the information about beneficiaries and providers with the sole purpose of complying to the maximum with its functions and responsibilities, in such a way that it achieves its goal of supporting the rendering of a quality and cost-effective health care.

a. Compliance with the Health Insurance Portability and Accountability Act (HIPAA) Federal Law at the Primary Care Physician's Office – Every person that uses the medical record has the moral and legal responsibility of protecting the privacy and security of the clinical information of the patients that receive treatment in that health facility. The primary care physician and his/her personnel are covered by the HIPAA Law and must be prepared to comply. They can use the HIPAA Toolkit, which Triple-S Salud, Inc. provides, as a reference manual. It should be used as a tool to assist them, particularly when working with the Final Privacy Rule and the Proposed Security Rule. The materials contained in the manual are illustrative and may not be seen as legal advice. The information may be subject to modifications, according to federal law changes.

Special cases, such as HIV positive, mental problems and prisoners should be managed under the strictest confidentiality terms, safeguarding the civil rights of these patients and complying with state laws.

b. Access to Medical Records by Triple-S Salud/GHP Personnel – Triple-S Salud is authorized, through a contract with the PMG, on Article XIV, Comment 14.2, 14.4, to revise and copy its medical records with the purpose of conducting audits and evaluations to determine the quality, adequacy, promptness, privacy, security and cost-effectiveness of the services rendered.
under GHP. According to HIPAA, Triple-S Salud, Inc. and its subsidiaries are subject to the applications of the Law to protect the confidentiality of the personal, financial and health information of its customers, plan members, and beneficiaries that it handles as part of its operations.

**CONTINUITY AND HEALTHCARE COORDINATION**

The Continuity and Health Care Coordination Policy establishes that every Primary Care Physician (PCP), specialist, hospital and non-hospital acute care facilities should offer health care services in an integrated manner, assuring continuity and coordination. The purpose is to assure that patients with medical problems receive their health care in a continuous, appropriate and unrestricted way all throughout the provider network. Triple-S Salud/GHP continually monitors the following areas:

a. **Referrals to Specialists**
   1. It is the responsibility of the PCP to know the diagnosis, treatment, medications and clinical history of his/her patients with medical problems.
   2. The PCP is responsible for determining services required by enrollees, provides continuity of care, and provides Referrals for enrollees when medically necessary.
   3. The PCP within a PMG is responsible to manages and coordinates the enrollee’s care in a timely manner.
   4. The PCP shall provide, manage and coordinate services to the enrollee, including coordination Behavioral Health personnel, in a timely manner, and in accordance with the guidelines, protocols, and practices generally accepted in medicine.
   5. If the medical diagnosis requires the services of a medical-surgical specialist, the PCP must follow the procedure for referrals established by the organization. The PCP must comply with the following aspects:
      - Have evidence of the use of the consulting physician in the medical record.
      - The consultation must be justified, according to the diagnosis and treatment.
      - Verify that the consultation form is completed.
      - The results of the consultation must be analyze by the PCP and documented in the progress note.
The PCP is responsible to provide the referral to the enrollee in a term no greater than five (5) days. In the case that the provider is not part of the ePPN, the PCP is responsible to schedule an appointment with the required specialist. The services should be rendering within a reasonable period, according to the beneficiary need. The term should not exceed 30 days after the appointment.

The PCP should provide orientation to the patient regarding the importance of bringing him the treatment plan that the specialist or provider gave him so the physician can make a better coordination for the patient's health care. A copy of this treatment plan must be included in the patient's medical record.

If the organization identifies cases in which the patient's health is at risk for lack of continuity and coordination of the service, the case will be clinically evaluated with the provider and then proceed to render the necessary services to the patient.

b. **Discharge Summary for Hospital Facilities**

To guarantee the coordination of the medical treatment to patients discharged from a hospital facility, it is necessary that the hospital provide the patient a summary of the discharge, to be handling to the beneficiary's PCP.

This is a requirement of the General Regulations for the Operation and Functioning of the Health Facilities in Puerto Rico, in Article G, Section B, Paragraph 6. The discharge summary provides information in order to evaluate the beneficiary’s need for proper medical treatment after hospitalization.

c. **Notification Process for Unsubscribing from a Primary Care Physician or Health Care Provider**

Triple-S Salud will notify the beneficiary's, in writing, 30 calendar days before the effective date of the withdrawal of a PCP or health care provider.

d. **Continuation of access to a primary care physician or health provider**

In those cases in which the patient has an active treatment, when the PCP or health care provider cancellation becomes effective, the patient can remain 90 additional calendar days in a transition plan to assure de continuity of services set forth in the Puerto Rico Patient’s Bill of Rights, Law 194 of August 25, 2000.
PREFERENTIAL TURN

Under Laws No. 86 enacted on August 16, 1997 (Articles 1-4) and Law 200 enacted on August 5, 2004 it is required that all network providers give priority in treating enrollees from the island municipalities of Vieques and Culebra so that they may be seen by a Provider within a reasonable time after arriving at the Provider's office. This priority treatment is necessary because of the remote locations and travel time required for the residents of Vieques and Culebra to seek medical attention.

ELECTRONIC HEALTH RECORD ("EHR") SYSTEM

An electronic record of health-related information on an individual that is created, gathered, managed, and consulted upon by authorized health care clinicians and staff and certified by The Office of the National Coordinator's Authorized Testing and Certification Bodies ("ONC-ATCBs").

The PMG and its participating providers must maintain an electronic information system, installed and fully operational, with the capacity to receive and transmit data electronically to PRHIA and TSS, as well as other entities contracted by PRHIA. This system must be operating 365 days a year, and must also be available to electronically manage:

(a) Verification of beneficiary eligibility;

(b) Verification of benefits;

(c) Verification of financial information (deductibles, co-payments, etc.);

(d) Verification of individual demographic data;

(e) Coordination of benefits

The PMG and its participating provider must also have an automated system providing the following information:

(a) Online history of services for each patient;

(b) Complete demographic data online, including coverage and enrollee financial responsibility;

(c) Online annotations (i.e. general notes about allergies, reminders, and other clinical information in a liberal manner);

(d) Analysis of activity by different data elements.
HEALTH INFORMATION EXCHANGE ("HIE")

The secure and effective electronic transmission (push-pull) of the Personal Health Information of patients between Providers, across organizations within a region, community or hospital system, within a jurisdiction and/or between jurisdictions. HIE is also an entity that provides services to enable the electronic sharing of health Information.

CLINICAL PRACTICE GUIDELINES

In a Coordinated Care Model, preventive medicine is the main focus in the provision of health services. Offering preventive services according to the established guidelines serves as a tool to the primary care physician in the early detection of different conditions and in promoting good health. This will have a positive impact on the utilization of medical services.

Triple-S Salud adopts the following clinical guidelines:

- Puerto Rico Department of Health
- National Committee of Quality Assurance
- US Preventive Services Task Force
- American Academy of Pediatrics
- American College of Obstetricians and Gynecologist
- Other professional organization such as ASA

These guidelines serve as a frame of reference to the primary care physician in clinical activities, such as:

- Identify risk factors
- Facilitating changes or lifestyle modifications
- Choosing immunizations or screening tests
- Make medical records and/or physical exam
- Offer advice and/or education

The Clinical Practice Guidelines summarize the primary preventive clinical measures recommended for conditions such as asthma, diabetes, congestive heart failure and hypertension. These should be used every time the patient visits his physician’s office, even when the reason for the visit is an illness.

Triple-S Salud Clinical Quality Department reviews annually the Preventive Clinical Practice Guidelines used in the following processes:

- Review of quality clinic for preventive services
- Educational workshops to members
The review of Clinical Guidelines will be based on clinical evidence or the recommendations of a panel of experts or as provided by local or federal regulations between them including, but not limited to, the Health Department and CMS. The updates and guides should be available for review of the provider network.

Triple-S Salud Quality Department has been distributing these guidelines to all the primary care physicians for the last two years. When a primary care physician joins Triple-S Salud provider network, he/she receives orientation on the Quality Program and receives a preventive services guide. If the physician or provider request additional information regarding preventive services guidelines, he/she can contact the Quality Department at (787) 273-1110, extensions 3287 or 3285.

**PATIENT’S SAFETY**

Triple-S Salud is committed to improving the patient’s safety through the health care it offers to the beneficiaries. The PMG and the primary care physician are responsible for developing a culture of safety and prevention of medical errors prevention through prospective analysis and redesign of vulnerable systems. It is important that they develop initiatives that promote safe clinical practices that may include orientations, workshops, newsletters for both the beneficiaries and primary care physicians, and collection of information about the steps taken by primary care physicians to improve the safety of the patient, etc.

**CLINICAL IMPROVEMENTS**

The Clinical Quality Program identifies opportunities for improvement through the results of quality evaluations performed to primary care physicians and participating providers and the results of the HEDIS Measures. The Quality Review Specialist is responsible for helping the PCP and the PMG to develop an action plan based on opportunities for improvement, identified in collaboration with the primary care physicians, PMGs and participating providers.

The Clinical Quality Program, in conjunction with the clinical analysis staff, will carry out an analysis of the cumulative data of the quality evaluations to identify opportunities for improvement, determine the causes of problems and take corrective actions.

**INCENTIVE PROGRAM**

To promote the quality and to raise the level of the preventive services provided to our participants, the Incentive Program has been developed. All the parameters follow the compliance with the requirements established by NCQA/HEDIS, the Department of Health, the EPSDT Guides and CMHC Guides.
At present, there are the following incentives:

1. **Triple-S Salud** has developed an Incentive Program for the Physicians. The purpose of the program is supporting the quality among the medical services and increase the preventive services provided to the member. All Triple-S Salud Providers and Medical Group are eligible. The incentive is based on quality parameters such as:

   - Preventive Level Services
   - Medical Record Documentation
   - Measures of secondary prevention in patients with chronic conditions
   - Preventive Services in Obstetrics/Gynecologist among other administrative measures.

The main goal of the incentive is the promotion and coordination of health services in compliance with Preventive Clinical Guidelines. During the measurement year (January to December of the previous year contract), the incentive is based on claims analysis, laboratory outcomes and medical record review. The following criteria are considered for the PCP incentive:

   a) Quality Preventive Evaluation
   b) HgbA1C Outcomes
   c) Utilization Outcomes ARB ACE Inhibitors
   d) HTN Outcomes
   e) Diabetes Mellitus outcomes for COL-LDL
   f) Medical Record Documentation
   g) Site Visit
   h) Participation in Continues Medical Education
   i) Integrated Model: PHQ-9, M- C-hat and ASQ
   j) Complaints and Grievances
   k) Percent Change in Points
   l) Fraud and Abuse

Also for the Obstetricians and Gynecologist the following criteria applies:

   a) Post-Partum Visit
   b) Prenatal Care
   c) Prenatal Laboratories
   d) C/S Rate

2. **Incentive for Vaccine Administration** – Every primary provider that is certified by the Department of Health as a vaccination center can participate in this incentive. It awards $5.00 per administered vaccine.
CONTINUING MEDICAL EDUCATION

Triple-S Salud will be offering a professional continuous medical education for primary care physicians. Educational topics will be selected according to member population necessities. Model of care and any other topic required by ASES. A minimum of six educational credits per region will be offered. Every medical provider is responsible for taking five (5) continuing educational hours per quarter from the program offered by Triple-S Salud, in order to complete twenty (20) hours per year. Provider participation in educational activities is also a criteria of the incentive program.

HEALTH EDUCATION SERVICES

Services for Education and Health Promotion - The PMG will be responsible for hiring at least one health educator and one nutritionist per every twenty thousand members as part of their multidisciplinary care team. If the PMG has less than twenty thousand members, it be required to have one health educator and one nutritionist. This health professional must possess professional license to practice as a health educator which is granted by Board of Examiners of Health Education in PR Office of Regulation and Certification of Professionals in the Department of Health of Puerto Rico. The PMG will have within their responsibilities to plan, develop, implement and evaluate a health and wellness education program for their group members. Professional to fulfill these responsibilities and others described below will be a licensed health education with a bachelor's degree or master's degree. For the development and implementation of this program, there will be the support and advice available from a health education coordinator from Triple-S Salud. Among the PMG's responsibilities to meet through health educator will be:

a) Provide a minimum of 40 educational group activities a month, which include but are not limited to: Prenatal care, postpartum care, chronic conditions, pediatrics, preventable issues aimed at promoting healthy lifestyles, among others.

b) Achieve a minimum of 85% of members and prenatal members through educational and wellness activities.

c) Reach 70% of pregnant women in registry with educational interventions regarding prenatal care topics such as:

1. Importance of prenatal and post partum visit
2. Breastfeeding
3. Stages of birth
4. Oral health
5. Family Planning
6. Behavioral health: Domestic violence, depression among others
7. Newborn care

d) Screen 50% of women in post partum period for that quarter for Depression using Edinburgh screening tool.
• Report the number of cases referred to the MBHO with an Edinburgh score of 10 and above.

e) Coordinate educational activities for members on Mental Health with the mental health provider contracted by Triple-S Salud.

f) Refer members to: Case Management Unit, Disease Management Unit and mental health provider according to identified need.

g) To administer screening tests such as: PHQ9 and Edinburgh.

h) Establish partnerships with government, municipal, private and community-based agencies to coordinate and provide educational activities to members.

i) Cooperate and implement on at least one educational campaigns quarterly. Educational campaigns are going to be developed on the following topics:

1) Nutrition and exercise; knowing your BMI
2) Importance of preventive dental exam
3) Awareness of HPV vaccination
4) Preventive cancer screening
5) Stress management among others.

j) Promote and participate in outreach events coordinated by the Coordinator of Community Outreach Triple-S as: Encuentros de Embarazadas, Ruta Asma and Bienestar Total.

k) The PGM health educator must participate in all announced health educators meeting in Triple-S Salud.

l) Provide monthly health education activities schedule in the format provided by Triple-S Salud. This calendar will be delivered on the 10th of the previous month.

m) Perform all productivity report, statistics, program evaluation, monthly, or on the date indicated as required by Triple-S Salud.

n) To use and distribute all educational materials to be supplied by Triple-S Salud with ASES logos and authorization number. This educational material will be used in all educational activities of Government Health Plan members.
The admission and termination policy for PMG’s, PCPs and ePPNs providers, intent to guarantee a continuous, agile and uniform process when a provider apply to a PMG.

The admission and termination forms can be request to the Financial Advisor representative designated to a PMG or at the Triple-S main office.

It is important to complete all fields in the form since it will be return to the sender if the information is incorrect or incomplete. Complete all information necessary to guarantee that the process will be fast and that the admission or termination of the provider will be complete as quickly as possible in accordance with this policy. The information will be uses to update the PMG Directory.

ADMITTING A PCP/EPPN PROVIDER TO A PMG

1. Providers who want to participate in a PMG as a primary medical physician shall complete the PCPs Request for Admission to PMG Form or the ePPN Request for Admission to PMG Form, if is a specialist. *(See Attachment 13– PMG Administration Department, Configuration Area Physician Request for Admission to PMG).*

2. The provider has to submit the form to the PMG Administrator to which he/she wants to be included.

3. The PMG Administrator shall verify that the PCP or ePPN provider is an active participant of Triple-S Salud, Inc. and that they have signed the GHP Addendum. If so, they can sign the admission request and send the form to:

   TRIPLE-S SALUD  
   PMG ADMINISTRATION DEPARTMENT  
   3RD FLOOR  
   PO BOX 363628  
   SAN JUAN, PR 00936

4. The PMG Administration Department shall verify that the admission Form includes:
   a) Correct information.
   b) All the fields are filling in.
   c) The provider is a participating physician of Triple-S Salud, Inc. and the Government Health Program.
   d) Validate through the Credentialing Department that all credentials are up to date the moment of the request for the admission.
5. The PMG Administration Department shall verify that the PCP who applies provides services only inside the towns and region where the PMG is contract.

6. The contract between the PMG and the provider must be submit in order to process the admission request.

   The following are general required admission:

   a) Be a participating provider in Triple-S Salud, Inc. and have signed the Triple-S Salud/GHP Amendment.
   b) Comply with the requirements for the re-credentialing process.
   c) The request must be voluntary between the PMG and the PCP.
   d) All PCPs can only offer services in the municipalities inside the region where the PMG is contract.

7. If the information on the Form (Physician’s Request for admission to PMG) is incomplete or does not comply with the requirements, it shall be return to the PMG Administrator. Triple-S Salud will stop the process until the form is summit with all the required documents.

8. Once the form is properly complete, the admission to PMG can be process. The effective date is the next business day from the date the request was received.

9. The physician’s information will be filling in the different archives of the provider system.

10. The PMG Administration Department will notify to the PMG Administrator the inclusion effective date.

TERMINATING A PCP/EPPN PROVIDER FROM A PMG

If the PMG wants to rescind services from a PCP or ePPN provider or if the provider decides to terminate the relation with the PMG, the following steps must be complete:

1. The provider must complete Section 1 of the form – “Request to Terminate a PCP from a PMG” or “Request to Terminate a ePPN from a PMG” (See Attachment 14 PMG Administration Department, Configuration Area, Request to Withdraw a PMG).

2. The PMG Administrator must complete Section 2 of the form and have to specify the Substitute(s) PCP(s), which the patients will be assign. A substitute only applies when the Termination is from a PCP. The patients assign to the Substitute PCP(s) shall not exceed the maximum limit established by contract between Triple-S Salud and PRHIA (to determine the maximum limit consider existing subscribers and those assigned provisionally.)
To determine the amount of beneficiaries that have a doctor, the PMG Administrator can contact the Financial Advisor assign to the PMG who will provide the information. The PMG can send the form by e-mail or to the following address:

**TRIPLE-S SALUD**  
**PMG ADMINISTRATION DEPARTMENT**  
**3RD FLOOR**  
**PO BOX 363628**  
**SAN JUAN, PR 00936**

3. The Substitute PCP(s) to whom subscribers will be assigning must be a Triple-S Salud participating provider and an active member of the PMG.

4. The PMG Administration Department shall verify the following:

   a) Correct information
   
   b) All the fields are filling in.
   
   c) The Substitute PCP(s) have to be part of the same PMG that the resigning provider.
   
   d) The Substitute PCP(s) cannot exceed the maximum limit of enrollees established by contract.
   
   e) The Substitute PCP must observe compliance with the criteria of accessibility and availability. These criteria establish that the Substitute PCP(s) shall offer services in similar location and schedule as the terminated provider.
   
   f) A written communication will be send to the subscribers notifying the provisional change of PCP in substitution of the terminated provider.

5. If the information on the Form is incomplete or does not comply with the above-mentioned requirements, it will be return to the sender. Triple-S Salud will not process the termination request until the application is re-submitted complete.

6. Once the Form is duly completed, the PMG Administration Department shall start the termination process. This includes:

   a) Determine the effective date of the termination. The Form must be received in the PMG Administration Department **with at least 45 days prior** to the month when the termination will be effective. If this timeframe is not followed, the termination shall be the month after the one requested by the PMG Administrator.

   b) Summit the information to the Configuration Unit to perform the change in the system and update
7. The PMG Administration Department shall notify to the PMG Administrator the termination date.

8. A written communication will be send to the subscriber notifying the provisional PCP that has been assign and their right to choose another PCP within the PMG or to change to another PMG.

9. The provider is responsible to offer services to the all enrollees during the termination process until the request is effective. The PMG is responsible to keep the physicians compensation agreement until its effectiveness.

If the terminated provider signature is unable to complete in the Form, the PMG Administrator must attach to the Form an explanation letter to proceed with an administrative cancelation.

• SELECTING A PMG AND A PCP

Enrollees can freely select the PMG and PCP of their choice when they disagree with the self-assignment made by the TSS. This change must be request within the period of ninety (90) days from the day the ID card is received. The PMG and the PCP selected must be within the same region where the enrollee resides. The policyholder must select a PCP for each family member.

To select a PCP the enrollee can call the Government Health Plan Call Center at (787) 775-1352 or 1-800-981-1352 toll free or for the Hearing Impaired TTY 1-855-295-4040. The enrollee will be assist by a Service Representative in the selection of a PCP using as reference the PMG’s Medical Directory.

To select a PCP the enrollee also can visit a Customer Service Office and will be attend by a Service Representative who will assist in selecting a PCP using as reference the PMG’s Medical Directory. The Directory shall include all PCPs who are members to each PMG. The Directory will be available in our website www.ssspr.com.

The Service Representative can assign an enrollee to a PCP if not exceeding the maximum amount of enrollees. However, if the Service Representative identifies that the PCP chosen by the enrollee is not part of the PMG, the Service Representative shall present another PCP available on the PMG’s Medical Directory to the enrollee. There are certain exceptions explained later in this document.

MAXIMUM CAPACITY OF ENROLLEES BY PRIMARY CARE PHYSICIAN

The Configuration Officer shall allocate in the system the highest capacity for a PCP. This amount shall not exceed the 1,700 enrollees for Family Physicians, Internal Medicine, General Practice and Pediatric. The Gynecologist-Obstetric ratio is 1:2,800. Once a PCP reaches its maximum, the Service Representative may not offer this physician as an option to the enrollees. Only those enrollees covered by the exceptions listed later in this policy could be attach to a PCP who has reached maximum capacity.
HOLD POLICY

This policy is establish to ensure that a maximum of members is assigned to a PCP according to the contractual agreement between Triple-S Salud (TSS) and PRHIA and thus ensures proper handling and delivery services of the population subscribed to each PCP.

Applies when a PCP do not want more subscribers to be assign under his or her care, but has not reached the maximum limit set by ASES. The process for allocating the hold is as follow:

a. The PCP and the PMG Administrator must complete the Hold Application. (See Attachment 15 PMG Administration Department, Configuration Area, Hold Request)

b. Ones the application is fill in all its parts, the PMG Administrator or the PCP should send the form to the Primary Medical Groups Administration Department by email or to following address:

TRIPLE-S SALUD, INC.
PMG ADMINISTRATION DEPARTMENT
3rd FLOOR
PO BOX 363628
SAN JUAN, PUERTO RICO 00936

c. The Financial Advisor will evaluate all applications individually. Taking in consideration the number of PCPs necessaries to manage the population subscribe under the PMG. This evaluation is required to assure the access of service.

d. If the Hold Application is approved, the Configuration Officer will perform the maintenance in the system the day before the change take place.

e. In cases the Hold Application specify a maximum quantity of enrollees, the Configuration Officer will allocate the number identify on the application. For example, if the Hold Application indicates 250 enrollees, the maximum quantity of enrollees in the system will be 250 enrollees. If the Hold Application does not specify a maximum quantity, the Configuration Officer will assign in the system 00001 maximum enrollees.

f. The Financial Advisor will notify the PMG Administrator the approval and effective date of the Hold.

g. If the Hold Application was not approved, the Financial Advisor will notify the PMG Administrator explaining the reasons of the denial.
h. To remove the Hold the PCP must request it by letter. The PMG Administration Department will evaluate the application, remove the hold system and notify the PMG Administrator.

**Hold Exceptions:**

Enrollees will be assigning to a PCP, even if the physician has a Hold, in the following scenarios:

a. Enrollees within family contract - enrollees will be assigning to the same PCP that attends all family members.

b. Pediatric new family member is integrated and all Pediatricians of the PMG have a Hold - the policyholder will select a pediatrician of his or her preference within his or her PMG.

c. Enrollee in a family contract that changes to an individual contract - enrollee will be assign to the same PCP.

d. A PCP resignation from the PMG is processed and all PCPs with the same specialty have a Hold - enrollee will be assign to any available PCP with the same specialty.

e. Enrollees will be subscribed under a PCP even if the provider has exceeded the set limit, as long as is the same PCP and the same PMG prior to cancellation.

f. When a pediatric enrollee enters a family contract and some pediatricians from the same PMG has a hold and others do not:

   i. If the policyholder selects a pediatrician with a Hold, the Service Officer will indicate to the subscriber that the selected PCP is not available and have the right to select another one.

   ii. If the Pediatrician selected has a Hold, but is the PCP of another pediatric family member the subscription will be an exception.

- **Changing Primary Care Physicians**

  When a PCP is terminated from a PMG and an enrollee requests a change of PCP and all other PCPs in the PMG are “On Hold”. The exception shall be accepted so the subscriber can have a PCP available in the PMG.
• **Re-certification**

A patient shall be accepted even if the limit has been surpassed if it is the same PCP and the same PMG prior to the cancellation.

• **New Contract certification**

Accept as an exception dependent subscribers from family contracts that are now individual contracts and select the same PCP. Only cases that are exceptions shall be referred to the subscription manager.

• **Subscription limit**

If the PMG has a limitation that affects its capacity to provide the services to enrollees under the Government Health Plan, the PMG Administration Department Director may stop the subscription of new enrollees into the PMG until the limitations have been resolved.

**NETWORK MANAGEMENT DEPARTMENT**

The purpose of this department is to contract the providers for our network and serve as liaison centralizing requests and individual needs of each provider within the network. Among its tasks is to establish and maintain a network that is adequate to supply needs identifying and provide on-time solutions to fulfill the needs of services access of our beneficiary population to facilitate the participation. Among other objectives, it also includes carrying out workshops for providers, promote the use of the Electronic System, evaluate fulfillment of Plan Compliance.

Any question or concerns can be address through your Provider Service Executives.

**CREDENTIALING**

Triple-S Salud, as part of its responsibility to ensure its members receive safe and high quality care, has established the following processes: a robust initial credentialing, a routine re-credentialing and continuous monitoring of sanctions and grievances for its network participants. Therefore, Triple-S Salud verifies and updates with regularity and at least every 3 years, all or part of the information submitted as part of their initial credentialing process. Triple-S will follow all applicable state and federal regulations as part of its Credentialing, Re-Credentialing and Ongoing Monitoring processes. Any change of information on Ownership, new Specialty, new Group affiliation, and new Line of Business participation may also require updating the provider’s credentialing file.
Triple-S Salud does not make credentialing decisions based solely on the health care practitioner race, ethnic/national identity, gender, age, sexual orientation, the types of procedures or types of patients in which the practitioner's specialties. Triple-S Salud does not discriminate against practitioners who serve high-risk populations or who specialize in treating costly conditions or who participate in other plans.

All network participants must submit a legible application, completed in its entirety and accompanied with all required and applicable licenses, certification, clinical privileges, attestation and insurance documents, as required by federal and state regulations, during the initial and subsequent credentialing processes. Credentialing staff cannot process incomplete applications, including required documents; hence, if any information is missing, the application and documents will not be considered as acceptable.

All documents and information collected must be no more than six months old on the date on which the health care professional is determined by the Credentialing Committee to be eligible for contract or to remain as an active network participant. The provider is responsible for providing the information required, in a timely manner; this includes but is not limited to, the disclosing information concerning the provider and fiscal agents about participation and control (refer to 42 CFR Parts 455.104, 455.105 and 455.106 and 1002.3(b). Providers are also responsible of requesting the Good Standing document issued by the State Health Department, which must be submitted directly to Triple-S. The provider is responsible for ensuring each health care professional in his staff who has direct contact with Triple-S’ members: is legally authorized (licensed, certified or registered) to practice in the State in which they practice and not currently sanctioned, suspended, debarred or excluded. The provider must not employ individuals with managerial responsibilities who are: excluded from participation in the Medicare or Medicaid programs or any other Federal program, convicted of Medicare, Medicaid or other health insurance, health care or any social service program-related crimes, convicted of physical, sexual, drug or alcohol abuse in any capacity where such individual's contact with patients would pose a potential risk.

Triple-S, as part of the credential/re-credential processes will confirm and validate the provider’s and his managerial and healthcare professional staff’s profile with different federal agencies or WEB sites, as required by state and federal regulations. Triple-S will verify from the Primary Source at least the following credentials: Board Certification in each clinical specialty area, current valid license to practice, highest level of education/training attained records.

Any provider not completing or submitting the required documentation shall not be eligible as a network participant. The provider shall receive in writing the results of the process in the next 30 days after the credentialing process has completed.

If after evaluating the documents related to credentialing, participation as a provider is denied or if the contract with Triple-S Salud, Inc. is cancelled, the physician has the right to appeal the decision as established in the process to appeal cancellation decisions.
RIGHTS OF THE HEALTH CARE PROFESSIONAL AND CONFIDENTIALITY

a) The applicant, participant or contracted provider can request a review of the information submitted in the admission request or reaccreditation. The access for reviewing information is during working hours and by previous appointment. This does not include references or protected information from peers. Documentation previously submitted may not be removed.

b) The applicant, participant or provider shall have the opportunity to clarify information from the application that is inconsistent, with information that can be verified with primary sources and part of the accrediting or credentialing process. The network administrator director shall notify the health care professional of the results.

Copies of the reports obtained from the “National Practitioner Data Bank” shall not be sent nor shall any information obtained from primary sources.

A request to clear any existing discrepancy shall be made in writing. If an answer is not received in the established timeframe, the admission request shall be denied.

c) The credentialing documents are kept confidential and are digitalized on a secure system. Upon document disposition, any document not required in original, shall be shredded, and except when required by applicable law, information about the professional shall not be offered to external organizations without the provider’s previous authorization.

d) The information obtained through the accreditation/reaccrediting process required to be kept in original are kept confidentially in a secure area under lock and key. Copies of the documents obtained from verification of primary sources that reflect reports of professional sanctions suits, shall not be included in files available to areas not having inherence in these processes.

ADDRESS AND SCHEDULE CHANGES FOR PCP AND EPPN PROVIDERS

The PMG, PCPs and ePPN providers are responsible for sending to Triple-S any change of address and/or service hours information. The provider has to fulfill a Form “Change of Address and Schedule”. (See Attachment 16 - PMG Administration Department Area, Configuration Area, Change Office Address and/or Schedule Form of Primary Care Physician on PMG).

The Form will be available through the Provider Service Executive assign to your regional area, through the Financial Advisor or at the Triple-S central office. The form must be complete in all its’ parts and sent by email or to the following address:

TRIPLE-S SALUD
PMG ADMINISTRATION DEPARTMENT
3rd FLOOR
PO BOX 363628
SAN JUAN, PR 00936
CLAIMS

Tools availables to providers to facilitate the billing and reconciliation process.

To help with the billing administrative process, Triple-S Salud, Inc. has various ways to obtain important information related to the beneficiary and the services to be rendered, as they are: in the Triple-S portal, we have available a tool titled “Electronic Service Center” and through the “Telexpreso”, which is an automated Interactive Voice Response system (IVR). Through these mechanisms, the provider can obtain information from the beneficiary’s eligibility up to the status of a claim. This automated system is available 24/7 and the provider can obtain information on:

- Status of claims
- Recent payments
- Amount ready for payment
- How to request an adjustment
- How to submit a claim pending for payment
- Beneficiary’s eligibility
- Payment schedules
- Approval of services
- Verification of services
- Admissions registry
- Fees
- Schedules
- Request service history
- Any other situation regarding the claim

The provider can access the Triple-S Salud portal at www.ssspr.com and the Telexpreso, calling (787) 775-1352 (Metro Area) or at 1-800-981-1532 (outside Metro Area). You must have your NPI at hand.

In addition, our Call Center you will be assisted by our Provider Customer Service Representatives, who are available to provide all the information you need, 7 days a week.

BILLING

An efficient process for billing and reconciliation of claim payment is vital for the success of the managerial practice. Through the claims, important information can be obtained to generate statistical reports and to make utilization comparisons. Below, we offer a few guidelines for the expedite handling of your claims.
BILLING PROCESS

The provider can send his claims for services rendered to GHP beneficiaries electronically or in paper. If the provider chooses to send the claims in paper, they must be delivered to Triple-S Salud Office, or mailed to the following address:

TRIPLE-S SALUD, INC.
PO BOX 70299
SAN JUAN PR 00936-8299

All claims from physicians, dentists, facilities and participating providers must be received at our office up to 90 days from the date of service, as provided by Law 104 of July 19, 2002, Prompt Payment Law. Those claims received after that date will be denied for time limitation.

Triple-S Salud has established an administrative procedure to resolve disputes arising under Chapter 30 of the Insurance Code of Puerto Rico (Rule No. 73 of the Regulations of the Puerto Rico Insurance Code) – Prompt Payment Law. Triple-S Salud participants or providers may request review of a decision regarding the return, denial or payment of a claim submitted to Triple-S Salud, Inc. that they understand did not comply with the terms established by the Prompt Payment Law. The form to request an evaluation because of Prompt Payment may be accessed through our website www.ssspr.com.

When submitting claims for a service rendered to a Medicare patient, you must include a copy of the Explanation of Payments of this plan.

ACKNOWLEDGEMENT OF RECEIPT OF TRIPLE-S SALUD

Triple-S Salud generates an acknowledgment of receipt report through the Health Care Claim Acknowledgment (277CA) standard transaction for claims submitted by the physician, dentist, facility or participating provider to Triple-S Salud. The standard transaction 277CA contains claims accepted or not, because they could not process. If the claim is not accepted, rejected, the provider should submit the claim corrected as new if the claim is within the contractual billing period.

You will receive this report with the following frequency:

- If you send the claims file electronically (Electronic Service Center or Clearinghouse) you will receive the acknowledgment of receipt at the moment you submitted the electronic claims file.
- If the claims is sent in paper or by mail, you will receive the acknowledgment of receipt once a week.
ENCOUNTER REPORT

An encounter means a distinct set of services provided to an Enrollee in a face-to-face setting on the dates that the services were delivered, regardless of whether the Provider is paid on a Fee-for-Service or Capitated basis. Encounters with more than one (1) Provider, and multiple encounters with the same Provider, that take place on the same day in the same location will constitute a single encounter, except when the enrollee, after the first encounter, suffers an illness or injury requiring an additional diagnosis or treatment.

The PMG and their PCPs are responsible for documenting and transmitting to Triple-S Salud all the services rendered to the Government Health Plan enrollees. These encounters should submit electronically or through the CMS-1500 Form. All claims from physicians, dentists, facilities and participating providers must be received at our office within the 90 days from the day of service, provided by Law 104 of July 19, 2002, Prompt Payment Law. Those claims received after that date will be denied for time limitation.

The documentation and transmission of this information is extremely important because in this way we collect information regarding utilization of services, clinical information and the tendencies of the cost of providing these services, through which they are recognized for payment to the primary care physicians.

HIPAA

Standard Codes

Triple-S Salud, Inc. uses the standard coding for the receipt of claims for services rendered by physicians and facilities.

Consistent with HIPAA, the local codes were changed to standard service codes (CPT) and the local service facilities were changed to standard service facilities. Another change related to HIPAA is the use of modifiers.

Important: You must not include the type of service in your billing.

CPT / HCPCS

These are used to indicate health care professionals service(s) provided to the beneficiary. CPT codes refer to five-digit numerical codes. HCPCS codes, refer to a code consisting of five digits where the first digit is a letter within the (A) and (V), followed by four numerical digits.
INSTITUTIONAL CODES

They are used by the facilities to bill the services rendered, matching a "Type of Bill" (TOB) and a "Revenue Code". Sometimes, they use a CPT or HCPCS.

MODIFIERS

Modifiers are part of the standard coding by which a participant or provider may indicate to the Insurance Company that the service or procedure billed was altered due to a specific circumstance, but does not change the definition of the code. The judicious application of modifiers obviates the necessity for separate procedure listings that may describe the modifying circumstance. Modifiers may be used to indicate to the recipient of a report that:

- A service or procedure had both a professional and technical component.
- A service or procedure was performed by more than one physician and/or in more than one location.
- A service or procedure was increased or reduced.
- Only part of a service was performed.
- An adjunctive service was performed.
- A bilateral procedure was performed.
- A service or procedure was provided more than once.
- Unusual events occurred

REFERRALS

The Government Health Plan, requires a written authorization, issued by the PCP chosen by the enrollee, to allow the enrollee obtain a service from another participating provider of Triple-S Salud that is not part of the enhance Preferred Provider Network.

There are currently two referral models: (1) the Referral for Facilities and (2) the Referral for Professional Services.

1. Referral for Facilities - (See Attachment 17 – Facility Referral Form)

Use to refer patients to a health care facility outside the EPPN for any of the service units. These units could be ambulatory surgery and in patience services, etc. No referral is required for outpatients in the emergency room. The Referral for Facilities is valid for 60 days, from the date the PCP issued it. Is not allow to photocopy Blank referrals to replace the original forms.
The primary care physician is responsible for completing the information of the referral in boxes #1 thru #3. The facility rendering the services will be responsible for completing box #4.

2. Referral for Professional Services - (See Attachment 18 – Professional Services Referral Form)

Use to refer patients to Triple-S Salud participating physicians who are not part of the ePPN, when the beneficiary needs to receive services from a specialists, clinical laboratories, radiology services and ancillary services. If the provider is not part of the ePPN the enrollee’s PCP will have to submit a referral in order to the enrollee receive the service. The referral is valid for 60 days from the date PCP issued the document.

The PCP is responsible for completing the information of the referral in the boxes of sections A and B. The provider rendering the services will be responsible for completing the box in sections C and D.

INTEGRATION OF PHYSICAL AND BEHAVIORAL HEALTH SERVICES

Purpose - ensure that Physical and Behavioral Health Services are fully integrated, to ensure optimal detection, prevention, and treatment of physical and Behavioral Health illness.

Model of Service Delivery:

- **Collocation** – An integrated care model in which Behavioral Health Services are provided in the same site as primary care.
  - Placement of a psychologist or other type of Behavioral Health Provider in PMG setting as defined in the ASES Guidelines for Co-location of the Behavioral Health Provider.

- **Reverse Collocation** – An integrated care model in which physical health services are available to Enrollees being treated in Behavioral Health settings.
  - Placement of a PCP (on site or on call) in Behavioral Health Facilities as defined in the ASES Guidelines for Reverse Collocation to monitor the physical health of the Enrollees.

Information Sharing:

Electronic communication between physical health and Behavioral Health Providers, such as:

- An information sheet for Enrollees on HIPAA requirements
- A Referral sheet
- An informed consent form
**Coordination of Mental Health Services:**

Mental Health services can be coordinated through various ways, depending on the beneficiary’s level of urgency:

- Direct referral to emergency services and hospitals.
- Referral for an evaluation by a provider contracted.
- Referral for evaluation by a mental health provider under the colocation model of the Primary Medical Group.

**AUTOMATIC ENROLLMENT - MA10**

A beneficiary that is eligible to the Government Health Plan will be automatically enrolled and insured with GHP. The enrollee could begin to receive health services from the same day the Medicaid Office from the Department of Health gives the MA-10 Form, Notice on Action taken on Application and/or reevaluation.

The date to determine since when the person is insured is the date that appears in the Certification Date of the MA-10. The beneficiary will also receive a Welcome Letter from GHP. The enrollee has to show both document when requesting a health service covered by GHP to evidence that his name appears in the MA-10, that he is enrolled, and that he can begin to receive services.

**ELECTRONIC SERVICE CENTER**

The invoices received through electronic means are generally less difficult to process. There is a low error volume in the information received. This is possible through **pre-edits** that are regularly included in the medical invoicing programs and that validate the information, when entering it. These invoices are processed quickly due to the low human intervention required during their processing. That is why we recommend our providers to invoice electronically. It is worth emphasizing that with electronic invoicing offers: prompt payment, fewer errors and prevents the handling of forms.

The **Electronic Service Center** allows for claims to be sent between Triple-S Salud, Inc. and its participants, through the Internet in the 837 format, required by the HIPAA Act using the claim upload options. This method of transmission significantly reduces the use of paper and time used in the processing. Reducing the use of paper invoices promotes an efficiency environment, both at your office and at Triple-S Salud, Inc.

Through the **Electronic Service Center** you will receive or may request electronically the following reports:

1. **Standard Claim Acknowledge(277CA):** Standards transaction that simplifies the electronic reconciliation for claims submitted in a standard format 837.
2. **Claim Status**: Allows you to request the status of a claim or a group of claims for a beneficiary in real time.

3. **Explanation of Payment**: The participants and providers that requested to receive the Explanation of Payment electronically will receive this file in the 835 format, required by HIPAA. This file must be read by your medical invoicing program and will be available in the Pending Invoices area.

4. **Eligibility**: In this option you may validate the status of a Triple-S Salud beneficiary benefit verification including dental and professional services.

5. **Obstetrics Registration**: The obstetrician can register GHP patients or search patients already registered.

6. **Referral Registry**: The PCP or Specialist may create or modify GHP patients’ referrals. They may also search for a referral.

**RECONCILIATION AND REQUEST FOR ADJUSTMENT**

The Provider has the right to request adjustments to previous payments. It is important to point out that Triple-S Salud will not be obliged to pay any additional amount, after 12 months from the payment date included in the initial explanation of benefits.

A claim for adjustment is that claim that has been denied or was partially paid and the provider understands that the denial does not proceed or that was paid incorrectly.

The information below details the procedure to follow when requesting for a claim or services:

1. All providers must identify the claims for which he/she is in disagreement with the determination, using the payment explanation or a history of claims paid provided by Triple-S Salud.

2. For every adjustment request you should include, the “Form to submit changes to a professional, institutional or dental claims paid or denied (adjustment)” and any additional documentation needed for consideration such as copy of the referral or preauthorization number, as applicable. It is important to remember not to mix in your payment claim the adjustment cases with the pending payment cases, nor the new claims with adjustments.

3. Once you have identified all the claims for which you are requesting an adjustment, you must fill out the Form to submit changes to a Claim Paid or Denied (Adjustment), according to the service you offer (professional, dental or institutional). *(See Attachment 19 – Form to Submit Changes to a Professional Claim Paid and Denied (Adjustment), Form to Submit Changes to a Dental Claim Paid and Denied (Adjustment), Form to Submit Changes to a Institutional Claim Paid and Denied (Adjustment)).* This form consists of 5 sections, which we explain below:
- **Section 1:** Information to identify the claim you wish to adjust. In this section you must identify the following:
  - The line of business to which the claim belongs
  - The Claim Reference Number (CRN) of the claim
  - NPI
  - Beneficiary’s contract number

- **Section 2:** In this section you must include the following:
  - Change in the beneficiary’s contract number
    - This filled will only be used if there was a change in the beneficiary’s contract number. For example: When billing for the service the contract number used was the one the person had under a family coverage and the beneficiary now has an individual contract.
  - Number of the preauthorization or referral, as applicable

- **Section 3:** Indicate the line where you wish to change the information. In this section you include changes regarding:
  - Dates of service (from – to)
  - Location of service
  - Code of the procedure
  - Modifiers
  - Diagnostic code
  - Number of services
  - If it is a group, the NPI of the provider within the group that rendered the service

- **Section 4:** This section will only be used to make other types of adjustments that have not been considered in Sections 2 or 3. In this section you must:
  - Fill the box that reads “Mark if you submit other type of adjustment”
  - Indicate the process notes
  - Indicate the amount of documents submitted

- **Section 5:** To add any comment to be considered in the evaluation of the claim.

4. You may deliver your request for adjustment at any of our offices or mail it to the following address:

  TRIPLE-S SALUD
  PO BOX 363628
  SAN JUAN, PUERTO RICO 00936-3628
PROCESS FOR CLAIMS PENDING OF PAYMENT

The claims considered pending, are those in which more than 30 days have been elapsed since submitted to Triple-S Salud and you have not received payment or the denial for those claims. In these cases, these are the steps to be follow:

1. Request a history of payment for the period you are reconciling.

2. Verify that these claims are not in the history of payment. If the claim is in the history of payment, and you are in disagreement with the determination, you must follow the "Adjustment Request" process explained before.

3. If the claim is not in the history of payment, you must do the following:
   a. Prepare the invoice in the corresponding form (CMS-1500, UB-04, or ADA 2006) and verify that it is completed correctly.
   b. Photocopy the acknowledgement of receipt, sent by Triple-S Salud, identifying the case you are claiming, as evidence that you sent the invoice within the regulatory time.
   c. Photocopy the referral, if applicable.
   d. In the cases where preauthorization and/or admission registration is required, you must write this preauthorization ID in the corresponding box of the invoice.
   e. Photocopy the explanation of payment of the primary health plan for the invoices that are complementary.
   f. Photocopy any documentation that could be submitted with the original claim, if applicable.

4. Place all claims pending in order of service date and complete the document from Triple-S Salud. (See Attachment 19 – Pending Claims)

5. Once the process is completed, you must contact one of our provider services representatives to deliver pending claims. The officer will verify the request delivered by you and will carry out the corresponding paperwork to process this request.

MA-10 CLAIMS

The MA-10 claim corresponds to covered services provided to beneficiaries certified by Medicaid, who as of the service date, did not have current coverage with GHP. Below we offer a guide to follow for the billing process of an MA-10:
1. When a patient receives emergency services using the form known as MA-10, the provider will get in touch with our Call Center to validate the patient’s eligibility with the Plan. When making the call, you must have the following patient information available: The case number found in the MA-10 form, the social security number, and the patient’s full name.

2. If when you called, the eligibility information is not available, you could submit the claims following specific instruction under this scenario. The instructions are available in our web portal www.ssspr.com (please refer to circular letters).

**MA-10 RECONCILIATION**

The provider has the right to require adjustments in relation to a previous payment. It is important to point out that Triple-S Salud will not be obliged to pay any additional amount after the period of 12 months, as of the date in which the initial claim was process. The adjustment requests cannot be with the pending payment requests and/or “non-determined” claims. Claims subject to adjustment or pending claims should follow the regular process for these types of claims.

**ADJUDICATION NOTES**

For the definitions of standard notes regarding the adjudication of claims, you may access the website www.wpc-edi.com.

We hope this manual is useful for you and the administrative staff of your office, to facilitate the billing and reconciliation processes under GHP. At Triple-S we are always ready to assist you.

**SERVICE ACCESSIBILITY STANDARDS**

Triple-S Salud/GHP, as Triple-S Salud, Inc. is responsible for guaranteeing the accessibility and the rendering of health care services to beneficiaries of the Government Health Plan (hereinafter “GHP”) for the Metro North and West regions. Accessibility means the availability of health care service providers necessary for the access to the coverage of benefits of GHP, so that the medical needs of beneficiaries can be met.

The purpose of this policy is to measure the maximum time in which the patient obtains the available services, specifically those related to primary care, emergencies and coverage of benefits. To guarantee that there is a mechanism to ensure the accessibility to primary care services, emergency services, and beneficiary services. This standard must be measured once a year.
OPERATIONAL DEFINITIONS

1. **Accessibility** – is the availability of health care service providers, necessary for the access to the coverage of benefits of the Plan, so that the medical needs of beneficiaries can be met within the accepted standards.

2. **Routine Primary Services** - is non-urgent primary care for symptomatic conditions.

3. **Urgent Care Services** – A service offered for a provoked medical condition that does not pose risk of death or the integrity of the person. The condition may be treated in medical offices or offices with extended hour schedules and not necessarily in emergency rooms. In addition, it means any urgency according to generally accepted medicine in Puerto Rico.

4. **Emergency Services** – covered services rendered in an outpatient clinic or a hospital that at the same time are offered by a provider qualified to render these services and that are necessary to evaluate or stabilize a medical emergency. This refers to a medical condition due to acute symptoms of great severity, including severe pain, where a reasonably prudent layperson, who has a general knowledge of health and medicine, may expect that, in the absence of immediate medical assistance, one of the following may happen:
   
   a) He or she may place the person’s health in grave danger, or
   b) It would result in a serious dysfunction of any body organ or member, or
   c) In relation to a pregnant woman who is suffering from contractions, there is not enough time to transfer her to another facility before the birth or that transferring her would present a threat to the woman’s health or the unborn child.

5. **Preventive Services** – services received to maintain the patient healthy or to detect or prevent disease.

**Procedure:**

A. **Accessibility Standards**

   1. **Primary Care Services**

      ➢ An beneficiary will have a routine appointment between 30 days from the request with his or her primary care physician.

   2. **Urgent Care and Emergency Services**

   

   

   2 It is important that the primary care physician take into consideration the urgency and clinical safety of the patient’s situation when coordinating an appointment.
Follow-up appointments for urgent conditions shall be obtained on the same day of the request. In relation to emergency services it is required that the provider have a protocol for handling emergency situations. This protocol must include how to stabilize a patient and obtain emergency transport.

3. Beneficiary Services

A beneficiary who makes a telephone call to obtain information about the health plan shall be provided in average speed in at least eighty percent (80) of calls answered within thirty seconds (30).

The percent of abandoned calls must not be greater than 5%.

4. Beneficiary Services, after working hours.

Every primary care physician shall have in his or her office telephone equipment with a recorded message, in his or her office, indicating the patient where he or she may access services after working hours, including the referral to government Health Plan Call Center.

An beneficiary who makes a telephone call for Teleconsulta services shall be provided service in average speed in at least eighty percent (80) of calls answered within thirty seconds (30).

The percent of abandoned calls for GHP Call Center services shall not be greater than 5%.

B. Methodology

The evaluation of these standards will be performed using the following sources of information:

1. Primary Care Services

Results obtained in the Consumer Assessment of Health Plans Study survey (CAHPS 3.0H). Question #20 quotes:

“In the last 6 months, not counting the times your needed immediate medical care, how many days did you normally had to wait between making an appointment and actually seeing the healthcare professional?”

Urgent Care and Emergency Services

Results obtained in the Consumer Assessment of Health Plans Study Survey (CAHPS 3.0H). Question #17 quotes:
“In the last 6 months, when you needed immediate medical care, for an illness, wound, or condition, how much did you have to normally wait between attempting to receive treatment and actually seeing the healthcare professional?”

2. **Beneficiary Services**
   - Statistics gathered from the Customer Service Call Center.

3. **Beneficiary Services, after business hours**
   - Results gathered on the Compliance Form evaluated by Independent Provider Services Officials. Statistics gathered in call services to Government Health Plan Call Center.

**LEGAL ASPECTS**

This section presents various legal aspects that an administrator should know. Among these, we discuss the terms and clauses that should be considered in a contract with those people who will be providing services to the beneficiaries of the Plan. An administrator must ensure that each of the aspects herein specified be considered in the contracts with its providers.

There is also information provided that is relevant to the procedures developed by Triple-S Salud to respond adequately to the complaints that may be filed by the beneficiaries of a Primary Medical Group (PMG). Finally, we also present those elements that will be evaluated as part PRHIA Compliance Plan.

It is worth to mention here that this section does not pretend to cover all legal aspects inherent to an organization under a Managed Care Model. To this end, we recommend the contracting of legal professional services in the legal area to advice the administrator and/or the Board of Directors.
The Triple-S Group (Triple-S Management and its subsidiaries, hereafter, Triple S) has adopted a Corporate Compliance Program in order to comply with its commitments and comply with federal and local laws and regulations apply. This plan provides the basis for communicating to our employees and contractors organizational values and expectations about their behavior. It also helps everyone understand the possible consequences of non-compliance would lead both to Triple-S and for each individual.

The Compliance Program is a partner commitment between Triple-S, its employees and contractors. As partners, we all have rights and responsibilities that we know and exercise properly to ensure the best service to our constituents and perpetuate the operation of Triple S as a responsible corporate citizen.

The Compliance Program is based on seven main elements:

1. The appointment of Compliance Officers in each company.
2. Commitment of senior management and the Board of Directors in the management. Content and program outcomes. The program should promote and encourage an ethical climate that prevents failure and allow to set responsibilities effectively.
3. Guides of conduct, policies and procedures written, published and distributed.
4. Training and education for employees and contractors.
5. Open lines of communication to inform or prevent unlawful acts committed.
6. Periodic audits to verify compliance with standards.
7. Responding to detected violations, taking corrective action and reporting to the authorities, if necessary.

**Mission and Statement of Policy of the Corporate Compliance Program**

**Mission:** To ensure organizational processes are efficient, effective and in compliance with applicable federal and local laws, and to foster a corporate ethical climate to satisfy the necessities of our constituents with integrity, honesty and professionalism.

**Statement of policy:**

1) It is the policy of Triple-S to obey all federal and local laws and regulations, as well as fulfill all its contractual obligations.

2) Every employee or contractor must make every effort to be aware of all laws and regulations, and to comply with them.

3) Every employee or contractor must make every reasonable effort to ensure that other employees and contractors comply with the law.
4) Every employee or contractor has the obligation to report to the CECD, the Compliance Officer, Internal Auditor, Legal Counsel or Ethics line any activity that the employee or contractor suspects, or reasonably should suspect, violates any law, regulation or internal policy.

5) Every employee or contractor is required to cooperate with any audit performed by (or on behalf of) Triple-S to review Triple-S’ corporate compliance.

6) No employee or contractor may discriminate or retaliate against another employee or contractor who has, in good faith, complied with the requirements of the Compliance Program by reporting his/her concerns.

**The designation of a CECD and Compliance Officers accountable to senior Management**

The Ethics and Compliance Director (CECD) and the Compliance and Privacy Officer (CPO) designated in the company are the focal points for compliance of all activities. These personnel have a direct reporting relationship to the President and Chief Executive Officer of its respective company. The CECD and the Compliance Officer are responsible for overseeing and monitoring the implementation of the plan, and in a joint collaboration with the operational areas ensuring that all policies and procedures are accurate and are implemented and integrated into Triple-S’ operations. The CECD and Compliance Officers also advise the corporation on legal issues relating to compliance.

If you have any doubt as to whether an act may be contrary to corporate policy, or information about the commission or suspected improper or illegal, you should contact the Triple-S Salud Compliance and Privacy Officer.

**Triple-S Salud Compliance and Privacy Officer**

PO Box 363628  
San Juan, Puerto Rico 00936-3628

Telephone: (787) 277-6686  
Fax: (787) 749-4030

emails:  
privacidad@ssspr.com  
MiSaludCompliance@ssspr.com

**Effective lines of communication**

Since ethics and compliance are a collaborative effort, Triple-S Salud is willing to provide channels through which employees and contractors can report violations to the Program and applicable laws without fear of retaliation. To report such violations, the contractor should contact the Office of Internal Audit, the Legal Affairs Office, the CECD or the Compliance Officer.
At the parent company level, and in compliance with the Sarbanes-Oxley Act, the Internal Audit Committee of the Board of Directors is responsible for the implementation and maintenance of a phone line and a website through which contractors may report violations anonymously. It is known in Spanish as Programa de Confidencias (the Confidence Program). Services under this program are available in English and Spanish, twenty-four hours a day, seven days a week. The Audit Committee receives the information directly from the vendor; conducts the investigation and resolves the issues according to its merits. The Compliance and Ethics Manual describes the appropriate use of the services and a reaffirmation of our corporate ethical values.

Reports received by the CECD through any communication source that may suggest a violation of compliance policies, Federal and state health care program requirements, regulations or statutes will be documented and investigated promptly to determine their veracity and significance. The CECD will maintain a log that records such reports, including the nature of any investigation and its results. This information will be included in reports to the CEO and the Audit Committee of the Board of Directors.

**CONTRACTING WITH PROVIDERS**

Contracts are essential instruments in the administration of an Organization under the manage care model. Contracts with participant primary care physicians must be carefully designed in accordance with the formalities required by law. This contract not only must discuss the agreed upon financial arrangements, but includes all services, terms conditions agreed between the parties.

Listed below are some of the term and conditions that shall be included in the contracts with participating providers:

1. The provider must work to integrated model of Physical and Behavioral Health Services to the GHP beneficiaries.

2. The provider is subject to compliance with state and federal laws, as provided in his contract with Triple-S Salud, the contract between Triple-S Salud and ASES or any other requirement or mandate from PRHIA or CMS.

3. The contracted provider must verify the eligibility of each beneficiary of the GHP prior to offering services or issuing a referral for the beneficiary to receive services from another provider.

4. The provider will not deny, delay or limit covered services to the GHP beneficiaries, according to the provisions in Section 6 of Article VI of Law 72 or Sub-part I of the CFR Part 438 (Sanctions).

5. The provider agrees not to submit claims for administrative expenses not allowed.

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3 Ethics and Compliance Hot Line 866-384-4277 or by Internet: [www.ethicspoint.com](http://www.ethicspoint.com)
6. The provider will not share or transfer, free of charge or for pecuniary purposes, any information that belongs to PRHIA or to the GHP without due authorization. Information that belongs to PRHIA includes any information created, any document, message (oral or electronic) report or minute of a meeting that includes or arises from its relationship with Triple-S Salud or PRHIA. Non-compliance with this clause will lead to the imposition administrative and economic sanctions, including the immediate termination of his contract as well as any criminal consequence that may arise under the applicable laws.

7. The provider recognizes that his contract shall be subject to the legal requirements that may arise in future situations that may not be under the control of PRHIA or Triple-S Salud.

8. The contracted provider must submit all the reports required under his/her contract or the contract between Triple-S Salud and PRHIA and particularly those reports on the Information of Encounters for services rendered, as well as reports of any instances in which there is suspicion of fraud or abuse.

9. The contracted provider agrees that he will not try to obtain any remuneration directly from the beneficiary for services covered under the GHP, except the copayments and coinsurances that correspond under coverage. The Contracted Provider will accept as compensation the payment contracted with Triple-S Salud for the services renders under GHP.

10. The Provider agrees to cooperate actively with the quality improvement and utilization management programs implemented by Triple-S Salud.

11. The provider will have total freedom to, within his legal faculties, provide medical advice or defend a medical opinion for the best interest of the beneficiary’s health, medical care, treatment options or refusal of said treatment options.

12. The contracted provider will have total freedom to advocate in any grievance process or utilization management process or in an individual authorization process to obtain a medically necessary health service.

13. The Provider shall comply with the terms of access to services established at the request of PRHIA.

14. The Provider shall comply with the legal provisions applicable to the continuity of treatment to GHP beneficiaries if he intends to terminate his relationship with Triple-S Salud.

15. The Provider will provide special attention to the beneficiaries in his charge to determine if they have a medical condition that suggests Care Management or Disease Management services are warranted.

16. The provider shall not discriminate against high-risk populations or beneficiaries requiring expensive treatments.
17. The provider not may dispense medication directly to beneficiaries if he lacks a license issued under the pharmacy Act of Puerto Rico, except those drugs that are traditionally administrator by the physician, as it is the case with injectables.

18. The Provider acknowledges that the Federal Department of Heal (HHS), its agencies, PRHIA and Triple-S Salud will have the faculty to inspect, evaluate and audit any book, financial record, document, paper or file that contains information from financial transactions related to the GHP Program.

19. "Medically necessary services" are be those which, based on generally accepted medical practices in the light of the conditions at the time of treatment, are related to the prevention, diagnosis, and treatment of health conditions, or the ability to achieve growth and development appropriate to the age, and the ability to attain, maintain or regain functional ability, and that are:

   i. Appropriate and consistent with the diagnosis of the Provider, without which the medical condition of the beneficiary will be adversely affected.

   ii. Compatible with acceptable standards of medical practice in the community.

   iii. Provided in a safe, appropriate and cost effective environment, considering the nature of the diagnosis and severity of symptoms.

   iv. Not provided solely for the convenience of the Enrollee or the convenience of the Provider or hospital; and

   v. Are not primarily custodial care services.

20. The provider will attend promptly and without delay to any request for pre-authorization or referral based on medical need, in compliance with the time parameters set by PRHIA or by any applicable law or regulations.

21. The provider shall not establish schedules or exclusive days intended for handling referrals or pre-authorizations.

22. The provider must register as a provider under the GHP Program prior to participating in the Medicare Advantage Platino Program.

23. The contracted provider agrees to comply with the Plan of Cultural Competence established by Triple-S Salud.

24. The provider, prior to the development or distribution of any promotional material, is obliged to submit it for the consideration and prior approval of PRHIA and Triple-S Salud.

25. The contracted provider will charge the copayments corresponding to the beneficiaries of the GHP.
26. The provider agrees that he will not offer employment or will out-source with individuals who are in the list of excluded persons (Puerto Rico or Federal Exclusions list) or with entities that may be excluded from the Medicaid program under 42 CFR 1001.1001 (ownership or control of sanctioned entities) or under the 42 CFR 1001.1051 (entities under the control or ownership of people excluded).

27. The provider shall not discriminate against the beneficiary of the GHP by providing different office hours, or treating them differently.

28. Those providers contracted with a FQCH (Federally Qualified Health Center) designation or RHC (Rural Health Center) won't come obliged to enter into contracts with clauses of exclusivity.

29. The provider acknowledges that rates negotiated with Triple-S Salud are subject to adjustments, in the event that the Executive Director of PRHIA requires it to make adjustments that reflect budgetary changes in medical assistance programs.

30. The contracted provider recognizes that, in the event of breach of contract or violation of laws or federal or State regulation, he shall be subject to the imposition of sanctions and penalties.

31. The provider agrees to perform all his effort to identify and notify Triple-S Salud with respect to any service whose cost should be borne by a third party, including those that should be covered under the Medicare program.

32. The contracted provider will not submit invoices for services covered by the Medicare program, or bill simultaneously to both programs, the GHP and Medicare for services provided to beneficiaries who qualify as "Dual eligible."

33. The provider agrees that he will authorize PRHIA and Triple-S Salud to access information regarding his billing for beneficiaries of the GHP that qualify as Dual eligible, provided they are authorized by CMS and subject to the applicable provisions of HIPAA.
34. The provider shall immediately notify Triple-S Salud in the event that its President, Vice President, Director, Executive Director, Member of the Board of Directors, or person performing the equivalent functions, is convicted of or is declared guilty, in Puerto Rico, United States or other jurisdiction, of a crime that involves corruption, fraud, embezzlement or misappropriation of public funds, in accordance with the terms of Law 458, as amended, or Law 84 of 2002. Similarly, the contracted provider recognizes that PRHIA and Triple-S Salud reserve the right to contract with any entity whose main owner or principal agent or senior manager has been convicted of a federal crime for personal involvement with the Medicare program, Medicaid or other program under Title 20th, as provided by 42 CFR 455.106 (c). The convicted contracted provider as previously established will be obliged to return any payments received under the contract.

35. The contracted provider shall attach his NPI to any report submitted to Triple-S Salud.

36. Provider shall submit monthly to Triple-S Salud Encounters Report ("Encounter Data").

**COMPLAINTS, GRIEVANCE AND APPEALS**

Triple-S Salud/GHP developed the procedures necessary to respond adequately to complaints, grievance and appeals that may be filed by the beneficiaries of the Plan.

The purpose of this procedure is for beneficiaries to be informed of their right to submit a complaint, grievance or appeals and of receiving a prompt solution.

All beneficiaries are informed in writing, in the *Beneficiary Guide* that is given to them during the period of enrollment, of their right to file a grievance and what are the procedures developed by the Plan for this. The decision made by the Plan with respect to a grievance will be notified to the beneficiary, as well as his or her right to appeal the Plan’s decision or to the relevant state and federal agencies.

**For the purposes of Triple-S Salud/GHP:**

- **Grievance**: An expression of dissatisfaction about any matter other than an Action.

- **Complaints**: The complaint must be filed within a period not exceeding 15 days from the date of the event motivated it.

- **Appeal**: The appeal shall be filled that may be no less than 20 days and not to exceed 60 calendar days from the date of the received notice of action, directly with the Contractor, or its delegated representatives. The Contractor may delegate this authority to an Appeal Committee, but the delegation shall be writing.
Procedure

At Triple-S Salud we are interested in obtaining all those dissatisfaction statements presented by our clients (beneficiaries and providers). These may be received through electronic or postal mail, telephone, field personnel, regional/satellite offices and/or the central office.

It is necessary to clarify that said dissatisfaction statement may be a result of lack of information about policies, procedures, medical practice or Company claims. Said statement is resolved through orientation, providing the client with the requested information.

Nevertheless, if the statement is not due to lack of information or the client is not satisfied with the provided information, said statement will be considered as a formal complaint where one or several of the following classifications will be questioned.

Classifications

- **Access and Availability** – Statements in which beneficiary alleges difficulty to access the services of a provider and/or participant of the GHP. This includes, but is not limited to office hours, appointment schedules, allegations of communication problems by telephone with the providers, ratio of physicians per region and specialty.

- **Collections** – The allegation from the beneficiary that a provider and/or participant is charging the patients for a covered service in excess of what is established by the coverage of the GHP. It might occur on or before the service is rendered.

- **Illegal Collection** – The allegation that there was a payment made by the beneficiary in excess of what is established by the coverage of the GHP.

- **Delay of Services** – The allegation that a provider delays a service that is medically necessary or medical care included in the coverage of benefits.

- **Denial of Referrals** – Allegation that a provider of the Plan prevents a beneficiary from receiving from a specialist a service that is medically necessary or medical care included in the coverage of benefits.

- **Denial of Medications** – Allegation that a Plan participating provider:
  - Does not authorize a medication within the Preferred Drug List (PDL) of the GHP.
  - Changes the dosage or medication, prescribed by another included in the PDL without justification.
• Does not pre-certify necessary medications not on the PDL.

• **Denial of Procedures and/or Surgeries** – Allegation that a Participating provider of the Plan refuses to authorize or offer a procedure and/or surgery that is medically necessary and included in the coverage of benefits.

• **Denial of Studies, Laboratories and/or X Rays** - Allegation that a participating provider of the Plan refuses to authorize or offer services, laboratories, x rays or any other diagnostic test that is medically necessary and included in the coverage of benefits.

• **Rights of the Beneficiary** – Statement in which noncompliance with the patient’s rights is alleged, as provided in Public Law 194, Patient’s Bill of Rights and Responsibilities of August 25, 2000. *(See Attachment 20 – Patient’s Bill of Rights and Responsibilities)*

• **Limitation of Free Selection** – Allegation that the beneficiary cannot freely choose or select a participating provider from the Triple_S Salud network.

• **Internal Administrative Process** – Statement related with the services provided by the insurer.

• **Physician–Patient Relationship** – Statement in which a noncompliance from the beneficiary of its responsibilities is referred, in accordance to what is provided in Public Law 194, Patient’s Bill of Rights and Responsibilities of August 25, 2000.

• **Adjustment Requests in Case of Delay or Denial** ⁴- Statements that are written, presented or requested by an IPA in which it is alleged that another IPA, one of its members, agents or employees, requested or caused the beneficiary to change PMG as a result of denial of services, undermining the right to free selection.

• **Advance Directive** - An advance directive by a competent beneficiary is a written expression of his/her preference regarding health care treatment, including a preference whether to continue or refuse life-sustaining treatment in the event that her or she becomes incapacitated as a consequence of any medical procedure, terminal health condition or a persistent vegetative state. The document where the advance directive is written is known as the Preliminary Manifestation of Consent Act regarding Medical Treatment. The beneficiary may pre-designate an agent, so that if he/she is unable to make decisions regarding a medical situation, such agent is enabled to make decisions in his/her stead, considering the best interests of the beneficiary. In lieu of such designation, a

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⁴ This classification will be worked in the Compliance and Legal Offices
family member can be designated by law, depending on the provisions of the regulation. In Puerto Rico, the Advance Directive may comply with the Law 160 of 2001 requirements.

If you do not agree with the decision regarding your claim, you may initiate a formal grievance process. To establish any grievance or claim any right related to the Government Health Plan, the beneficiary and/or provider shall follow the procedure established below:

1. Shall complete and sign the form that is available in our offices and shall present evidence for its claim.

2. Shall present before Triple-S Salud, Inc. your grievance for the Government Health Plan, in the case of beneficiaries, on or before 90 calendar days following the events giving rise to your claim. In the case of providers, on or before the six (6) months of having occurred the events giving rise to your claim. Must include sufficient evidence to sustain your allegations.

3. The grievance will be answered by Triple-S Salud, Inc., in a term no greater than 90 days as of the date in which it was received. If needing an additional term to answer said grievance, the beneficiary will be notified of the extensions and its reasons.

4. Once all the aspects of the grievance are investigated, a final resolution will be issued, in writing, which will be notified to all parties involved in the case.

Said Resolution will contain a notice stating that the grievant has the right to appeal the decision before the Puerto Rico Health Insurance Administration (PRHIA), in a term no greater than 30 days, from the date in which the final decision is notified by certified mail. In that case your correspondence will be addressed to:

EXECUTIVE DIRECTOR
PUERTO RICO HEALTH INSURANCE ADMINISTRATION
PO BOX 195661
RIO PIEDRAS, PR 00919-5661
Attachment 1
The GHP offers a broad Service Coverage with minimum exclusions. Your services will not be reduced, limited or will be excluded because you had a preexisting conditions before enrolling in the GHP. You will not have to comply with a waiting period to receive any of the Covered Services. Services will be covered from the moment Medicaid grants your eligibility. Services will be provided if medically necessary. Medically necessary means:

Services related to (i) the prevention, diagnosis, and Treatment of health impairments; (ii) the ability to achieve age-appropriate growth and development; or (iii) the ability to attain, maintain, or regain functional capacity. Additionally, Medically Necessary services must be:

- Appropriate and consistent with the diagnosis of the treating provider and the omission of which could adversely affect your medical condition;
- Compatible with the standards of acceptable medical practice in the community;
- Provided in a safe, appropriate, and cost-effective setting given the nature of the diagnosis and the severity of the symptoms;
- Not provided solely for your convenience or the convenience of the Provider or Hospital; and
- Not primarily custodial care (for example, foster care).

In order for a service to be Medically Necessary, there must be no other effective and more conservative or substantially less costly Treatment, service, or setting available.

The information that follows details all the services covered.
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Preventive Services

- Vaccines -- Provided by the Health Department for the Federal Population. The GHP Plan will cover the administration of the vaccines following the dates established in the schedule provided by the Health Department. Vaccines for other eligible population will be covered by the GHP.

- Healthy Child Care - during the child's first 2 years of life.

- Healthy Child Care - One comprehensive annual assessment performed by a certified health professional. This annual assessment supplements the services for children and young adults is provided during the period established in the schedule of the American Academy of Pediatrics and Title XIX (EPSDT).

- Vision test.

- Hearing exam, including the newborn hearing screening before they are released from the Hospital nursery.

- Nutritional evaluations and tests.

- Laboratory tests and all the diagnostic and screening tests according to the beneficiary's age, sex and health condition.

- Prostate and gynecologic cancer screening according to the accepted medical practices, including Papanicolaou, mammography and PSA tests when medically necessary and according to the age of the beneficiary.

- Puerto Rico public policy sets the age of 40 years as a starting point for mammograms and breast cancer screening.

- Sigmoidoscopy and colonoscopy to detect colon cancer in adults aged 50 or more, classified by risk group, according to the accepted medical practices.

- Education on physical, nutritional and oral health.

- Reproductive Health Counseling (Family Planning). Such services shall be provided voluntarily and confidentially, including circumstances where the Enrollee is under age eighteen (18). Family planning services will include, at a minimum, the following:
  - Education and counseling necessary to make informed choices and understand contraceptive methods;
  - Pregnancy testing;
  - Diagnosis and treatment of sexually transmitted infections;
  - Infertility assessment;
  - At least one of every class and category of FDA-approved contraceptive medication as specified in ASES's preferred drug list (PDL); and
  - At least one of every class and category of FDA-approved contraceptive method as specified by ASES.
- Other FDA approved contraceptive medications or methods when it is Medically Necessary and approved through a Preauthorization or through an exception process and the prescribing provider can demonstrate at least one of the following situations:
  - Contra-indication with drugs that are in the PDL that the Enrollee is already taking, and no other methods available in the PDL.
  - History of adverse reaction by the Enrollee to the contraceptive methods covered as specified by ASES; or
  - History of adverse reaction by the Enrollee to the contraceptive medications that are on the PDL.

- Syringes for the administration of medications at home.
- Health certificates covered under the GHP (any other health certificates are excluded).
- Health Certificates that include tests for sexually transmitted diseases (VDRL) and tuberculin tests. The certificate must have the seal of the Health Department with a Copayment that will not exceed $5.00. The PR Department of Health charges a nominal administrative fee of $5.00 for the certificate. This is not a co-payment to receive the service or the results.
- Any certification for the GHP beneficiaries related to the Medicaid and CHIP Program eligibility (e.g. Medications History) will be provided to the beneficiary free of charge.
- Any certification required for programs such as Head Start, WIC and Child Care will be provided to the beneficiary free of charge or copayments.
- Any Copayment that applies to necessary procedures and laboratory tests for the issuance of a Health Certificate will the responsibility of the beneficiary.
- Annual physical exam and follow-up to diabetic Patients according to Treatment guidelines for the Treatment of diabetic Patients and the protocols of the Health Department.

**Dental Services**

You may visit the dentist of your choice that accepts the GHP. Covered dental services will be identified using the codes published by the American Dental Association (ADA) for the procedures established by ASES. The services that follow are covered under the GHP:

- Preventive services for children.
- Preventive services for adults.
- Restorative services.
- A comprehensive oral exam.
- A periodic oral evaluation every 6 months.
• Limited oral evaluation- problem focused.
• Intraoral X-rays complete series, including bitewings, every 3 years.
• One intraoral/periapical first film.
• Up to a maximum of 5 additional intraoral/periapical X-rays a year.
• Bitewing single film a year.
• One Bitewings double film a year.
• One set of panoramic film every 3 years.
• Prophylaxis – adult, every 6 months.
• Prophylaxis – children, every 6 months.
• Topical fluoride application for children under age 19, every 6 months.
• Topical application of sealant, per tooth, on posterior teeth for beneficiaries up to 14 years old. Includes deciduous molars up to 8 years of age when it is medically necessary because of a tendency to cavities. This service is limited to one lifetime Treatment.
• Resin composite restorations.
• Amalgam restoration.
• Pediatric therapeutic pulpotomy.
• Stainless steel crowns for primary teeth followed by a pediatric therapeutic pulpotomy.
• Root canals.
• Palliative Treatment.
• Oral surgery.

**Diagnostic Testing Services**

• Clinical labs, including but not limited to, any laboratory order for disease diagnostic purposes, even if the final diagnosis is a condition or disease whose treatment is not a Covered Service.
• Hi-tech Labs.
• X-Rays
• Electrocardiograms
• Radiation therapy (Prior Authorization required)
• Pathology
• Arterial gases and Pulmonary Function Test
• Electroencephalograms
• Diagnostic services for Enrollees who present learning disorder symptoms
• Services related to a diagnostic code included in the Diagnostic and Statistical Manual of Mental Disorders ("DSM IV or DSM V").
• Diagnostic and testing services for Enrollees under age twenty-one (21) required by EPSDT, as defined in Section 1905(r) of the Social Security Act.

Ambulatory Rehabilitation Services

• Physical therapy (limited to a maximum of fifteen (15) treatments per Enrollee condition per year, unless Prior Authorization of and additional fifteen (15) treatments is indicated by an orthopedist, physiatrist or chiropractor)
• Occupational therapy – unlimited.
• Speech therapy – unlimited.

Medical and Surgical Services

• Visits to primary care providers, including PCPs and nursing services.
• Treatments by Specialists and sub-specialists, without Referral, if they belong to the Preferred Provider Network of your PMG.
• Treatments by Specialists and sub-specialists outside the Preferred Provider Network of your PMG with a Referral of your PCP.
• Physician home visits when it is medically necessary.
• Respiratory therapy, without limits.
• Anesthesia services, except epidural anesthesia.
• Radiological services.
• Pathology services.
• Surgery.
• Use of ambulatory surgery facilities.
• Diagnostic services for cases of learning disabilities.
• Practical nurse services.
• Voluntary sterilization for men and women of appropriate age after being previously informed on the consequences of the medical procedure. The physician must have the written consent of the Patient.
- Prosthesis: includes the supply of all body extremities including therapeutic ocular prosthesis, segmented instrument tray and spinal fusion in scoliosis and vertebral surgery.
- Ostomy equipment for Patients ostomized ambulatorily.
- Blood, plasma and their derivatives.
- Services to Patients with chronic kidney disease in the first two levels (levels 3 to 5 are included in the Special Coverage).
- Breast reconstruction surgery after a mastectomy because of cancer.
- Treatments and surgery in cases of morbid obesity.
- Abortions are covered in the following instances: (i) life of the mother would be in danger if the fetus is carried to term; (ii) when the pregnancy is a result of rape or incest; and (iii) severe and long lasting damage would be caused to the mother if the pregnancy is carried to term, as certified by a physician.
- Durable Medical Equipment (DME) is not covered; however, DME may be covered on a case-by-case basis under an exceptions process according to your Health Plan's policies and procedures. Mechanical respirators and ventilators with oxygen supplies are covered without limits as required by local law to Enrollees under age twenty-one (21).

**Ambulance Services**

- Sea, air and land transportation will be covered within Puerto Rican territory limits in cases of emergency. These services do not require Preauthorization or precertification.

**Non-Emergency Transportation Services (NEMT)**

- Each municipality in Puerto Rico has a variety of free transportation services available to assist you in getting to your medical appointments. You can access the service by contacting your local municipal office or your Health Plan and asking about how to obtain transportation services.
- The Health Plans and some providers do offer transportation for members with certain conditions through case management. If you need the help of a case manager and you do not have one, call your Health Plan at the number in the back of your ID Card.
Maternity and Prenatal Services

- Women have the freedom to choose a gynecologist/obstetrician among the providers of their PMG or from their Health Plan's General Network. The different interventions until the confirmation of the pregnancy are not part of this coverage.
- Pregnancy tests.
- Pre-natal services.
- Services of the physician and an obstetric nurse during a normal delivery, c-section and in any other complication that may arise.
- Maternity hospitalization or for pregnancy secondary conditions, when medically recommended.
- Hospitalization of at least 48 hours for the mother and the newborn in case of a vaginal delivery and of 96 hours in case of c-section.
- Anesthesia, except epidural anesthesia.
- Use of incubator, unlimited.
- Nursery room care for the newborn.
- Circumcision and dilatation services for the newborn.
- Transportation of the newborn to tertiary facilities.
- Assistance of a pediatrician during a c-section or high risk delivery.

Emergency Room Services

You do not need a Preauthorization or a precertification to receive these services.

- Visits, medical attention, routine emergency room necessary services.
- Services for trauma.
- Use of emergency room and surgery.
- Necessary and routine emergency room services.
- Respiratory services, without limitations.
- Treatment by a Specialist or a sub-specialist when requested by the emergency room physician.
- Anesthesia, excluding epidural anesthesia.
- Surgical supplies.
- Clinical laboratory tests.
- X-rays.
- Drugs, medications and intravenous solutions to be used in the emergency room.
- Blood, plasma and their derivatives, without limitations.

Emergency services outside Puerto Rico will be covered only for the Federal Population according to non-participating providers' fees in Puerto Rico.

**IMPORTANT:**

No Hospital can refuse emergency services for not having the Government Health Plan card. Under EMTALA you have the right to receive adequate emergency services, including evaluation and Treatment of an emergency condition or delivery in Hospital Emergency Rooms.

**Post-Stabilization Services**

- Post-Stabilization Services are services that are provided after the Enrollee is stabilized to maintain or improve the Enrollee's condition after experience an emergency medical condition or psychiatric emergency for one hour while awaiting responses on a Preauthorization request.
- The attending Emergency Room physician or other treating provider shall be responsible for determining whether the Enrollee is sufficiently stabilized for transfer or discharge. That determination will be binding for the Health Plan with respect to its responsibility for coverage and payment.
- An Enrollee who has been treated for an emergency medical condition or psychiatric emergency shall not be held liable for any subsequent screening or Treatment necessary to stabilize the Enrollee.

**Hospitalization Services**

- Semi-Private Room, available 24 hours a day, year round.
- Isolation room for medical reasons.
- Nursery.
- Meals, including specialized nutrition services.
- Regular nursing services.
- Use of specialized rooms such as surgery room, recovery room, treatment and delivery room, without limitations.
- Drugs, medications and contrast agents, without limitations.
- Materials such as bandages, gauze, plaster bandages or any other therapeutic dressing materials.
• Therapeutic and maintenance care services, including the use of the necessary equipment to render the service.
• Specialized diagnostic tests such as electrocardiograms, electroencephalograms, arterial blood gases, and other specialized test available at the Hospital and necessary during the beneficiary's hospitalization.
• Supply of oxygen, anesthesia and other gases, including their administration.
• Respiratory therapy, without limitations.
• Rehabilitation services during hospitalization, including physical, occupational and speech therapy.
• Blood, plasma and their derivatives, without limitations.

Mental Health Services

• Evaluation, screening and Treatment to individuals, couples, families and groups.
• Ambulatory services rendered by psychiatrists, psychologists and social workers.
• Hospital and ambulatory services for substance abuse and alcoholism.
• Intensive ambulatory services.
• Emergency and crisis intervention services available 24 hours a day, 7 days a week.
• Detoxification services for beneficiaries that use illegal drugs, have had suicidal attempts or accidental poisoning.
• Administration of treatment with Buprenorphine (requires Preauthorization).
• Clinics for injectable extended-release medications.
• Escort, professional assistance and ambulance services when the services are necessary.
• Prevention services and secondary education.
• Pharmacy coverage and Access to medications within 24 hours.
• Laboratory tests that are medically necessary.
• Treatment for Patients diagnosed with Attention Deficit Disorder (ADD) with or without hyperactivity (ADHD). This includes, but is not limited to, visits to neurologists and tests related to the treatment of this diagnosis.
• Consultations and coordination with other Agencies.
• Substance abuse treatment.
Mental Health Hospitalization Services

- Hospitalization that presents a mental pathology that is not drug abuse when referred by a psychiatrist for primary phase diagnosis and Treatment, according to the parity provisions of Law 408 of October 2, 2000. This is the most restrictive level of mental health care in which the treatment is provided by an admission to a hospital setting.

- Partial hospitalization services (subject to pre authorization) - An intensive and structured ambulatory treatment in which a person attends 4 or 5 days per week to receive mental health services from an interdisciplinary team according to an individualized treatment plan.

- Court Orders for hospitalization to any level of treatment according to the parity provisions of Law 408 of October 2, 2000.

Pharmacy Services

- The GHP has Prescription drug coverage for the Physical and Mental Health needs of beneficiaries established in the Preferred Drug List (PDL).

- The pharmacy benefit coverage is generic-bioequivalent mandatory as general rule.

- Copayments are required for prescribed medication covered by the GHP.

- No co-payments will be charged to Medicaid and CHIP children under eighteen (18) years of age, and pregnant women.

- Medications included in the Master Formulary are covered through the exception processes.

- Pharmacy Management Program: Program of 90 days dispensing for Patients with chronic conditions: Providers can prescribe a 90-day supply for certain medications. This program allows the beneficiary to pay one (1) co-payment for a 90-day supply of medications instead of paying three (3) co-payments (1 co-payment per month).

Services Excluded from the Basic Coverage

The following services are excluded from Basic Coverage; if you have any questions about the list or regarding your coverage please call your Health Plan.

- Services to Patients not eligible to the GHP.

- Services for non-covered illnesses or trauma.

- Services for automobile accidents covered by the Administration of Compensation for Automobile Accidents (ACAA, for its acronym in Spanish).

- Accidents on the job that are covered by the State Insurance Fund Corporation.
- Services covered by another insurance or entity with primary responsibility (third party liability).
- Specialized nursing services for the comfort of the Patient when they are not medically necessary.
- Hospitalizations for services that can be rendered on an outpatient basis.
- Hospitalization of a Patient for diagnostic services only.
- Expenses for services or materials for the Patient’s comfort such as telephone, television, admission kits, etc.
- Services rendered by Patient’s relative (parents, children, siblings, grandparents, grandchildren, spouse, etc.).
- Organ and tissue transplants, except skin, bone and corneal transplants.
- Weight control treatments (obesity or weight increase for aesthetic reasons).
- Sports medicine, music therapy and natural medicine.
- Cosmetic surgery to correct physical appearance defects.
- Services, diagnostic tests ordered or provided by naturopaths, and iridologists.
- Health Certificates except for (i) venereal disease research laboratory tests, (ii) tuberculosis tests and (iii) any certification related to the eligibility for the Medicaid program or associated with programs such as WIC, Head Start and Child Care.
- Mammoplasty or plastic reconstruction of breast for aesthetic purposes only.
- Outpatient use of fetal monitor.
- Services, Treatment or hospitalization as a result of induced, non-therapeutic abortions or their complications. The following are considered induced abortions (code and description):
  ✓ 59840 – Induced abortion – dilation and curettage;
  ✓ 59841 – Induced abortion – dilation and expulsion;
  ✓ 59850 – Induced abortion – intra-amniotic injection;
  ✓ 59851 – Induced abortion – intra-amniotic injection;
  ✓ 59852 - Induced abortion – intra-amniotic injection;
  ✓ 59855 - Induced abortion – by one or more vaginal suppositories (e.g. prostaglandin) with or without cervical dilation (e.g. laminate) including admission and visits, expulsion of the fetus and afterbirth;
  ✓ 59856 - Induced abortion – by one or more vaginal suppositories (e.g. prostaglandin) with dilation and curettage or evacuation; and
  ✓ 59857 - Induced abortion – by one or more vaginal suppositories (e.g. prostaglandin) with hysterecomy (failed medical evaluation).
- Rebetron or any other prescribed medication for Hepatitis C Treatment. Both treatment and medications for this disease are excluded from the GHP coverage.
- Medications delivered by a provider that does not have a pharmacy license, with the exception of medications that are traditionally administered in a doctor's office such as an injection.
- Epidural anesthesia services.
- Services that are not reasonable or necessary according to the regulations accepted in the practice of medicine. Services rendered in excess to those normally required for diagnostics, prevention, diseases, Treatment, injury or organ system dysfunction or pregnancy condition.
- Mental health services that are not reasonable or necessary according to the accepted regulations for the practice of medical psychiatry or the services rendered in excess to those usually required for the diagnostic, prevention and Treatment of a mental illness.
- Educational tests, educational services.
- Peritoneal dialysis or hemodialysis services (Covered under the Special Coverage).
- New or experimental procedures not approved by ASES to be included in the Basic Coverage.
- Custody, rest and convalescence once the disease is under control or in irreversible terminal cases (hospice care for Members under 21 is part of basic coverage).
- Services covered under the Special Coverage.
- Services received outside the territorial limit of the Commonwealth of Puerto Rico, except for emergency services for Medicaid or CHIP beneficiaries.
- Judicial orders for evaluations for legal purposes.
- Travel expenses, even when ordered by the PCP or specialist are excluded.
- Eyeglasses, contact lenses and hearing aids (for members over age 21).
- Acupuncture services.
- Procedures for sex changes, including hospitalizations and complications.
- Treatment for infertility and/or related to conception by artificial means including tuboplasty, vasovasectomy, and any other procedure to restore the ability to procreate.
- Expenses incurred for the Treatment of conditions resulting from services not covered under the GHP (maintenance Prescriptions and required clinical laboratories for the continuity of a stable health condition, as well as any emergencies which could alter the effects of the previous procedure, are covered).
Special Coverage Services

Enrollees with special health care needs caused by serious illnesses may be enrolled into Special Coverage Registry to receive Special Coverage services.

Your PCP, the personnel designated by your PMG or the case coordinator of your PMG can instruct you on the conditions that qualify for the special coverage. Any of them can help you to get included in the Special Coverage by sending all the necessary information on your medical condition to your Health Plan.

Once enrolled in special coverage, Enrollees have the freedom to choose the providers for these services among the providers in the Preferred Provider Network of their PMG or their Health Plan’s General Network, differential diagnostic interventions up to the verification of the final diagnosis are not part of the Special Coverage.

Medications, laboratory test, diagnostic test and other related procedures specified in this coverage as necessary for ambulatory treatment or convalescence are part of this coverage and do not require the referrals from your PCP or Health Plan. Your Health Plan must identify the Enrollees included under this coverage to facilitate Access to the contracted services. The GHP Special Coverage will be activated when the Enrollee reaches the limit of any other Special Coverage the Enrollee may have under any other plan.

The purpose of this coverage is to facilitate the effective management of beneficiaries with special health condition that require specialized medical attention. This coverage will become effective when the diagnosis is confirmed through the results of tests or procedures performed.

The benefits under this coverage are:

- Coronary disease services and intensive care, without limitations.
- Maxillary surgery, with a Referral.
- Neurosurgical and cardiovascular procedures, including pacemakers, valves and any other instrument or artificial device (requires Preauthorization).
- Peritoneal dialysis, hemodialysis and related services (requires Preauthorization).
- Clinical and pathological laboratory test that must be sent outside Puerto Rico for their processing (requires Preauthorization).
- Neonatal intensive care unit services, without limitations.
- Treatment with radioisotopes, chemotherapy, radiotherapy and cobalt.
- Gastrointestinal conditions, allergies and nutritional evaluation for autistic Patients.
- The following procedures and diagnostic tests, when medically necessary (require Preauthorization):
  - Computerized tomography;
  - Magnetic resonance tests;
  - Cardiac catheterism;
  - Holter Test;
  - Doppler Test;
  - Stress Test;
  - Lithotripsy;
  - Electromyography;
  - Tomography test (SPECT);
  - Ocular Pletismography test (OPG);
  - Impedance Pletismography (IPG);
  - Other neurological cerebral-vascular and cardiovascular tests, invasive or non-invasive;
  - Nuclear Medicine tests;
  - Diagnostic Endoscopies; and
  - Genetic Studies.
- Physical therapy – up to 15 additional Treatments per condition per beneficiary a year, when ordered by an Orthopedist, Physiatrist or Chiropractor (requires Preauthorization from your Health Plan).
- General Anesthesia.
  - General anesthesia for dental treatment to children with special needs.
- Hyperbaric chamber.
- Immunosuppressive drugs and laboratory tests required for the maintenance Treatment of Patients who have been operated to receive any transplant, which assure the stability of the beneficiary's health and the emergencies that may arise after this surgery.
- Treatment for the following conditions after being confirmed by the results of laboratory tests and the diagnosis has been established:
  - Positive HIV Factor and Acquired Immunodeficiency Syndrome (AIDS) – Ambulatory and hospitalization services are included. You do not need a Referral or Preauthorization from your Health Plan or your PCP for the visits and Treatment at the Immunology Regional Clinics of the Health Department;
✓ Tuberculosis;
✓ Leprosy;
✓ Lupus;
✓ Cystic fibrosis;
✓ Cancer;
✓ Hemophilia;
✓ Aplastics Anemia;
✓ Reumatoid Arthritis;
✓ Autism;
✓ OBG Obstetricians;
✓ Post Organ Transplantation; and
✓ Children with special needs, except:
  o Asthma and diabetes, which are included in the Disease Management Program,
  o Psychiatric disorders, and
  o Intellectual disabilities, behavior manifestations will be managed by the mental health providers under the basic coverage, with the exception of a catastrophic disease.

- Scleroderma.
- Multiple Sclerosis and Amiotrofic Sclerosis Lateral (ALS).
- Services for the Treatment of conditions resulting from self-inflicted damage or as a result of a felony committed by a beneficiary or negligence.
- Chronic renal disease in levels 3, 4 and 5. (Levels 1 and 2 are included in the Basic Coverage). The following is a description of the stages of chronic renal disease:
  o **Level 3** - GFR (glomerular filtration - ml / min. per 1.73 m $^2$ per corporal surface area) between 30 and 59, a moderate decrease in kidney function
  o **Level 4** - GFR between 15 and 29, a serious decrease in kidney function
  o **Level 5** - GFR under 15, renal failure with probability of dialysis or kidney transplantation.
- The medications required for the ambulatory treatment of tuberculosis and leprosy are included under the Special Coverage. Medications required for the ambulatory Treatment or hospitalization for beneficiaries diagnosed with AIDS or that are HIV positive are covered under the Special Coverage, except protease inhibitors, which will be provided by the Clinics for the Prevention and Treatment of Sexually Transmitted Diseases (CPTET, for its acronym in Spanish).
Services excluded from the Special Coverage
Exclusions and limitations under the Basic Coverage are not covered under the Special Coverage unless expressly included in the Special Coverage.

Medicare Coverage Services
For Medicare Parts A and B Beneficiaries, the following factors will be considered to determine the coverage to be offered:

- Beneficiaries eligible to Part A:
  ✓ They will be offered the regular GHP coverage, excluding the benefits covered by Part A until they reach their limit. In other words, once you reach the benefit limit of Medicare Part A coverage, the GHP will be activated.
  ✓ Part A Deductibles are not included.
  ✓ The payment of Copayments for the regular coverage will be according to the payment capacity table provided to all the GHP beneficiaries.

- Beneficiaries eligible to Parts A/B:
  ✓ They are offered the regular the GHP pharmacy and dental coverage.
  ✓ Part A Deductibles are not included.
  ✓ Part B Deductibles and Copayments will be included.

- Dual eligible (Medicare and Medicaid eligible) may not be simultaneously enrolled in the GHP and in a Medicare Platino plan, for the reason that the Platino plan already included GHP benefits. In addition, as an Enrollee in the plan, the dual eligible may access Covered Services only through the PMG, not through the Medicare Provider List.
Attachment 2
DIRECTIVES TO COORDINATE THE PAYMENT OF SERVICES

A. TRIPLET-S SALUD, INC. SUBSCRIBER WITH COMMONWEALTH OF PUERTO RICO HEALTH INSURANCE PLAN AND WITH OTHER HEALTH INSURANCE PLAN

Step #1

Bill the other plan first.

Step #2

Once you receive the payment from the other plan, proceed to bill to Triple-S Salud the difference not paid by the other plan. Bills for differences not paid cannot be sent through electronic means.

Complete Triple-S Salud invoice form and ensure that you fill out the information in Box D. Include the evidence of the payment by the primary plan with the invoice form. If you rendered the services through a referral from the PMG (Primary Medical Group) to which the beneficiary belongs, be sure to include the referral of the patient.

If Triple-S Salud does not receive a copy of the patient's referral, they will not coordinate the payment for the service, for the claim does not comply with the coverage requirements set by them.

B. TRIPLE-S SALUD, INC. WITH THE HEALTH PLAN OF THE GOVERNMENT OF THE COMMONWEALTH OF PUERTO RICO AND MEDICARE PART A OR PART A AND B

For the beneficiaries of Medicare Part A or Part A and B, the agreement with ASES provides that Triple-S Salud will cover the payment of the Part B co-insurances and deductibles, as long as the services have been rendered or have been referred by the primary care physician. The financing of these services will be through the per capita payments sent to the PMG. In these cases the process is as follows:

Coordination with Medicare Part A

Remember that the coverage excludes the hospital admission deductible and the co-insurances applicable to the services covered by Medicare Part A. In addition, institutional services such as the use of ambulatory surgery facilities and the use of the emergency room are excluded from the coverage, since they can be recovered through the Medicare Cost Reports (bad debts). Triple-S Salud will not coordinate the deductibles and co-insurances related to those services.

Coordination with Medicare Part B

Step #1

Bill Medicare indicating the information of the following boxes in the HCFA 1500 form:
In box #9 (Other Insurer’s Name) Triple-S Salud Insurance Company.

In box #9a (Other Insured’s Policy or Group Number) the subscriber’s contract number.

If applicable, enter in box #29 (Amount Paid) the amount paid by the beneficiary.

Step #2

If you bill Medicare electronically, you must ensure that in your billing system the patient’s secondary plan is updated with the contract number of the Health Insurance of the Commonwealth of Puerto Rico. The 13 numbers that compose the patient’s contract number must be updated.

When you bill Medicare, your billing system will generate the second plan information and will send it to Medicare, which at the same time will send it to us, so we can process the payment of the deductibles and coinsurances.

Medicare will transfer your claim electronically to Triple-S Salud and will describe the transaction when it identifies it Forward to Triple-S in its payment explanation. It is important that the provider validates in the acknowledgment of receipt it sends to Triple-S Salud, that the claim was received and accepted for processing. If the claim does not appear in the acknowledgment of receipt, the provider must bill using the corresponding form (i.e. HCFA 1500) and attach a copy of the Medicare explanation of payment. Remember that the provider has 90 days from Medicare’s date of payment to send the claim. The $110.00 annual deductible and the 20% coinsurance are covered by the Health Insurance Plan of the Commonwealth of Puerto Rico.

If you rendered the services through a referral from the PMG to which the beneficiary belongs, ensure that you send the patient’s referral to Triple-S Salud.

If Triple-S Salud does not receive a copy of the patient’s referral, they do not have the obligation to coordinate the payment for the service, for the claim does not comply with the coverage requirements set by them.

C. FORM TO INFORM OTHER HEALTH INSURANCE PLAN

To set an effective Benefits Coordination System, Triple-S Needs that participants help in collecting the information on those subscribers that have another health insurance plan.

We appreciate that when you find out that the subscriber has another health insurance plan, you send us the document enclosed indicating the information requested, This will allow us to update our computer files in order to guarantee the correct handling of the claims.
Formulario de Coordinación de Beneficios

I. Información sobre el Suscriptor - Subscriber Information

<table>
<thead>
<tr>
<th>NOMBRE / Name</th>
<th>APELLIDO PATERNO / Lastname</th>
<th>APELLIDO MATERNO / Surname</th>
<th>NUMERO DE CONTRATO / Contract Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Su cubierta de seguro médico incluye una cláusula de Coordinación de Beneficios. El procesamiento de las reclamaciones bajo su seguro médico y dental podría depender de su contestación. Tu salud en tu seguro médico y dental puede responder por su respuesta.

POR FAVOR, COMPLETE Y DEVUELVA ESTE FORMULARIO DENTRO DE LOS PRÓXIMOS QUINCE (15) DÍAS.

Please, fill and return this form within fifteen (15) days.

¿Usted o algún miembro de su familia que esté actualmente cubierto por el plan de salud tiene cubierto bajo otro seguro médico, dental, farmacia o Medicare?

- O NO
  - Si marcó “NO”, favor de firmar y devolver el formulario.
  - ¡Si marcó “SI”, favor de completar las siguientes secciones:
  - Si marcó “Sí”, favor de completar las siguientes secciones:
  - Si marcó “Cambio”, favor de indicar el plan, la efectividad y/o cancelación del mismo.
  - ¡Si “Update” was checked, please indicate health plan, effectivity date and cancelation date.

II. Información sobre el otro seguro - Information about other insurance

<table>
<thead>
<tr>
<th>NOMBRE DE LA OTRA COMPAÑÍA SEGURO / Name of other Insurance Company</th>
<th>NÚMERO POLIZA / Policy Number</th>
<th>NÚMERO CONTRATO / Contract Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

TIPO DE PLAN/Plan Type
- Plan Salud Grupal
- Póliza Individual (Pago Directo)/Individual Policy
- ELA
- Plan Empleados Federales/FEHB
- Medicare A o B
- Medicare Parte D
- Medicare Advantage
- TriCare
- Mi SALUD/Government Health Plan
- Otro/Other

COVERAGE/Cubiertas
- Hospital
- Médico Quirúrgico/Medical Surgical
- Ambulatorio/Ambulatory
- Maternidad/Maternity
- Odontológico/Dental
- Farmacia/Pharmacy
- Gastos Médicos Mayores/Major Medical
- Complementaria/Complementary

FECHA INICIO / Start Date | FECHA CANCELACIÓN / Cancelation Date
MESMO DIA/DAY | AÑO/Year |
MESMO DIA/DAY | AÑO/Year |

DIRECCIÓN DEL OTRO SEGURO MÉDICO / Other Insurance Address

TELEFONO / Phone
FACSÍMIL / Fax

III. Información sobre dependientes en el otro seguro - Information about dependents on other insurance

<table>
<thead>
<tr>
<th>NOMBRE Y APELLIDOS / Name and Surname</th>
<th>FECHA DE INICIO / Start Date</th>
<th>SEGURO SOCIAL / Social Security</th>
<th>SEXO / Sex</th>
<th>PARENTESCO DEL SUSCRIPTOR / Relationship with subscriber's insured</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4

5

Utilice otro formulario para añadir dependientes adicionales. Use another form to include additional dependents.

Incluya la información de Medicare el dorso. Include Medicare information on reverse.

Favor de firmar al dorso
Please, sign on reverse of form.
IV. Divorciados, separados o con custodia - Divorced, separated, or with custody

Complete esta sección si usted es divorciado(a), separado(a) o tiene custodia de algún menor dependiente bajo seguro médico/insurance. Importante que indique información incluida en la Sección II de este formulario. Complete this section if you are divorced, separated, or have custody of any dependent child under your health insurance contract. Please, complete this section even if some of the information is already included in Section II of this form.

NOMBRE Y APELLIDOS/Name, Last and Surnames
FECHA NACIMIENTO/Date of Birth
SEGURO SOCIAL/ Social Security
SEXO/SEX
PAREJERO CON ASEGURADO DE SUBSCRITOR Relationship with insuror's insured

1. 
2. 
3. 
4. 

INFORMACIÓN DEL SEGURO QUE PROVEE CUBIERTA A LOS MENORES DEPENDIENTES/ Information of the Health Insurance providing minor's coverage:

NOMBRE DE LA OTRA COMPAÑÍA SEGURO/ Name of other Insurance Company
TIPO DE PLAN/Plan Type
COVERAGE/ cubiertas

NÚMERO POLIZA/Policy Number
NÚMERO CONTRATO/Contract Number
FECHA APERTURA/OPEN DATE
FECHA CANCELACIÓN/Cancelation DATE
DIRECCIÓN DEL OTRO SEGURO/ Other Insurance Address

INDIVIDUO RESPONSABLE DEL SEGURO DE LOS MENORES DEPENDIENTES/ Individual responsible for minor’s coverage:

NOMBRE Y APELLIDOS/ Name, Last and Surnames
FECHA NACIMIENTO/Date of Birth
SEGURO SOCIAL/ Social Security
SEXO/SEX
PAREJERO CON MENOR/Related with minor

V. Información sobre Medicare - Medicare Information

Complete la siguiente información para cada asegurado bajo su contrato de plan de salud que tenga cubierta de Medicare. Complete the following information for each member on your health plan contract that is also covered by Medicare.

NOMBRE Y APELLIDOS DE BENEFICIARIO DE MEDICARE/Name, Last and Surnames of Medicare Beneficiary
FECHA NACIMIENTO/Date of Birth
SEGURO SOCIAL/ Social Security
SEXO/SEX
FECHA DE EFECTIVIDAD/Effective Date
PARTE A/PART B

RAZÓN PARA CUBIERTA DE MEDICARE (MARQUE TODAS LAS QUE APLiquen) Reason for Medicare coverage (check all that apply)

NÚMERO MEDICARE / Medicare Claim Number

VI. Certificación - Certification

Certifico que la información antes provista es correcta y veraz. Reconozco además que proveer información falsa o incorrecta podría conllevar no sólo la cancelación de mi seguro médico con TRIPLE-S SALUD, así como las disposiciones aplicables de las leyes contra el fraude. I hereby certify that the information provided hereabove is accurate and true. I further recognize that providing false or inaccurate information may lead to the cancellation of my health insurance and to filing of criminal charges under the anti-fraud statutes.

Su Firma / Your Signature
Fecha / Date

COB2011

Departamento de Operaciones de Servicio
TRIPLE-S SALUD
PO Box 365282
San Juan, PR 00936-3628
Attachment 3
<table>
<thead>
<tr>
<th>Services</th>
<th>Federal</th>
<th>CHIPS</th>
<th>Población Estatal</th>
<th>ELA*</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>100</td>
<td>110</td>
<td>230</td>
<td>300</td>
</tr>
<tr>
<td>HOSPITAL</td>
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<td>Admissions</td>
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<td>Nursery</td>
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<tr>
<td>EMERGENCY ROOM (ER)</td>
<td>EMERGENCY ROOM (ER)</td>
<td>EMERGENCY ROOM (ER)</td>
<td>EMERGENCY ROOM (ER)</td>
<td>EMERGENCY ROOM (ER)</td>
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<tr>
<td>Non-emergency visit to a hospital emergency room.</td>
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<td>$3.80</td>
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<td>Trauma</td>
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<td>AMBULATORY VISITS TO</td>
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<td>AMBULATORY VISITS TO</td>
<td>AMBULATORY VISITS TO</td>
<td>AMBULATORY VISITS TO</td>
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<td>Primary Care Physician (PCP)</td>
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<td>Specialist</td>
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<td>Sub-Specialist</td>
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<td>Pre-natal services</td>
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<td>Clinical Laboratories**</td>
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<tr>
<td>X-Rays**</td>
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<tr>
<td>Preventive (Child)</td>
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</tr>
<tr>
<td>Preventive (Adult)</td>
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<td>Restorative</td>
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<td>$0</td>
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<tr>
<td>PHARMACY***</td>
<td>PHARMACY***</td>
<td>PHARMACY***</td>
<td>PHARMACY***</td>
<td>PHARMACY***</td>
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<tr>
<td>Generic (Children 0-18)</td>
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<td>$0</td>
<td>$0</td>
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<tr>
<td>Generic (Adult)****</td>
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<tr>
<td>Brand (Children 0-18)</td>
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<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Brand (Adult)****</td>
<td>$3</td>
<td>$3</td>
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<td>$3</td>
</tr>
<tr>
<td>Services</td>
<td>Federal</td>
<td>CHIPS</td>
<td>Población Estatal</td>
<td>ELA*</td>
</tr>
<tr>
<td></td>
<td>100</td>
<td>110</td>
<td>230</td>
<td>300</td>
</tr>
</tbody>
</table>

*Code 400 in ELA column refers to the population that subscribes as public employees of the Puerto Rico Government.

**Apply to diagnostic tests only. Copays do not applied to tests required as part of a preventive service.

***Copays apply to each drug included in the same prescription pad. Pharmacy exception (children 0-18) does not apply to 400 ELA employees.

****Co-pays for children 0-18 years of age are not applicable for Medicaid, Commonwealth medically indigent eligible, and for children 0-18 enrolled in the CHIP Program in group ages 0-18.

Co-pays may apply to children ages over 18 years old as well as to adults.
Attachment 4
# OBSTETRICS REGISTRATION FORM

## PATIENT INFORMATION

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Date of Birth</th>
<th>Age</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Contract number:</th>
<th>GMP Number:</th>
<th>Patient Telephones:</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>First Visit</th>
<th>Weeks pregnant at first visit</th>
<th>Date of last menstruation</th>
<th>Estimated date of expectancy</th>
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<table>
<thead>
<tr>
<th>Month</th>
<th>Date</th>
<th>Year</th>
<th>Month</th>
<th>Date</th>
<th>Year</th>
<th>Month</th>
<th>Date</th>
<th>Year</th>
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</table>

## OBSTETRICS INFORMATION

<table>
<thead>
<tr>
<th>Name of Obstetrician:</th>
<th>Provider Number</th>
<th>NPI</th>
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</table>

<table>
<thead>
<tr>
<th>Office Telephone</th>
<th>Fax Number</th>
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</table>

## MEDICAL HISTORY

## CLINICAL HISTORY

<table>
<thead>
<tr>
<th>Gyn-Obstetric History</th>
<th>Recent abortions? Yes or No</th>
<th>Yes, please complete</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>G</th>
<th>P</th>
<th>A</th>
<th>SB</th>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>

If this is a high risk, select the following indicating the condition in order of relevance: (1 Primary, 2 Secondary, 3 Tertiary)

### Diagnosis:

- [ ] Diabetes
- [ ] Respiratory condition
- [ ] Hypertension
- [ ] Cardiovascular

### Relevance:

<table>
<thead>
<tr>
<th>Diagnosis:</th>
<th>Relevance:</th>
</tr>
</thead>
</table>

| [ ] Cancer | Relevance: |
| [ ] HIV | Relevance: |
| [ ] History of premature labor | Relevance: |
| [ ] Other, specify: | Relevance: |

### Comments:

Obstetric Signature  
X Date

Note: Please send this form accompanied by all pertinent information, by fax to 774-4835 or via email to the following address: cubiertasespeciales@sspr.com.

IMPORTANT: This document is sent for individual use or entities and may contain CONFIDENTIAL information and disclosure free under the law. If you are not the correct recipient, you are notified that any distribution, disclosure or copy of this document is strictly prohibited. If you receive this document by error, please notify immediately by telephone and return the original by mail at the above address.

Rev. Nov, 2014

15-105-214E
Attachment 5
**Section A**

### PATIENT INFORMATION

**Referral Criteria:**
- **Asthma:** 1 admission; 2 or more visits to emergency room; presenting symptoms 3 or more days/week
- **Diabetes:** A1C > 9; De Novo Diabetes
- **Heart Failure:** Stages 3 and 4; 1 or more admissions
- **Hypertension:** >160/90, 1 or more admissions due to hypertension crisis
- **Prenatal:** High risk pregnancy due to existing chronic conditions; Premature delivery history, etc.
- **Depression:** Mayor depression; 1 or more admissions; 2 or more visit to stabilization room
- **Obesity:** BMI 30.0kg/m² – 39.9kg/m²

<table>
<thead>
<tr>
<th>Referral Date:</th>
<th>Referral Reason:</th>
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</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Name:</th>
<th>Address:</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>Phone number:</th>
<th>Cellular:</th>
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<table>
<thead>
<tr>
<th>Health Plan ID:</th>
<th>Birth Date:</th>
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<th>Sex:</th>
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<th>Female</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Diagnosis:</th>
<th>Referral by:</th>
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</thead>
<tbody>
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**Section B**

### PROVIDER INFORMATION

<table>
<thead>
<tr>
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<th>Phone number:</th>
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<table>
<thead>
<tr>
<th>Provider ID:</th>
<th>Fax number:</th>
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**Section C**

### CLINICAL MANAGEMENT ANALYST INFORMATION

<table>
<thead>
<tr>
<th>Date Received:</th>
<th>Enrollment Date:</th>
<th>Clinical Management Analyst Name:</th>
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</thead>
<tbody>
<tr>
<td></td>
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</table>

| Decision: | |
|-----------||

<table>
<thead>
<tr>
<th>Date:</th>
<th>Signature:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

Please send to Disease Management Unit by fax: (787)-625-8402 or by email: manejodeenfermedades@ssspr.com. To confirm receipt call: (787)706-2547.

Rev 06/2015
Attachment 6
POTENTIAL PATIENT REFERRAL
Case Management Department
Triple-S Salud

Referral date

*Patient's name

* Contract #

Home Address:


* Gender

* Age

* Diagnosis

* Beneficiary’s telephone number

* Relative’s Name and number

* Referred by:

* Title

* Telephone/ext.

* Fax

Admitting primary care physician

Telephone

Fax

PMG

*Reason for referral:


* Medications and dosages currently in use

Currently Hospitalized?:  [ ] Yes  [ ] No

Hospital:

Room Number

Admission Date

Discharge Date

Referral via:

[ ] Fax  [ ] Phone  [ ] In Person  [ ] E-mail

Send the referral:

☑ Via Fax at (787)774-4837 for Government Health Plan

All referral that do not include the information identified as basic information (*) will be rejected.

Please include the medical order with referral.

Reviewed: 11/26/2014
Attachment 7
## Codes That Require a Precertification Through Triple-Salud Call Center

### Reconstruction Surgery
- Mammoplasty
  - Code: 19316 - 19361

### Gastrointestinal Endoscopies
- **Upper GI Endoscopy**
  - **Para > 12 y/o < 65 y/en Lugar de Servicio 22 y 24.**
  - **En hospital (lugar de servicio 21), no es requerido**
  - Codes: 43180-43259
- **ERCP**
  - Code: 43260-43278
- **Colonoscopy**
  - **Para > 12 y/o < 65 y/en Lugar de Servicio 22 y 24.**
  - **En hospital (lugar de servicio 21), no es requerido**
  - Code: 45378 – 45398

### Gastric By Pass for Morbid Obesity
- Codes: 43842 – 43865, 43882-43999

### Kidney
- **ESWL and Lithotripsy**
  - Codes: 50590, 52353
- **Ablation, 1 or more renal tumor(s); percutaneous, by radiofrequency**
  - Code: 50592
## Radiosurgery

Stereotactic Radiosurgery

61796 - 61800, 63620 - 63621, 70557-70559 (MRI)

## Neurosurgery and Neurology

63650, 63655, 63661, 63664, 63685, 63688

Injection of anesthetic agents (neuro block and neurostimulators)

64479-64489, 64483-64484, 64550-64595

## Radiology: High Tech

**CT – Head + Neck & CTA - Head + Neck**

70450, 70460, 70470, 70480 - 70482, 70486 - 70488, 70490 - 70492  CTA -70496, 70498

**MRI – Head + Neck & MRA - Head + Neck**

70336, 70540 – 70543 ; 70551 – 70553; 70554-70559  MRA -70544-70549

**CT – Chest, Thorax & CTA Chest, Thorax**

71250-71270, CTA -71275

**MRI & MRA – Chest**

71550 – 71552, MRA -71555

**CT – Spine & CTA Spine**

72125 - 72133 ; CTA - 72191-72194

**MRI & MRA – Spine**

72141 – 72158, MRA - 72159

**CT & CTA – Pelvis**

CTA - 72191  CT- 72192-72194

**MRI & MRA – Pelvis**
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>72195 - 72197</td>
<td>MRA - 72198</td>
</tr>
<tr>
<td>CT &amp; CTA Upper extremities</td>
<td></td>
</tr>
<tr>
<td>73200 - 73202</td>
<td>CTA - 73206</td>
</tr>
<tr>
<td>MRI &amp; MRA – Upper extremities</td>
<td></td>
</tr>
<tr>
<td>73218 - 73223</td>
<td>MRA - 73225</td>
</tr>
<tr>
<td>CT &amp; CTA – Lower extremities</td>
<td></td>
</tr>
<tr>
<td>73700 - 73702</td>
<td>CTA - 73706</td>
</tr>
<tr>
<td>MRI &amp; MRA – Lower extremities</td>
<td></td>
</tr>
<tr>
<td>73718 - 73723</td>
<td>MRA - 73725</td>
</tr>
<tr>
<td>CT &amp; CTA – Abdomen and Pelvis</td>
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<tr>
<td>74150-74170, 74176-74178</td>
<td>CTA - 74174-74175</td>
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<tr>
<td>MRI &amp; MRA - Abdomen</td>
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<tr>
<td>74181 - 74183</td>
<td>MRA - 74185</td>
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<tr>
<td>CT colonography</td>
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<td>74261-74262</td>
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<tr>
<td>CT &amp; CTA - Heart</td>
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<td>75571-75573</td>
<td>CTA - 75574</td>
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<td>MRI – Heart</td>
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<td>75557 - 75565</td>
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CT Angiography abdominal aorta and bilateral iliofemoral lower extremity

75635

CT limited or localized follow up study

76380

CT – Bone mineral density
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<thead>
<tr>
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<th>Description</th>
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</thead>
<tbody>
<tr>
<td>77078</td>
<td>MRI - Breast</td>
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<tr>
<td>77058</td>
<td>Fetal Non Stress Test *solo en oficina (lugar de servicio 11)</td>
</tr>
<tr>
<td>59025*</td>
<td>Non-Stress Test</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>HIDA</td>
<td>Nuclear Medicine</td>
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<tr>
<td>78226-78227</td>
<td>Myocardial perfusion and cardiac blood pool</td>
</tr>
<tr>
<td>78451 – 78454, 78459 – 78469, 78472 - 78473, 78481 – 78483, 78491- 78496</td>
<td>Myocardial perfusion and cardiac blood pool imaging studies</td>
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<tr>
<td>78600 – 78601, 78605 – 78607</td>
<td>Brain Imaging</td>
</tr>
<tr>
<td>78608-78609</td>
<td>Cerebral vascular flow, only</td>
</tr>
<tr>
<td>78610</td>
<td>Cerebrospinal fluid flow with SPECT</td>
</tr>
<tr>
<td>78647</td>
<td>Kidney Imaging</td>
</tr>
<tr>
<td>78700 – 78701, 78707 – 78709</td>
<td>Kidney imaging tomographic w/ SPECT</td>
</tr>
<tr>
<td>78710</td>
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</tr>
<tr>
<td>Gallium Scan and Octreo Scan</td>
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<tr>
<td>-----------------------------------</td>
<td></td>
</tr>
<tr>
<td>78800 – 78807</td>
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</tr>
<tr>
<td>PET Scan &amp; PET CT</td>
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<tr>
<td>78811 – 78813, 78814 - 78816</td>
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**Special EEG Tests**

*EEG video-monitoring, recording and interpretation each 24 hours.*

*Solo para unidades de video-monitoring seriado*

| 95950 - 95953                      |

**Physical Medicine & Rehabilitation (excedente de 15 terapias, requiere preautorización)**

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<thead>
<tr>
<th>Supervised</th>
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<tr>
<td>97012 - 97028</td>
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<tr>
<td>Constant Attendance</td>
</tr>
<tr>
<td>97032 - 97039</td>
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<tr>
<td>Therapeutic Procedures</td>
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<tr>
<td>98777, 97110, 97140, 97530</td>
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**Cardiovascular Diagnostic studies** *Solo para servicios ambulatorios*

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<tr>
<th>Holter 24 hrs. electrocardiography</th>
</tr>
</thead>
<tbody>
<tr>
<td>93224-93229 ; 93268-93272; 93278</td>
</tr>
<tr>
<td>Echocardiogram; Doppler Echocardiography and Color flow</td>
</tr>
<tr>
<td>93303-93308 ; 93312-93318; 93320-93325</td>
</tr>
<tr>
<td>Echo with stress test</td>
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<tr>
<td>93350-93355</td>
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</table>
### Cerebrovascular diagnostic studies

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<th>Description</th>
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<td>93880-93895</td>
<td>Extremity arterial studies (Doppler &amp; Duplex)</td>
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<tr>
<td>93965-93971</td>
<td>Extremity venous studies (Doppler &amp; Duplex)</td>
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<tr>
<td>93975-93981</td>
<td>Visceral and Penile Vascular Studies</td>
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</tbody>
</table>

### Prosthesis

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<th>Code Range</th>
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<tr>
<td>Lower limb prosthesis</td>
<td>L5000 – L5984</td>
</tr>
<tr>
<td>Upper limb prosthesis</td>
<td>L6020 – L6450</td>
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<tr>
<td></td>
<td>L8699</td>
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</tbody>
</table>

### BRAC & Oncotype

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<th>Code Range</th>
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<td>BRAC</td>
<td>81211 – 81217</td>
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<tr>
<td>Oncotype</td>
<td>81519</td>
</tr>
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</table>
# REQUEST FORM FOR NUCLEAR STUDIES

(Please be advised that all questions must be answered completely. Failure to do so may delay a determination)

**Telephone:** 1-866-365-9024  
**Fax:** (787) 749-9980

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Contract Number</th>
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</thead>
<tbody>
<tr>
<td>MD requesting services</td>
<td>Specialty</td>
</tr>
<tr>
<td>MD Telephone #</td>
<td>NPI</td>
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<td></td>
<td>Fax Number</td>
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<table>
<thead>
<tr>
<th>Requested Study</th>
<th>ICD-9 Code</th>
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<tbody>
<tr>
<td>Diagnosis or Suspicion</td>
<td>CPT Code</td>
</tr>
<tr>
<td>Symptoms/ Main Complaint</td>
<td></td>
</tr>
</tbody>
</table>

| Findings in Physical Exam | |
| Treatment | |

<table>
<thead>
<tr>
<th>Laboratories or Previous Studies</th>
<th>Date</th>
<th>Results</th>
</tr>
</thead>
</table>

*If there is a previous record of clinical data that supports the requested study, it can be send in an additional sheet.*
Attachment 9
**SPECIAL COVERAGE REGISTRATION FORM**

**ENROLLEE AND PHYSICIAN INFORMATION**

<table>
<thead>
<tr>
<th>Name of the enrollee:</th>
<th>PCP name:</th>
<th>Specialist name:</th>
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</thead>
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<td>Contract number:</td>
<td>Date of Birth</td>
<td>PCP provider number:</td>
</tr>
<tr>
<td>Enrollee telephone number:</td>
<td></td>
<td>Number of Specialist provider:</td>
</tr>
<tr>
<td>PCP telephone:</td>
<td>Specialist telephone:</td>
<td></td>
</tr>
<tr>
<td>PCP Fax:</td>
<td>Specialist Fax:</td>
<td></td>
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</tbody>
</table>

**DIAGNOSIS**

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<thead>
<tr>
<th>APLASTIC ANEMIA</th>
<th>SCLEODERMA</th>
<th>SYSTEMIC LUPUS ERYTHEMATOSUS</th>
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<tbody>
<tr>
<td><strong>Evaluation requirements:</strong></td>
<td><strong>Evaluation requirements:</strong></td>
<td><strong>Evaluation requirements:</strong></td>
</tr>
<tr>
<td>— Hematologist certification</td>
<td>— Evidence of diagnostic tests</td>
<td>— Rheumatology evaluation</td>
</tr>
<tr>
<td>— Evidence of bone marrow biopsy results</td>
<td>— Skin biopsy</td>
<td>— ANA Test, DS-DNA, Anti Sm,</td>
</tr>
<tr>
<td>— Cyto genetic diagnosis confirmation</td>
<td>— Include Rheumatology Certification</td>
<td>Anti Phospholipids laboratories</td>
</tr>
<tr>
<td>— Neutrophils absolute count, platelets count, retic count</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| RHEUMATOID ARTHRITIS | MULTIPLE SCEROSIS/AMIOOTROPHIC LATERAL SCEROSIS | TUBERCULOSIS |
|----------------------|---------------------------------------------|----------------|---|
| **Evaluation requirements:** | **Evaluation requirements:** | **Evaluation requirements:** |
| — Condition certified by a rheumatologist | — Neurologist evaluation | — X-rays or positive culture for infection |
| — Evidence of ESR, CRP, ANA Test, RA factor test and/or pertinent x-ray results. | — Brain MRI | |
| | — Spinal Cord MRI | |
| | — Lumbar puncture result | |

<table>
<thead>
<tr>
<th>AUTISM</th>
<th>CYSTIC FIBROSIS</th>
<th>HIV/AIDS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Evaluation requirements:</strong></td>
<td><strong>Evaluation requirements:</strong></td>
<td><strong>Evaluation requirements:</strong></td>
</tr>
<tr>
<td>— Evidence of diagnosis by neurologist and psychiatrist</td>
<td>— Sweat test</td>
<td>— Positive Western Blot</td>
</tr>
<tr>
<td>— MCHAT/Age and stages tests (Questionnaires ASQ3) results</td>
<td>— Diagnostic certification from a pulmonologist</td>
<td>— HIV viral load</td>
</tr>
<tr>
<td></td>
<td>— Evidence of medications taken for the condition</td>
<td>— Positive 4th generation test with subtype antibodies or antigens validation for acute infection</td>
</tr>
<tr>
<td></td>
<td></td>
<td>— Opportunistic disease evidence in AIDS patients</td>
</tr>
</tbody>
</table>

**CHRONIC RENAL DISEASE**

<table>
<thead>
<tr>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5*</th>
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</thead>
<tbody>
<tr>
<td>GFR between 30 and 59</td>
<td>GFR between 15 and 29</td>
<td>GFR less than 15</td>
</tr>
<tr>
<td>Data dialysis started:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mo</td>
<td>Date</td>
<td>Year</td>
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</tbody>
</table>

**HEMOBILIA**

<table>
<thead>
<tr>
<th>Hematologist evaluation and condition certification</th>
<th>Coagulation factors levels results</th>
<th>Current treatment</th>
</tr>
</thead>
</table>

**HEMOPHILIA**

<table>
<thead>
<tr>
<th>— Hematologist evaluation and condition certification</th>
<th>— Coagulation factors levels results</th>
<th>— Current treatment</th>
</tr>
</thead>
</table>

**LEPROSY**

| — Evidence of positive biopsy or culture for infection | — Include Certification of expert on infectious diseases |

**POST TRANSPLANT**

<table>
<thead>
<tr>
<th>Requirements which should be included with this form:</th>
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</thead>
<tbody>
<tr>
<td>Type of Transplant:</td>
</tr>
<tr>
<td>Date of transplant:</td>
</tr>
<tr>
<td>— Medical evidence of transplant</td>
</tr>
<tr>
<td>— Immunosuppressant drugs used by the patient</td>
</tr>
</tbody>
</table>

**INDICATE IF THE ENROLLEE HAS:**

- Medicare A
- Medicare B
- Medicare A and B

**ADDITIONAL COMMENTS:**

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**Continue at Reverse Side**

15-105-256
### Treatment Plan Special Coverage

#### MEDICAL HISTORY

#### DIAGNOSIS

<table>
<thead>
<tr>
<th>Diagnosis ICD9 and Its Description</th>
<th>Diagnosis Date</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Mo / Day / Year</td>
</tr>
<tr>
<td></td>
<td>Diagnosis Date</td>
</tr>
<tr>
<td></td>
<td>Mo / Day / Year</td>
</tr>
<tr>
<td></td>
<td>Diagnosis Date</td>
</tr>
<tr>
<td></td>
<td>Mo / Day / Year</td>
</tr>
</tbody>
</table>

#### INDICATE FREQUENCY AND SPECIALIZED CLINICS VISITED (IF APPLY)

#### MEDICATIONS OR TREATMENTS CURRENTLY USED (DOSES AND FREQUENCY)

#### INDICATE RECENT HOSPITALIZATION (IF ANY)

<table>
<thead>
<tr>
<th>DATE</th>
<th>HOSPITAL</th>
</tr>
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</table>

#### INDICATE RECENT OR PENDING (IF ANY) SURGICAL PROCEDURES

<table>
<thead>
<tr>
<th>SURGICAL PROCEDURES</th>
<th>DESCRIPTION</th>
<th>DATE</th>
<th>CPT CODE</th>
<th>WHERE WAS SERVICE RECEIVED</th>
</tr>
</thead>
</table>

Name and signature of the person who completed this form:

Date:

---

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Revised: Nov. 2014

15-105-256
ONCOLOGY INITIAL REGISTRATION FORM

Part A: Enrollee Information

Enrollee Name: ___________________________ Date of Birth: ___________ Connect #: ___________

ICD9: ___________________________ Stage(TNM): ___________________________

Date of Pathology: ___________ / ___________ / ___________ Patient's telephone number: ___________________________

Comorbidity: □ Allergies □ Diabetes □ Hypertension □ Cardiac disease
□ Pulmonary disease □ Others ___________________________

MEDICAL HISTORY

Comments: ___________________________

Part B: Treatments Received

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Approximate Date</th>
<th># Treatments</th>
<th>Treatment Description</th>
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<tbody>
<tr>
<td>□ Surgery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Radiotherapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Hormonal therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Bone marrow transplant</td>
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Chemotherapy /Hormonal Agents

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<tr>
<th>Approximate Date</th>
<th>Dose</th>
<th>Frequency</th>
<th>Duration</th>
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<tbody>
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<td>Peripheral</td>
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<tr>
<td>Central Line</td>
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<tr>
<td>S/C</td>
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<tr>
<td>IM</td>
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<tr>
<td>PO</td>
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Antiemetics

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<tr>
<th>Compazine</th>
<th>Decadron</th>
<th>Reglan</th>
<th>Zofran</th>
<th>Anzemet</th>
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</table>

Other Medications:

Part C: Providers

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<tr>
<th>Name</th>
<th>Provider Number</th>
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<th>Fax</th>
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<tbody>
<tr>
<td>□ Surgeon</td>
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<tr>
<td>□ Radiotherapist</td>
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<tr>
<td>□ Oncologist</td>
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<tr>
<td>□ Others</td>
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</tr>
</tbody>
</table>

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Rev. Nov. 2014

Person who documents: ___________________________ Date: ___________________________
# CHILDREN WITH SPECIAL NEEDS FORM

## ENROLLEE AND PHYSICIAN INFORMATION

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<thead>
<tr>
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<th>Contract number:</th>
<th>Subscriber's Telephone:</th>
<th>PMG Number:</th>
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<td>Age</td>
<td>PCP Name:</td>
<td>Provider Number:</td>
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<td></td>
<td>PCP Telephone:</td>
<td>PCP Fax:</td>
</tr>
<tr>
<td>Subscriber's Postal Address:</td>
<td></td>
<td>Specialist's Telephone:</td>
<td>Specialist's Fax:</td>
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<tr>
<td>Specialist's Name:</td>
<td>Provider Number:</td>
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<td>Record Number:</td>
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## MEDICAL HISTORY

## DIAGNOSIS

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<th>Diagnosis (ICD10)</th>
<th>Diagnosis Date:</th>
<th>INDICATE TREATMENT</th>
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<tbody>
<tr>
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<td>M/o D/y Y</td>
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</table>

## INDICATE FREQUENCY AND SPECIALIZED CLINICS VISITED (IF APPLY)

## INDICATE RECENT HOSPITALIZATION (IF ANY)

<table>
<thead>
<tr>
<th>DATE</th>
<th>HOSPITAL</th>
</tr>
</thead>
</table>

## INDICATE RECENT OR PENDING (IF ANY) SURGICAL PROCEDURES

<table>
<thead>
<tr>
<th>SURGICAL PROCEDURES</th>
<th>DESCRIPTION</th>
<th>DATE</th>
<th>CPT CODE</th>
<th>WHERE WAS SERVICE RECEIVED</th>
</tr>
</thead>
</table>

Name and signature of the person who completed this form: Date:

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Rev. Nov. 2014
**OBSTETRICS REGISTRATION FORM**

**PATIENT INFORMATION**

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<thead>
<tr>
<th>Patient Name:</th>
<th>Date of Birth</th>
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<table>
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<th>Patient Telephones:</th>
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<table>
<thead>
<tr>
<th>First Visit</th>
<th>Weeks pregnant at first visit</th>
<th>Date of last menstruation</th>
<th>Estimated date of expectancy</th>
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<th>Date</th>
<th>Year</th>
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<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

**OBSTETRICS INFORMATION**

<table>
<thead>
<tr>
<th>Name of Obstetrician:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider Number</th>
<th>NPI</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Office Telephone</th>
<th>Fax Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**MEDICAL HISTORY**

**CLINICAL HISTORY**

<table>
<thead>
<tr>
<th>G</th>
<th>P</th>
<th>A</th>
<th>SB</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If this is a high risk, select the following indicating the condition in order of relevance: (1 Primary, 2 Secondary, 3 Tertiary)

<table>
<thead>
<tr>
<th>Diagnosis:</th>
<th>Relevance:</th>
<th>Diagnosis:</th>
<th>Relevance:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td></td>
<td>Cancer</td>
<td></td>
</tr>
<tr>
<td>Respiratory condition</td>
<td></td>
<td>HIV</td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td></td>
<td>History of premature labor</td>
<td></td>
</tr>
<tr>
<td>Cardiovascular</td>
<td></td>
<td>Other, specify:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Obstetric Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

**Note:** Please send this form accompanied by all pertinent information, by fax to 774-4835 or via email to the following address: cubiertasespeciales@asspr.com.

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Rev. Nov. 2014
Attachment 10
**Physician Information**

Name: 

License: 
Physician specialty: 
Address: 
Telephone: 
Fax: 

**Patient Information**

Name: 
Diagnosis: 
Date of birth: 
Sex: □ M  □ F  Weight: 

**Medication requested:**

Drug name 
Dose: 

**Medical Information for Exception Requirement:**

*Please select the reason to request the exception and provide medical justification*

- □ Non Formulary Drug: 
- □ Step Therapy: 
- □ Dose limit, or quantity limit: 

You may provide any additional medical information which may support approval:

1) Laboratories required:

Please provide the following information:

Physician signature:  
Date: 

---

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# POLICY AND PROCEDURE

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy Department</td>
<td>Procedure number: FA/OP-27</td>
</tr>
<tr>
<td>Effective date:</td>
<td>Pending for ASES approval</td>
</tr>
<tr>
<td>Prepared by Clinical Pharmacist:</td>
<td>Approved by Operations Manager of Pharmacy:</td>
</tr>
<tr>
<td></td>
<td>Approved by Executive Director of Pharmacy:</td>
</tr>
<tr>
<td>Mayra Castillo, R.Ph.</td>
<td>Caroll Correa, R.Ph.</td>
</tr>
<tr>
<td>Purpose:</td>
<td>Describe the process of realizing drug exceptions to assure that they are performed effectively and uniformly.</td>
</tr>
<tr>
<td>Scope:</td>
<td>Employees of Triple-S’s Pharmacy Department Clinical Revision Unit.</td>
</tr>
</tbody>
</table>

## Policy

All Pharmacy staff must perform the procedure as established at the moment of evaluating drugs that require an exception process to be authorized. This should be done to ensure complying with the criteria established by ASES according to the agreed policy period.

## Definitions:

1. **CCMS® (CareEnhance Clinical Management System)** - System where all clinical interventions are documented and letters and notifications are generated.

2. **Exception Process** - It is the process of evaluating drugs that are not in the "PDL" the following way:
   - Primary physician or specialist (for beneficiaries with registry of special conditions) has to certify:
     - Contraindication to the drugs included in the "PDL".  
     - History of adverse reactions to the drugs included in the "PDL".  
     - Therapeutic failure to all the alternatives available in the "PDL".  
     - Nonexistence of a therapeutic alternative in the "PDL".

3. **Regular or standard evaluation** - Request evaluation for preauthorizing a drug which should be concluded in a term no longer than 72 hours in accordance with the current policy. If there was a change in the term by contract this policy will be amended. An evaluation is considered to be regular or standard if the physician does not document urgency in the prescription.

4. **Expeditious evaluation** - Request evaluation for preauthorizing a drug which should be concluded in a term of 24 hours. If there was a change in the term by contract this policy will be amended. The physician should document on the prescription the prompt request: Eg. "Stat" or "rush".

5. **Pharmacy Benefit Management (PBM)** - Organization hired by ASES responsible for the administration of the reclaims of pharmacies, management of formularies, drug utilization review, hiring and managing the network of pharmacies and service of information for the pharmacies.
Procedure:

1. The evaluator will analyze the following:

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>IF THE ANSWER IS YES, THEN</th>
<th>IF THE ANSWER IS NO, THEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>The prescription contains diagnosis and justifies one of the following points:</td>
<td>Continue with the instruction (2)</td>
<td>Continue with the instruction (6)</td>
</tr>
<tr>
<td>a) Contraindication to drugs included in the “PDL.”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) History of an adverse reaction or allergy to the drugs included in the “PDL.”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) Therapeutic failure to all the alternatives available in the “PDL.”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d) Nonexistence of a therapeutic alternative in the “PDL.”</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. If there is a proper justification and diagnosis on the prescription the pharmacy technician will evaluate the request the following way:

   i. He/she will create a review or consult to the medical advisors so they can determine if the justification complies with the process of exception.
   ii. The medical advisor will answer approving or denying the request according to his/her criterion and clinical evaluation in a term no longer than 72 hours.

Note: If the advisor needs additional information to make a determination on the case the Medical Information Request (Annex #3) form will be sent to the prescribing physician.

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>IF THE ANSWER IS YES, THEN</th>
<th>IF THE ANSWER IS NO, THEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was the case approved by the advisor?</td>
<td>Continue with the instructions (3) to (5).</td>
<td>Continue with the instruction (6).</td>
</tr>
</tbody>
</table>

3. Create a note in the system of CCMS® documenting the determination and evaluation of the case following the instructions of the Operational Procedure for Documentation of Drug Authorization in CCMS® System - FA/OP-25.

4. An event will be created on the CCMS® system, a service number of the event will be obtained and the required fields will be documented.
5. If the drug has been approved:
   i. It should be documented on the created event that the case was APPROVED and it will be classified as an "Exception".
   ii. The pre-authorization will be set up in the PBM’s system filling the required fields.
   iii. The service number obtained during step (4) will be documented and the repetitions according to the prescription’s validity.
   iv. The pharmacy will be contacted to process the prescription during the call. If the pharmacy is not reached a notification will be sent of the approval via fax to the pharmacy and the notification will be documented on the CCMS® system. See Annex 1.
   v. The evaluation request will be closed on CCMS® system.

6. If the drug has been denied:
   i. It should be documented on the created event that the case was DENIED and it will be classified as Non Formulary.
   ii. A notification of the denial will be sent via fax to the provider who made the request. See Annex 2.
   iii. A letter by mail will be sent to the beneficiary which will state the reason for the refusal. See Annex 2.
   iv. The letter sent to the beneficiary and the notification to the provider will both be documented on the CCMS® system.
   v. The evaluation request will be closed on CCMS® system.

References:

2) Operational Procedure for Documenting Drug Pre-Authorization on CCMS System
3) Preferred drug list (PDL)
NOTIFICATION TO PHARMACY <<Service Number>>

Date: <<today_date_dd_mmm_yy>>

Pharmacy Name: __________

Pharmacy NABP: ____________

Pharmacy Telephone Number: ____________

Pharmacy Fax Number: ________

Policy Holder: <<m_full_name>>

Policy number: <<m_coverage_policy_number>>

DRUG NAME: ________________

COMMENTS: ________________

xxx

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Annex #2: Notification of Refusal to Exception Request

REFUSAL NOTIFICATION TO EXCEPTION REQUEST

<<today_date_mmdyyyy>>
<<m_full_name>>
<<m_full_address>>

Policy number:

Dear policy holder:

We have received your application to evaluate the drug _____________, on _____________.

Your request has been evaluated by one of our medical advisors and it was determined that it does not meet the criteria to grant an exception of the drug.

The reason (s) is (are) the following:

(Write the detailed reason (s) in this space)

If you do not agree with this determination and have additional information, you can request an appeal in a term of 90 calendar days as of the date of this letter.

We are sending you a copy of the Appeal Rights where you will find the process that you should follow according to the type of request.

You have the right to request a copy of the criteria used for the evaluation of the application.

If more information is needed you can contact our Mi Salud call center which is available 24 hours 7 days of the week:

Island 1.800.981.1352
Metro Area 787.775.1352
TTY 1.855.295.4040

Sincerely,

Signature and Title
Appeal Rights
for the beneficiaries of MI Salud - Pharmacy

What is an appeal?

If we denied your cover petition either partially or completely or if you do not agree with our determination you can request for us to reconsider our decision. This is known as an appeal. If you wish to appeal you should do so within 20 to 90 calendar days after the date indicated in your notification of cover determination.

You or the representative that you assign can request an appeal. You can name a family member, friend, defender, lawyer, physician or any other as a representative but it needs to be confirmed written in a document with the date and your signature.

You or your authorized representative can request an appeal to Triple-S Salud either written or verbally. If requesting your appeal verbally you will have to deliver it in written form and signed, unless it is an expedited appeal.

Who will attend my appeal?

Your appeal will be attended by a person that did not participate in the initial determination. It will be a Healthcare Professional with the clinical knowledge to treat your health condition if deciding the following:
   a. An appeal to a refusal based on lack of medical necessity
   b. A lawsuit regarding the refusal to an expedited resolution for the appeal or
   c. A lawsuit or appeal that involves clinical aspects

How long will it take for my appeal to be responded?

How fast we decide your appellation depends on the type of appellation. The pre-service standard appeal should be managed and the determination should be notified as fast as the health condition requires it, within a term no longer than 45 calendar days since the date in which the cover’s request was received. This term could be extended for 14 additional days if:
   a. Your or your authorized representative requests the extension; or
   b. Triple-S Salud justifies the need for additional information and how the extension’s to your benefit. You or your authorized representative has 45 calendar days to turn in the requested information.

If it were to be an appellation where your life, health or ability to function are at risk, you should receive the answer to your appeal as fast as your health condition requires it in a period no longer than 72 hours since the request was received. This term can be extended for an additional 14 days if:
   a. You or your authorized representative requests the extension; or
   b. Triple-S Salud justifies the need for additional information and how the extensions in your benefit.

The appeal request should include the following: name of the beneficiary, policy number, service date, clinical record copy, type of service you’re appealing, name and address of the physician or provider, letter exposing the reasons why the service should be authorized, certification of the medical need, clinical documents and any other information that supports the clinical need or that is relevant to the beneficiaries clinical condition.
What are my rights?

If the term is extended without you or your representative requesting it, Triple-S Salud should notify you your right to eradicate a lawsuit if you do not agree with the extension.

If Triple-S Salud rejects the request of an expedited appeal it must change the expedited appeal to a standard one. Moreover, they should notify the beneficiary verbally of the refusal and send them a written notification within 2 calendar days.

You have the right to request copy of the criteria utilized in the appeal evaluation through the phone:

Island 1.800.981.1352
Metro Area 787.775.1352
TTY 1.855.295.4040

You have the right to receive, if requested, reasonable access and copy of all the documents relevant to the appeal.

What will be included in the resolution of the appeal?

The notification of the appeal’s resolution should include the following:

a. The results of the investigation and the date in which it culminated  
b. For decisions not favorable to the beneficiary: 
   I. The right to request an Administrative Law Hearing
   II. How to request the administrative law hearing
   III. The right to request an extension of benefits during the hearing’s period and how to request it; and
   IV. Notification to the beneficiary that she/he may be responsible for the cost of receiving services during the waiting period of the hearing if the plan’s decision maintains the same

Can I still receive services during the appeal process?

Yes, you have the right to receive services under the plan MI Salud del Gobierno de Puerto Rico while a resolution for your appeal is emitted. Triple-S Salud should continue their benefits if:

a. You or your authorized representative made the appeal within 10 days after Triple-S Salud sent you their notification of action or within the effectivity date of the proposed action;  
b. The appeal involves the termination, suspension, or reduction of a course of treatment previously authorized;  
c. The services were ordered by an authorized provider;  
d. The period originally covered by the original authorization has not expired; and  
e. The beneficiary requests a benefit’s extension

Triple-S Salud must continue to offer the extension of benefits until one of the following happens:

a. You or your authorized representative withdraws the appeal;  
b. ASES takes an adverse decision for the beneficiary;  
c. The period of time or limits of service of a previous service of a service previously authorized has been fulfilled.
Responsibility of the beneficiary and Triple-S Salud for the services received while the appeal is being transmitted:

- If the final resolution of the appeal is adverse for you and confirms the action of Triple-S Salud, Triple-S Salud can recover the cost of the services that were given to you while the appeal was being processed.
- If Triple-S Salud reverses a decision to refuse, limit, or delay services that were not offered while the appeal was pending, Triple-S Salud must authorize or provide the services disputed as soon as possible and as fast as the health condition of the beneficiary requires it.

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Time to Request an Appeal</th>
<th>Time for Triple-S Salud to answer an Appeal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Service</td>
<td>As fast as the beneficiaries health condition requires it but no more than 90 days since the plan sent the Action Notification</td>
<td></td>
</tr>
<tr>
<td>Expedited</td>
<td>You can request via phone: Island 1.800.981.1352 Metro Area 787.775.1352 TTY 1.855.295.4040</td>
<td></td>
</tr>
<tr>
<td></td>
<td>You can also send it to the following address:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Triple-S Unidad de Quejas y Apelaciones PO Box 363628 San Juan, P.R. 00936-3628</td>
<td></td>
</tr>
<tr>
<td>Pre-service</td>
<td>As fast as the beneficiaries health condition requires it but no more than 90 days since the plan sent the Action Notification</td>
<td></td>
</tr>
<tr>
<td>Standard</td>
<td>You can request via phone: Island 1.800.981.1352 Metro Area 787.775.1352 TTY 1.855.295.4040</td>
<td></td>
</tr>
<tr>
<td></td>
<td>You can also send it to the following address:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Triple-S Unidad de Quejas y Apelaciones PO Box 363628 San Juan, P.R. 00936-3628</td>
<td></td>
</tr>
</tbody>
</table>

It must be managed and answered as fast as the health condition of the beneficiary requires it, in a term no longer than 72 hours following receipt of the request for an appeal.

An extension of 14 calendar days may be requested if the beneficiary requests it or if Triple S demonstrates that there is a need for additional information.

If you are not satisfied with the determination, you can request a second appeal.

If you need information about your rights under the process of complaints, appeals and/or request for impartial hearing call us at our call center Tele Mi Salud at 1-800-981-1352 or refer to the Subscriber Guide. Telephone services for audio disabled persons (TTY), call at 1-855-295-4040, free of charge.
Annex #3: Medical Information Request

<table>
<thead>
<tr>
<th>Request for:</th>
<th>☐ Preauthorization (PA)</th>
<th>☐ Exception</th>
</tr>
</thead>
</table>

### Physician Information

<table>
<thead>
<tr>
<th>Name:</th>
<th>[ ]</th>
<th>License:</th>
<th>[ ]</th>
<th>Physician specialty:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>[ ]</td>
<td>Telephone:</td>
<td>[ ]</td>
<td>Fax: [ ]</td>
</tr>
</tbody>
</table>

### Patient Information

<table>
<thead>
<tr>
<th>Name:</th>
<th>[ ]</th>
<th>Date of birth:</th>
<th>[ ]</th>
<th>Sex: ☐ M ☐ F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis:</td>
<td>[ ]</td>
<td>Weight:</td>
<td>[ ]</td>
<td></td>
</tr>
<tr>
<td>ID #:</td>
<td>[ ]</td>
<td>[ ]</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Medication requested:

<table>
<thead>
<tr>
<th>Drug name:</th>
<th>[ ]</th>
<th>Dose:</th>
<th>[ ]</th>
</tr>
</thead>
</table>

### Medical Information for Exception Requirement:

Please select the reason to request the exception and provide medical justification

- ☐ Non Formulary Drug: [ ]
- ☐ Step Therapy: [ ]
- ☐ Dose limit, or quantity limit: [ ]

You may provide any additional medical information which may support approval:

Laboratories required:

Please provide the following information that is required for case evaluation:

<table>
<thead>
<tr>
<th>Physician signature:</th>
<th>Date:</th>
</tr>
</thead>
</table>

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<table>
<thead>
<tr>
<th>Procedure</th>
<th>Policy and Procedure of Drugs Preauthorization of the Health Plan of the Government</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department of Pharmacy</td>
<td>Procedure Number</td>
</tr>
<tr>
<td>Effective Date</td>
<td>Pending for ASES approval</td>
</tr>
<tr>
<td>Prepared by Clinical Pharmacist:</td>
<td>Approved by Operations Manager of Pharmacy:</td>
</tr>
<tr>
<td>Mayra Castillo, R.Ph.</td>
<td>Caroll Correa, R.Ph.</td>
</tr>
<tr>
<td>Purpose:</td>
<td>Describe the process of carrying-out drugs pre-authorization to ensure that it should be executed in a uniform and effective form.</td>
</tr>
<tr>
<td>Annexes:</td>
<td></td>
</tr>
<tr>
<td>1. Notification of Authorization to Provider</td>
<td>2. Notification of Refusal to Policyholder</td>
</tr>
<tr>
<td>3. Notification of Information Need</td>
<td>4. Request for Medical Information</td>
</tr>
</tbody>
</table>

**Policy**

All Pharmacy staff should perform the procedure as it has been established at the moment of evaluate drugs that require pre-authorization, in order to comply with the criteria and protocols established by ASES, according to the period agreed in the contract.

**Definitions:**

1. **Preferred drugs list (PDL)-** is a guide of the drugs included in the pharmacy benefit. The Health Insurance Administration (ASES) is responsible for establishing and reviewing this cover in the Physical and Mental Health section. The PDL aims to improve, update, and achieve the use of cost-effective drugs within the cover of the Health Plan of the Government.

2. **Standard or regular evaluation-** Evaluation of request for drug's preauthorization which must be completed in a period of 72 hours or less, according to current contract. If you change this term in the contract, this policy will be amended. A standard or regular evaluation is considered when the doctor does not document urgency in the prescription.

3. **Expeditious evaluation-** Evaluation of request for drug’s preauthorization which must be completed in a period of 24 hours. If you change this term in the contract, this policy will be amended. The physician must document in the prescription the expedited request (for example: stat or rush).

4. **Pharmacy Beneficiary Administrator (PBM)-** Organization hired by ASES, responsible for the administration of claims from pharmacies, management of the formularies, drug use evaluation, hiring and management of pharmacy network and the information service for the pharmacies.

5. **CCMS® (CareEnhace Clinical Management System)-** System where all clinical interventions are documented, and letters and notifications are generated.
6. **Clerk** - Pharmacy Technician with or without license that pre-evaluates cases following the Policy and Procedure of Pre-evaluation of Drugs in the Clinical Revision Unit of Pharmacy Department FA/OP-28. All cases with incomplete information and the prescriptions that do not meet with requirements of Law of Pharmacy are return to the pharmacies.

7. **Evaluator** - Pharmacy Technician with license that evaluates cases of pre-authorization and exception according to the procedures established for this. The evaluator informs the final decision to the pharmacy.

**Procedure**

1. The clerk of Clinical Revision Unit will receive the request for drug preauthorization. He/she will follow the instructions describe in the Policy and Procedure of Pre-evaluation of Drugs in the Clinical Revision Unit of Pharmacy Department FA/OP-28.

2. The evaluator will receive the "Reminder" (request for evaluation) assign by the supervisor or team leader. Then the evaluator will follow these steps:
   a. Open the Reminder in the system CCMS®, by priority and in order as they come. If the reminder indicates expeditious, will be evaluated with priority.
   b. Evaluate the information included in the Reminder, according these steps:
      i. Choose the prescription and documents related to the case.
      ii. Confirm that the prescription met with Pharmacy Law requirements.
      iii. Check that the information documented by the pharmacy is the same that contains the prescription.
      iv. Enter to PBM billing system, verify that the physician that sign or against-sign the prescription is included in the Physicians Group which the patient belongs:

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>IF ANSWER YES, THEN</th>
<th>IF ANSWER NO, THEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the doctor who signs the prescription belong to the medical group of the policyholder, or is the specialist of the special condition registered (if it applies)?</td>
<td>See instruction (v)</td>
<td>Denied the case following the instruction (2f)</td>
</tr>
</tbody>
</table>
v. Evaluate the drug according to clinical protocol of ASES for this drug.

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>IF ANSWER YES, THEN</th>
<th>IF ANSWER NO, THEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does the case meet with all the criteria for authorization included in the clinical protocol of ASES for the drug evaluate?</td>
<td>Authorize and classify like Pre-autho. Continue with the instructions (2c)-(2e) for case’s documentation.</td>
<td>Continue with the instruction (2f).</td>
</tr>
</tbody>
</table>

c. Create a note in CCMS® system with the evaluation and determination of the case following the instructions of the *Operational Procedure for the Documentation of Authorization of Drugs in CCMS® System- FA/OP-25.*

d. Create an event in CCMS® system, you will get the service number of the event and will perform the following steps:

i. Document in the created event that the case was APPROVED and classified as "PreAutho".

ii. Elaborate the pre-authorization in the system of the PBM and fill all the required fields.

iii. Document the service number on the platform of the billing system obtained in step (2d) and the refills according to the duration of the prescription.

iv. Call the pharmacy to process the prescription online. If failing to contact by phone, send an approval notification by fax to the pharmacy. Document the approval notification in CCMS® system. See Annex 1.

v. Close the evaluation request in CCMS® system.
f. Reason for refusal:

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>IF ANSWER YES, THEN</th>
<th>IF ANSWER NO, THEN</th>
</tr>
</thead>
</table>
| 1. Was case rejected because it does not meet any criteria of the Clinical Protocol? | i. Create a note in CCMS® system with the evaluation and determination of the case following the instructions of the Operational Procedure for the Documentation of Authorization of Drugs in CCMS® System- FA/OP-25.  
ii. Create an event in CCMS® system, you will get the service number of the event  
iii. Document in the created event that the case was DENIED and classified as "Criteria Not Meet".  
iv. Close the evaluation request in CCMS® system.  
v. Send a refusal notification by fax to the provider who performed the request. See Annex 1  
vi. Send a refusal letter with the reason for this refusal by postal mail to the beneficiary. See Annex 2.  
vi. Document in CCMS® system that the notification to the provider and the beneficiary's letter were sent.  
viii. Close the evaluation request in CCMS® system. | i. Create a note in CCMS® system documenting that the case cannot be evaluated due to lack of information or because the prescribing physician is not your primary MD. Specify which information is missing.  
ii. Send a notification by fax to the provider who performed the request indicating the missing information to evaluate the case. See Annex 1  
iii. Send a letter to the beneficiary notifying the information that is required to evaluate the case. In addition, the form Request for Medical Information will be enclosed for doctor documentation. See Annex 3 and 4. |

Note: This step is a Technical Decision, since the case cannot be evaluated due to lack of information. If the information arrives prior to 72 hours of the date of dispatch of the notification, the case will reopen and the evaluation will begin on instruction no. 2. If the information not reached in that period of time, the case is deemed closed.

References:

2) Procedimiento Operacional para documentación de Autorización de Medicamentos en Sistema CCMS® - FA/OP-25  
3) Política y Procedimiento de Pre-evaluación de Medicamentos en el Área de Revisión Clínica de Farmacia FA/OP-28.  
4) Lista de Medicamentos Preferidos del Plan de Salud de Gobierno
Anexx #1: Notification of Authorization o Refusal to the Provider

TRIPLE-S SALUD

NOTIFICATION TO PHARMACY <<service_number>>

Date: <<today_date_dd_mmm_yy>>

Pharmacy's Name: ________

Pharmacy NABP: ____________

Pharmacy's Phone number: __________

Pharmacy's Fax Number: ________

Policyholder: <<m_full_name>>

Policy: <<m_coverage_policy_number>>

DRUG: ________________

COMMENTS: ________________

xxx

CONTAINS CONFIDENTIAL INFORMATION- The information contained in this document is CONFIDENTIAL and sensitive. We are sending this information considering the recipients' authorization or for situations where we are allowed by law. You, as the recipient of this information, are responsible to keep this information in a safe place and handle in a confidential manner. The use or dissemination of this information without prior authorization of the recipient or for situations allowed by law is prohibited. The unauthorized use or dissemination of this information or the use without observing measures of handling the information in a safe and confidential manner is subject to fines and penalties as established by Federal and State Laws and Regulations.

IMPORTANT NOTICE- If the reader/recipient of this message is not the person to whom it was addressed to, or is not an employee or authorized agent of the entity to which this communication was addressed to, you are duly notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you receive this message by error, please notify us immediately and destroy all related documents to this message.
Annex #2: Notification of Refusal to the Policyholder

TRIPLE-S SALUD

REFUSAL NOTIFICATION TO REQUEST FOR PREAUTHORIZATION

<<today_date_mmdyyy>>

<<m_full_name>>
<<m_full_address>>

Policy Number:

Dear Policy Holder:

We received your request to evaluate the drug ____________, the ________________.

We evaluated the request and determined that it does not meet the criteria for granting a pre-authorization for the drug.

The reason(s) is (are) the following:

(Write in this space the reasons for the refusal)

If you do not agree with this determination and have additional information, you can request an appeal within a period of 90 calendar days from the date of this letter.

We are sending you a copy of Appeals Rights, where you will find the process to be followed depending on the type of request.

You have the right to request a copy of the criteria used for the evaluation of your request.

If you need more information, may contact our call center of "Mi Salud", which is available 24 hours 7 days of the week:

Island 1.800.981.1352
Metro Area 787.775.1352
TTY 1.855.295.4040

Sincerely,

Sign and degree
Appeal Rights
for the beneficiaries of Mi Salud - Pharmacy

What is an appeal?

If we denied your cover petition either partially or completely or if you do not agree with our determination you can request for us to reconsider our decision. This is known as an appeal. If you wish to appeal you should do so within 20 to 90 calendar days after the date indicated in your notification of cover determination.

You or the representative that you assign can request an appeal. You can name a family member, friend, defender, lawyer, physician or any other as a representative but it needs to be realized written in a document with the date and your signature.

You or your authorized representative can request an appeal to Triple-S Salud either written or verbally. If requesting your appeal verbally you will have to deliver it in written form and signed, unless it is an expedited appeal.

Who will attend my appeal?

Your appeal will be attended by a person that did not participate in the initial determination. It will be a Healthcare Professional with the clinical knowledge to treat your health condition if deciding the following:

a. An appeal to a refusal based on lack of medical necessity 
b. A suit regarding the refusal to an expedited resolution for the appeal or 
c. A suit or appeal that involves clinical aspects

How long will it take for my appeal to be responded?

How fast we decide your appellation depends on the type of appellation. The pre-service standard appeal should be managed and the determination should be notified as fast as the health condition requires it, within a term no longer than 45 calendar days since the date in which the cover's request was received. This term could be extended for 14 additional days if:

a. Your or your authorized representative requests the extension; or 
b. Triple-S Salud justifies the need for additional information and how the extensions in your benefit. You or your authorized representative has 45 calendar days to turn in the requested information.

If it were to be an appellation where your life, health or ability to function are at risk, you should receive the answer to your appeal as fast as your health condition requires it in a period no longer than 72 hours since the request was received. This term can be extended for an additional 14 days if:

a. You or your authorized representative requests the extension; or
b. Triple-S Salud justifies the need for additional information and how the extensions in your benefit.

The appeal request should include the following: name of the beneficiary, policy number, service date, clinical record copy, type of service you’re appealing, name and address of the physician or provider, letter exposing the reasons why the service should be authorized, certification of the medical need, clinical documents and any other information that supports the clinical need or that is relevant to the beneficiaries clinical condition.

What are my rights?

If the term is extended without you or your representative requesting it, Triple-S Salud should notify you your right to eradicate a suit if you do not agree with the extension.

If Triple-S Salud rejects the request of an expedited appeal it must change the expedited appeal to a standard one. Moreover, they should notify the beneficiary verbally of the refusal and send them a written notification within 2 calendar days.

You have the right to request copy of the criteria utilized in the appeal evaluation through the phone:

Island 1.800.981.1352  
Metro Area 787.775.1352  
TTY 1.855.295.4040

You have the right to receive, if requested, reasonable Access and copy of all the documents relevant to the appeal.

¿What will be included in the resolution of the appeal?

The notification of the appeal’s resolution should include the following:

a. The results of the investigation and the date in which in culminated

b. For decisions not favorable to the beneficiary:

   I. The right to request an Administrative Law Hearing

   II. How to request the administrative law hearing

   III. The right to request an extension of benefits during the hearing’s period and how to request it; and

   IV. Notification to the beneficiary that she/he may be responsible for the cost of receiving services during the waiting period of the hearing if the plan’s decision maintains

Can I still receive services during the appeal process?

Yes, you have the right to receive services under the plan MI Salud del Gobierno de Puerto Rico while a resolution for your appeal is emitted. Triple-S Salud should continue their benefits if:
a. You or your authorized representative made the appeal within 10 days after Triple-S Salud sent you their notification of action or within the effectiveness date of the proposed action;
b. The appeal involves the termination, suspension, or reduction of a course of treatment previously authorized;
c. The services were ordered by an authorized provider;
d. The period originally covered by the original authorization has not expired; and

e. The beneficiary requests a benefit's extension

Triple-S Salud must continue to offer the extension of benefits until one of the following happens:

a. You or your authorized representative withdraws the appeal;
b. ASES takes an adverse decision for the beneficiary;
c. The period of time or limits of service of a previous service of a service previously authorized has been fulfilled.

Responsibility of the beneficiary and Triple-S Salud for the services received while the appeal is being transmitted:

a. If the final resolution of the appeal is adverse for you and confirms the action of Triple-S Salud, Triple-S Salud can recover the cost of the services that were given to you while the appeal was being processed.
b. If Triple-S Salud reverses a decision to refuse, limit, or delay services that were not offered while the appeal was pending, Triple-S Salud must authorize or provide the services disputed as soon as possible and as fast as the health condition of the beneficiary requires it.

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Time to Request an Appeal</th>
<th>Time for Triple-S Salud to answer an Appeal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Service Expedited</td>
<td>As fast as the beneficiaries health condition requires it but no more than 90 days since the plan sent the Action Notification. You can request via phone: island 1.800.981.1352 Metro Area 787.775.1352 TTY 1.855.295.4040 You can also send it to the following address: Triple-S Unidad de Quejas y Apelaciones PO Box 363628 San Juan, P.R. 00936-3628</td>
<td>It must be managed and answered as fast as the health condition of the beneficiary requires it, in a term no longer than 72 hours following receipt of the request for an appeal. An extension of 14 calendar days may be requested if the beneficiary requests it or if Triple S demonstrates that there is a need for additional information. If you are not satisfied with the determination, you can request a second appeal.</td>
</tr>
<tr>
<td>Pre-service Standard</td>
<td>As fast as the beneficiaries health condition requires it but no more than 90 days since the plan sent the Action Notification</td>
<td></td>
</tr>
<tr>
<td>----------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
</tbody>
</table>
|                      | You can request via phone: Island 1.800.981.1352  
                        Metro Area 787.775.1352  
                        TTY 1.855.295.4040 |
|                      | You can also send it to the following address:  
                        Triple-S  
                        Unidad de Quejas y Apelaciones  
                        PO Box 363628  
                        San Juan, P.R. 00936-3628 |
|                      | It must be managed and answered as fast as the health condition of the beneficiary requires it, in a term no longer than 45 calendar days following receipt of the request for an appeal. |
|                      | An extension of 14 calendar days may be requested if the beneficiary requests it or if Triple S demonstrates that there is a need for additional information. |
|                      | If you are not satisfied with the determination, you can request a second appeal. |

If you need information about your rights under the process of complaints, appeals and/or request for impartial hearing call us at our call center Tele Mi Salud at 1 800 981 1352 or refer to the Subscriber Guide. Telephone services for audio disabled persons (TTY), call at 1-855-295-4040, free of charge.
Annex # 3

NOTIFICATION FOR NEED OF INFORMATION

<<today_date_mmdyyyy>>
<<m_full_name>>
<<m_full_address>>

Policy Number:

Dear policy holder:

We received your request to evaluate the drug ____________, the ________________.

The requested drug is on the List of Preferred Drugs for the Physical Health of the Government Health Plan of Puerto Rico with pre-authorization requirement. At the moment, we cannot assess your request due that additional information is required.

To evaluate your request, you must submit the following information in a term of not more than 72 hours, if not get in that period of time the case is considered closed:

(Space to write information require to drug authorization)

You can send this information via fax 787-625-8698.

If you need more information, may contact our call center of "Mi Salud", which is available 24 hours 7 days of the week:

   Island 1.800.981.1352
   Metro Area 787.775.1352
   TTY 1.855.295.4040

Sincerely,

Sign and degree

Prepare by: Jessenia Ortiz, Triple-S Salud 2014
Last Revision and Approval:  

11 of 12
Request for:  □ Preauthorization (PA)  □ Exception

Physician Information
Name: ________________________________
# License: ___________________________ Physician specialty: _______________________
Address: ______________________________
Telephone: ___________________________ Fax: ___________________________

Patient Information
Name: ________________________________ Date of birth: _______________________
Diagnosis: ______________________________ Sex: □ M  □ F
Weight: ______________________________

Medication requested:
Drug name ___________________________ Dose: _______________________

Medical Information for Exception Requirement:
Please select the reason to request the exception and provide medical justification

□ Non Formulary Drug: ________________________________
□ Step Therapy: ________________________________
□ Dose limit, or quantity limit: ________________________

You may provide any additional medical information which may support approval:

1) Laboratories required:

Please provide the following information:

Physician signature: ___________________________ Date: _______________________

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Attachment 12
GENERAL GUIDELINES
USE OF GROUND AMBULANCE SERVICE

Ambulance Services coverage

A. Emergencies

Ambulance services in case of emergency are part of the benefits coverage of the Government Health Plan.

The term emergency ambulance services is defined as that service provided after a health situation that arises suddenly that is manifested by acute symptoms (including severe acute pain), which in the absence of immediate medical attention may result in one of the following situations:

- May jeopardize the patient’s health
- Cause serious impairment to body function;
- Serious dysfunction of a body organ or part of said body organ;
- The patient’s condition is such that any other means of transportation is contraindicated;
- In case of a pregnant woman with contractions, may put at risk the life of the woman or the life of the child to be born.

Any ambulance trip that does not comply with the criteria previously stated will not be considered an emergency service. The Plan will only cover services rendered by duly certified ambulances and the transportation is required:

- To transport a patient to another facility or hospital because the institution or hospital in which the patient is confined does not have available the services the person needs. The patient is transported back to the institution or hospital to which he is confined. This charge corresponds to the institution or hospital requesting the service.
- Transportation when the patient is discharged from the hospital and is taken to his home, a skilled nursing facility or a nursing home, except those previously approved (precertified) by the Precertifications Analysts of the Clinical Management Division, the Clinical Care Department at the Utilization Review and Precertifications Unit. Transportation of patients to Dialysis
- Centers (only those previously authorized by the Clinical Care Department of the TSS Utilization Review and Precertification Unit.
Transportation of patients certified as dead by a legally authorized person before the trip begins.

Ambulance transportation to physicians’ offices, clinics, etc.

B. Non-emergency transportation

Ambulance services required in non-emergency cases will only be covered for bed-ridden patients. To establish whether a patient is bed-ridden and requires ambulance transportation, they will base the decision on the following definition:

“A bed-ridden patient will be eligible for this service only if he cannot move himself out of bed because of a condition and does not tolerate any other kind of transportation.”

To transport the patient, the plan will require a Medical Need Certification for Ambulance Transportation (see Attachment) duly filled out by a physician duly authorized to exercise his profession under the laws of the Commonwealth of Puerto Rico.

This regulation is adopted using the policy of the Center for Medicare and Medicaid Services (CMS), which requires a certification of medical need for ambulance transportation services in non-emergency situations. It is essential to mention here that in those cases in which ambulance transportation non-emergency services are provided to Medicare Part B beneficiaries, Triple-S Salud will only pay the copayment, as long as the patient is bed-ridden, as defined in the previous paragraph.

C. Ambulance Precertification Procedure for Non-emergency Cases

This process requires sending certain information to the Utilization Review and Precertification Unit of the Clinical Care Department to the following fax numbers (787) 774-4835 or (787) 774-4837. The medical order, which may be sent by the hospital staff, a relative or the service provider must include:

- Contract number
- Diagnostic
- Medical reason that justifies the transportation
- Date of service
- Telephone and fax number of the contact person
- Negative coverage certification from other health plan if the patient has another health plan that does not have ambulance service coverage.
Enclosed is the general form, Certification of Medical Need for Ambulance Transportation, which can be used to expedite the case review process. Once the information is received, the designated staff will verify the eligibility of the beneficiary and that the documents are duly filled out. The requests for precertification of ambulance transportation must be submitted at least 48 hours prior to transport. This includes Medicare cases. If the documents are complete, the case will be registered and will be assigned to a Precertification Analyst.

The Precertifications Analyst will:

- evaluate the request to determine if there is a medical need,
- determine the approval or denial, as the case may be,
- send the determination to the contact person via fax.

D. Billing

To bill for ambulance services, they will use the following procedure codes according to the emergency or non-emergency classification in Form HCFA 1500.

- **Emergencies:**

**Ambulance Type II**

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>A0429</td>
<td>One unit (basic service within the municipality)</td>
</tr>
<tr>
<td>A0425</td>
<td>Additional miles (for each additional mile)</td>
</tr>
</tbody>
</table>

**Ambulance Type III**

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>A0427</td>
<td>Emergency transport Level 1 – Advance Life Support</td>
</tr>
<tr>
<td>A0434</td>
<td>Special Care Transportation</td>
</tr>
<tr>
<td>A0425</td>
<td>Additional miles (for each additional mile)</td>
</tr>
</tbody>
</table>
- **Non-emergency- require precertification:**

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>A0428</td>
<td>One unit (basic service within the municipality)</td>
</tr>
<tr>
<td>A0425</td>
<td>Additional miles (for each additional mile)</td>
</tr>
</tbody>
</table>

If you need additional information, you may contact our officers at the Government Health Plan Call Center at 1-800-981-1352, outside metropolitan area or, at (787) 775-1352, metropolitan area.
Certificate of Medical Necessity for Ambulance Services

INFORMATION OF THE PATIENT

Name: ___________________________ Contract #: ___________________________

Telephone: ________________________ Gender: ____________________________

DOB: ___________ Invoice #: ___________________________

Age: ___________ Gender: _______ M _______ F _______

Type of Service: Home to hosp. ______ Hosp. to home ______ Hosp. to facility for study ______ Dialysis ______

TO BE FILLED OUT BY PHYSICIAN

I certify the need to transport in a stretcher and ambulance: ______ With a Diagnosis of: ______

Physician’s name: ___________________________ Date: ___________________________

License number: ___________________________ Time: ___________________________

Signature: ___________________________

INFORMATION ABOUT SERVICE TO BE RENDERED

SYMPTOMS | MOST SEVERE CONDITION

- Unconscious
- Incoherent
- Combative
- Burns
- Hemorrhage
- Difficulty Breathing
- Acute Chest Pain
- Acute Abdominal Pain
- Heart Problem
- Fracture
- Injury
- Shock
- Poisoning
- Respiratory Failure
- Multiple Injuries
- Pain
- Amputation
- Explain: ___________________________
- Dislocation
- Laceration
- Avulsion
- Burns
- Abrasions
- Other: ___________________________

SERVICES RENDERED

- Administer Oxygen
- Clear airways
- CPR
- Artificial Respiration
- Control Hemorrhage
- Treatment
- Immobilize
- Bandage
- Obstetric Help
- Administer IV Fluids
- Monitor/Vitals
- Other: ___________________________

Diagnostic: ___________________________

Comments: ___________________________

Action: _______ Transport & Treat _______ Treat on Scene _______ Exam Only _______ Patient refused exam _______

Transported: _______ Back _______ Side _______ On Stomach _______ Sitting _______ Strapped _______ Feet Elevated _______

Not Transported: _______ Unnecessary _______ Refused _______ Other Vehicle _______

PRINT PLAN CARD ON BACK OF SHEET

Patient or relative signature: ___________________________ Date: ___________________________

Incident #: ___________________________ Date: ___________________________ Dispatcher: ___________________________

EMT Name: ___________________________ # Unit: ___________________________

Time of call: _______ AM/PM

Arrival time: _______ AM/PM Mileage: ___________

Departure time: _______ AM/PM Mileage: ___________

Time S.E.: _______ AM/PM Mileage: ___________

Closed: _______ AM/PM Mileage: ___________

VITAL SIGNS

<table>
<thead>
<tr>
<th>SUGAR</th>
<th>PULSE</th>
<th>PRESSURE</th>
<th>RESP</th>
</tr>
</thead>
</table>

[Table continued...]

[Table continued...]
Attachment 13
# PMG Administration Department
## Configuration Area

## PHYSICIAN'S REQUEST FOR ADMISSION TO PMG

### Section 1 - PMG Information

<table>
<thead>
<tr>
<th>Primary Medical Group Name</th>
<th>PMG Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrator Name</td>
<td></td>
</tr>
</tbody>
</table>

### Section 2 - Physician Information

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>NPI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty</td>
<td>E-Mail</td>
</tr>
<tr>
<td>Postal Address</td>
<td></td>
</tr>
</tbody>
</table>

### Section 3 - Providers Locations and Office Hours Information

<table>
<thead>
<tr>
<th>Address Office Belong to:</th>
<th>Provider does not have a office address performs home visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Primary Care Physician</td>
<td>□ Primary Medical Group</td>
</tr>
<tr>
<td>□ Provider does not have a office address performs home visits</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physical Address (location 1)</th>
<th>Physical Address (location 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Phone 1</th>
<th>Phone 2</th>
<th>Fax</th>
<th>Phone 1</th>
<th>Phone 2</th>
<th>Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicate the schedule for location 1</th>
<th>Indicate the schedule for location 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day</td>
<td>AM From</td>
</tr>
<tr>
<td>-----</td>
<td>---------</td>
</tr>
<tr>
<td>Monday</td>
<td></td>
</tr>
<tr>
<td>Tuesday</td>
<td></td>
</tr>
<tr>
<td>Wednesday</td>
<td></td>
</tr>
<tr>
<td>Thursday</td>
<td></td>
</tr>
<tr>
<td>Friday</td>
<td></td>
</tr>
<tr>
<td>Saturday</td>
<td></td>
</tr>
<tr>
<td>Sunday</td>
<td></td>
</tr>
</tbody>
</table>

### Section 4 - Economic Agreement

1. I certify that I will be submitting the encounter services provided to PMG members as follow:

   - □ Individual
   - □ Group
   - NPI Group Number

<table>
<thead>
<tr>
<th>PMG Administrator Signature</th>
<th>Physician's Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>Date</td>
</tr>
</tbody>
</table>

### Instructions
- Incomplete Information: If the information on this form is incomplete or incorrect in any way, it shall be returned to the sender. Triple-S Salud shall not process until the request has been resubmitted correctly.
- Fax number or Email to submit the request. Fax (787) 706-2895 E-mail: contratacion@pmgssapr.com

Review: July 2015

Pending for ASES Approval
# REQUEST TO TERMINATE A PCP FROM A PMG

## Section 1 - Physician's Information

<table>
<thead>
<tr>
<th>Physician Name</th>
<th>PMG Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of PMG to be withdrawn</td>
<td></td>
</tr>
<tr>
<td>Reason for withdrawal</td>
<td></td>
</tr>
<tr>
<td>Physician E-mail</td>
<td>Specialty</td>
</tr>
<tr>
<td>Resigning Physician's Signature</td>
<td>NPI</td>
</tr>
</tbody>
</table>

## Section 2 - PMG's Information

<table>
<thead>
<tr>
<th>State Provisional Substitute Physician</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substitute Physician's Name</td>
</tr>
<tr>
<td>1-</td>
</tr>
<tr>
<td>2-</td>
</tr>
</tbody>
</table>

Reasons to withdraw Physician's Services

Print PMG Administrator's Name

PMG Administrator's Signature | Date

## Instructions

- **Primary Care Physician.** The primary care physician who decides to terminate his contractual relationship with PMG must complete section 1 of this form and submit it to the PMG administrator to be withdrawn from.
- **PMG Administrator.** The PMG Administrator must complete section 2 of this form. Assigning substitute physicians that correspond to PMG.
- **Incomplete Information.** If the information on this form is incomplete or incorrect in any way, it shall be returned to the sender. Triple-S Salud shall not process until the request has been resubmitted correctly.

- **Fax Number or Email Address to submit the request.** Fax (787) 706-2895 E-Mail: contratacionespmg@ssspr.com

Review: december 2014

Pending for ASES Approval
Attachment 15
# HOLD REQUEST

## Section 1 - Physician and PMG Information

<table>
<thead>
<tr>
<th>Physician Name</th>
<th>Provider NPI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone 1</td>
<td>Phone 2</td>
</tr>
<tr>
<td>Name of PMG</td>
<td>PMG Number</td>
</tr>
<tr>
<td>Physician Email Address</td>
<td></td>
</tr>
</tbody>
</table>

## Section 2 - State Reasons for Requesting Hold


## Section 3 - Name and Signature from Physician that requesting the Hold

| Print Name of Physician | Date |

## Section 4 - Name and Signature from PMG Administrator

| Print Name of PMG Administrator |
| PMG Administrator Signature |
| Date |

### Instructions

- **Primary Care Physician.** Primary Care Physicians that request a HOLD (cease Beneficiary subscription) must fill out the hold request completely. If the information on this form is incomplete or incorrect in any way, it shall be returned to the sender. Triple-S Salud shall not process until the request has been resubmitted correctly.

- **PMG.** PMG Administrator must complete section 4 of this form.

- **Fax Number or Email Address to submit the request.** Fax (787) 706-2895 E-mail: contratacionespmg@ssspr.com

---

Review: December 2014

Pending for ASES Approval
Attachment 16
<table>
<thead>
<tr>
<th>Section 1 - Primary Care Physician Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Physician Name:</td>
</tr>
<tr>
<td>Specialty:</td>
</tr>
<tr>
<td>NPI</td>
</tr>
<tr>
<td>Email Address</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Section 2 - Information on locations of provider and office hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Address (Office A):</td>
</tr>
<tr>
<td>Office Address (Office B):</td>
</tr>
<tr>
<td>Phone 1</td>
</tr>
<tr>
<td>----------</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicate the schedule for location 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day</td>
</tr>
<tr>
<td>-----</td>
</tr>
<tr>
<td>Monday</td>
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<tr>
<td>Tuesday</td>
</tr>
<tr>
<td>Wednesday</td>
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<td>Thursday</td>
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<tr>
<td>Friday</td>
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<tr>
<td>Saturday</td>
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<tr>
<td>Sunday</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicate the schedule for location 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day</td>
</tr>
<tr>
<td>-----</td>
</tr>
<tr>
<td>Monday</td>
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<tr>
<td>Tuesday</td>
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<td>Wednesday</td>
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<td>Thursday</td>
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<tr>
<td>Friday</td>
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<tr>
<td>Saturday</td>
</tr>
<tr>
<td>Sunday</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Section 3 - Other related Information to Physician practice - Complete accordingly</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ I do not have private office</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section 4 - PMG Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>PMG's Name</td>
</tr>
<tr>
<td>Print name of PMG Administrator</td>
</tr>
<tr>
<td>PMG Administrator Signature</td>
</tr>
<tr>
<td>Physician's Signature</td>
</tr>
</tbody>
</table>

**Instructions**
- Incomplete Information. If the information on this form is incomplete or incorrect in any way, it shall be returned to the sender. Triple-S
- Fax Number or Email Address to submit the request. Fax (787) 706-2895 E-Mail: contratacionespmg@ssspr.com

Review: December 2014

Pending for ASIS Approval
**FORMULARIO REFERIDO FACILIDADES**

1. **NOMBRE DEL ASEGURADO**
   
   **FECHA DE CUBIERTA**

   **NUMERO DE CONTRATO**

   **NPI DEL MEDICO QUE REFIERE**

   **HOSP. A QUE SE REFIERE**

2. **INFORMACION DEL PROVEEDOR QUE REFIERE**

   **FECHA EMISSION DEL REFERIDO**

   **TELEFONO**

   **NOMBRE N.D. DE CABECERA**

   **FIRMA MEDICO DE CABECERA**

   **DIAGNOSTICO DE ADMISION / ICD9**

   **TIPO DE ADMISION**: ELECTIVA  ❑  EMERGENCIA ❑

   **CASO CATASTROFICO**: SI ❑  NO ❑

   **ADMITIDO A**: MATERNIDAD ❑  PEDIATRIA ❑  CIRUGIA ❑  MEDICINA ❑

3. **NATURALEZA DEL SERVICIO**

   **HOSPITALIZACION REGULAR**

   **INTENSIVO / CCU**

   **SQUIATRICA**

   **SUSTANCIAS - DEPENDENCIAS**

   **CIRUGIA CARDIOVASCULAR**

   **CIRUGIA AMBULATORIA**

   **RADIOLOGIA INVASIVA**

   **ELECTROSHOCK**

   **ANESTESIA**

   **QUIMIOTERAPIA**

   **UNIDAD QUEMADOS**

   **SKILLED NURSING (MANEJO DE CASO: AUTORIZACION; TRIPPLES)**

   **HEMODIALISIS**

   **OTROS**

4. **ORDEN DE ADMISION**

   

   

5. **INFORMACION DEL PROVEEDOR DEL SERVICIO**

   **FECHA DE SERVICIO DESDE**

   **FECHA DE SERVICIO HASTA**

   **TELEFONO**

   **NPI**

   **FIRMA**

---

**TRIPLE-S SALUD**

**MEDICO DE CABECERA**

**13-1212-479**

**Este documento es válido por 90 días a partir de la fecha que lo emite el médico de cabecera.**
FORMULARIO REFERIDO FACILIDADES

1. NOMBRE DEL ASEGURADO _________________________________ FECHA DE CUBIERTA _________________________________
   NÚMERO DE CONTRATO _________________________________
   NPI DEL MEDICO QUE REFIERE _________________________________
   HOSP. A QUE SE REFIERE __________________________________

2. INFORMACION DEL PROVEEDOR QUE REFIERE
   FECHA EMISION DEL REFERIDO _________________________________
   NOMBRE NO. DE CARGERA (fecha de nacimiento) _________________________________
   TELEFONO _________________________________
   FIRMA MEDICO DE CARGERA _________________________________
   DIAGNOSTICO DE ADMISION / ICD9 _________________________________
   EMERGENCIA _________________________________
   TIPO DE ADMISION: ELECTIVA ☐ EMERGENCIA ☐
   CASO CATASTROFIICO SI ☐ NO ☐ (CÁNCER, SIDA, CRÓNICORenAL, PREMATURO<1,500GRAS, CARDIOVASCULAR, NERVIOSURGIRICO, PROTESIS,
   LITOTRACIA, HORMONIA DE CRECIMIENTO, ENFERMEDADES MENTALES Y DEPENDENCIA QUÍMICA)
   ADMITIDO A: MATERNIDAD ☐ PEDIATRIA ☐ CIRUGIA ☐ MEDICINA ☐

3. NATURALEZA DEL SERVICIO
   ☐ HOSPITALIZACION REGULAR ☐ ELECTROSHOCK ☐ NICU
   ☐ INTENSIVO / CCU ☐ ANESTESIA ☐ PICU
   ☐ SIQUIATRICA ☐ QUIMIOTERAPIA ☐ LITOTRACIA
   ☐ SUSTANCIAS - DEPENDENCIAS ☐ UNIDAD QUEMADOS
   ☐ CIRUGIA CARDIOVASCULAR ☐ SKILLED NURSING (MANEJO DE CASO, AUTORIZACION, TRIPLE-S)
   ☐ CIRUGIA AMBULATORIA ☐ HEMODIALISIS
   ☐ RADIOLOGIA INVASIVA ☐ OTROS __________________________________________

4. INFORMACION DEL PROVEEDOR DEL SERVICIO
   FECHA DE SERVICIO DESDE _________________________________
   FORMA DE SERVICIO HASTA _________________________________
   NPI _________________________________
   FECHA DE SERVICIO DESDE _________________________________
   FORMA DE SERVICIO HASTA _________________________________
   TELEFONO _________________________________
   FIRMA _________________________________
**Sección A** **INFORMACIÓN DEL ASEGURADO**

<table>
<thead>
<tr>
<th>Nombre del Asegurado</th>
<th>Número de Contrato</th>
<th>Fecha de Cobertura</th>
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<tr>
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<table>
<thead>
<tr>
<th>¿Tiene el Asegurado Otro Seguro?</th>
<th>Nombre del Otro Seguro</th>
<th>HCO / FMG</th>
<th>Número de Contrato del Otro Seguro</th>
<th>Fecha de Efectividad</th>
</tr>
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<tbody>
<tr>
<td>[ ] No</td>
<td>[ ] Sí</td>
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**Sección B** **INFORMACIÓN DEL PROVEEDOR QUE REFIERE**

<table>
<thead>
<tr>
<th>Número del Proveedor que Refiere</th>
<th>Fecha de Emisión</th>
<th>Teléfono</th>
<th>Nombre</th>
<th>NPI</th>
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<table>
<thead>
<tr>
<th>Diagnóstico / Condición</th>
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Historial del Paciente / Examen Físico (Legible)

Resultado de Pruebas Diagnósticas Iniciales:

Resultado de Pruebas Diagnósticas Realizadas:

Imprisión Diagnóstica:

Plan de Tratamiento/Seguimiento

**Sección C** **CONTESTACIÓN A CONSULTA POR ESPECIALISTA**

Hallazgos Clínicos

Resultado de Pruebas Diagnósticas Realizadas:

Imprisión Diagnóstica:

Plan de Tratamiento/Seguimiento

**Sección D** **INFORMACION DEL PROVEEDOR DEL SERVICIO**

<table>
<thead>
<tr>
<th>Fecha de Servicio Desde</th>
<th>Fecha de Servicio Hasta</th>
<th>Número del Proveedor</th>
<th>NPI</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Nombre del Proveedor (Letra de Maíz)</th>
<th>Firma del Proveedor</th>
<th>Número de Teléfono</th>
</tr>
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<tbody>
<tr>
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</tbody>
</table>
**Sección A**  INFORMACION DEL ASEGURADO

<table>
<thead>
<tr>
<th>Nombre del Asegurado</th>
<th>Nombre del Otro Seguro</th>
<th>Número de Contrato</th>
<th>Fecha de Contratación</th>
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<tr>
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</table>

¿Tiene el Asegurado Otro Seguro?  
☐ No  ☐ Sí

<table>
<thead>
<tr>
<th>Nombre del Otro Seguro</th>
<th>Número de Contrato del Otro Seguro</th>
<th>Fecha de Contratación</th>
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<table>
<thead>
<tr>
<th>CUOTAS</th>
<th>MES</th>
<th>DIA</th>
<th>AÑO</th>
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**Sección B**  INFORMACION DEL PROVEEDOR QUE REFIERE

<table>
<thead>
<tr>
<th>Número del Proveedor que Refiere</th>
<th>Fecha de Emisión</th>
<th>Fecha de Cúbito</th>
<th>Nombre</th>
<th>NPI</th>
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<tr>
<th>Teléfono</th>
<th>Fecha de Emisión</th>
<th>Fecha de Cúbito</th>
<th>Nombre</th>
<th>NPI</th>
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Diagnóstico / Codiﬁcación

Historial del Paciente / Examen Físico (Legible)

Revisión del Pruebas Diagnósticas Básicas:

Se Refiere al paciente para (Se debe anotar un Rebatido para cada Tipo de Servicio)

☐ Laboratorios  ☐ Radiografías

☐ Pruebas Diagnósticas / Tratamientos / Cirugía  ☐ Consultas / Opción por:

**Sección C**  CONTESTACION A CONSULTA POR ESPECIALISTA

Hallazgos Cúlticos

Resultados de Pruebas Diagnósticas Realizadas:

Impresión Diagnóstica:

Plan de Tratamiento/Seguimiento

Fecha

<table>
<thead>
<tr>
<th>MES</th>
<th>DIA</th>
<th>AÑO</th>
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**Sección D**  INFORMACION DEL PROVEEDOR DEL SERVICIO

<table>
<thead>
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<th>Fecha de Servicio Desde</th>
<th>Fecha de Servicio Hasta</th>
<th>Número del Proveedor</th>
<th>NPI</th>
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<table>
<thead>
<tr>
<th>Nombre del Proveedor (Letra de Moño)</th>
<th>Teléfono</th>
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<th>Firmas del Proveedor</th>
<th>Número de Teléfono</th>
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TRIPLE-S SALUD

Este documento es válido por 60 días a partir de la fecha que lo emite el médico de cabecera para facturar a TRIPLE-S

13-1212-256
FORMULARIO REFERIDO SERVICIOS PROFESIONALES

Sección A  INFORMACION DEL ASEGURADO

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<thead>
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<th>Nombre del Asegurado</th>
<th>Número de Contrato</th>
<th>Fecha de Cubierta</th>
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<table>
<thead>
<tr>
<th>¿Tiene el Asegurado</th>
<th>Nombre del Ojo Seguro</th>
<th>HCO / PM/0</th>
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</thead>
<tbody>
<tr>
<td>No</td>
<td></td>
<td></td>
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<tr>
<td>Sí</td>
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<td></td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Número de Contrato del Ojo Seguro</th>
<th>Fecha de Efectividad</th>
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Sección B  INFORMACION DEL PROVEEDOR QUE REFIERE

<table>
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<th>Número del Proveedor que Reviene</th>
<th>Fecha de Emisión</th>
<th>Teléfono</th>
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<table>
<thead>
<tr>
<th>Nombre</th>
<th>NPI</th>
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<table>
<thead>
<tr>
<th>Diagnóstico / Codificación</th>
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<table>
<thead>
<tr>
<th>Historial del Paciente / Examen Físico (Legible)</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Resultado de Pruebas Diagnósticas Básicas:</th>
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<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Se Reviene al paciente para: (Se debe entregar un Relevado para cada Tipo de Servicio)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Laboratorios</td>
</tr>
<tr>
<td>☐ Rayos X</td>
</tr>
<tr>
<td>☐ Pruebas Diagnósticas / Tratamientos / Cirugía</td>
</tr>
<tr>
<td>☐ Consulta / Opción por:</td>
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</tbody>
</table>

Sección C  CONTESTACION A CONSULTA POR ESPECIALISTA

<table>
<thead>
<tr>
<th>Hallazgos Clínicos</th>
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<tr>
<th>Resultados de Pruebas Diagnósticas Realizadas:</th>
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<th>Impresión Diagnóstica:</th>
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<table>
<thead>
<tr>
<th>Plan de Tratamiento/Seguimiento</th>
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<table>
<thead>
<tr>
<th>Fecha</th>
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Sección D  INFORMACION DEL PROVEEDOR DEL SERVICIO

<table>
<thead>
<tr>
<th>Fecha de Servicio Desde</th>
<th>Fecha de Servicio Hasta</th>
<th>Número del Proveedor</th>
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<table>
<thead>
<tr>
<th>Nombre del Proveedor (Letra de Móvil)</th>
<th>Firma del Proveedor</th>
<th>Núm. de Teléfono</th>
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ESTE DOCUMENTO ES VALIDO POR 60 DÍAS A PARTIR DE LA FECHA QUE LO EMITE EL MÉDICO DE CABECERA

COPIA PARA EXPEDIENTE DEL PROVEEDOR DEL SERVICIO
**FORMULARIO REFERIDO SERVICIOS PROFESIONALES**

### Sección A  INFORMACION DEL ASEGRADO

<table>
<thead>
<tr>
<th>Nombre del Asegurado</th>
<th>Número de Contrato</th>
<th>Fecha de Cobertura</th>
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</thead>
<tbody>
<tr>
<td></td>
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</table>

¿Trata el Asegurado Otro Seguro?  
[ ] No  [ ] Sí

<table>
<thead>
<tr>
<th>Nombre del Otro Seguro</th>
<th>HCO / PMG</th>
<th>Número de Contrato del Otro Seguro</th>
<th>Fecha de Efectividad</th>
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### Sección B  INFORMACION DEL PROVEEDOR QUE REFIERE

<table>
<thead>
<tr>
<th>Número del Proveedor que Refiere</th>
<th>Fecha de Emisión</th>
<th>Teléfono</th>
<th>Nombre</th>
<th>NPI</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mes</td>
<td>Día</td>
<td>Año</td>
<td>Mes</td>
</tr>
</tbody>
</table>

Diagnóstico / Codificación

Historial del Paciente / Examen Físico (Lag64)

Resultado de Pruebas Diagnósticas Básicas:

Se Refiere al paciente para: (Se debe estar un Resumen para curta Tipo de Servicio)

[ ] Laboratorios  [ ] Radios X

[ ] Pruebas Diagnósticas / Tratamientos / Cirugía  [ ] Consulta / Opción por:

### Sección C  CONTESTACION A CONSULTA POR ESPECIALISTA

Hallazgos Clínicos

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Resultados de Pruebas Diagnósticas Realizadas:

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Impresión Diagnóstica:

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Plan de Tratamiento/Seguimiento

<p>| |</p>
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### Sección D  INFORMACION DEL PROVEEDOR DEL SERVICIO

<table>
<thead>
<tr>
<th>Fecha de Servicio Desde</th>
<th>Fecha de Servicio Hasta</th>
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<tbody>
<tr>
<td>Mes</td>
<td>Día</td>
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<table>
<thead>
<tr>
<th>Número del Proveedor</th>
<th>NPI</th>
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<table>
<thead>
<tr>
<th>Nombre del Proveedor (Lete de Matrícula)</th>
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<table>
<thead>
<tr>
<th>Firma del Proveedor</th>
<th>Número de Teléfono</th>
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</table>

Este documento es válido por 60 días a partir de la fecha que lo emite el Médico de Cabecera

COPIA PARA ENTREGAR AL SUSCRIPTOR CON RESPUESTAS

13-1212-256
Attachment 19
Form to Submit Changes to a Dental Claim Paid or Denied (Adjustment)

Section 1 – Information to identify the claim that you want to adjust

ICN Number (Internal Control Number) Provider Number (NPI)

Insurer's Number

Required fields Provider Name: ___________________________________________

Section 2 – Indicate the information that you want to change

Insurer's Number

Predetermination Number

Section 3 – Indicate the information that you want to change by lines

<table>
<thead>
<tr>
<th>Line</th>
<th>Date of Service (MMDDCCYY)</th>
<th>Oral Cavity</th>
<th>Tooth</th>
<th>Surface</th>
<th>Service Code</th>
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</tbody>
</table>

Section 4 – Other types of adjustments

Check if you submit other adjustment

*Process Note *Process Note Total documents included

Section 5 - Comments:
_____________________________________________________________

_____________________________________________________________

_____________________________________________________________

Dental Adjustment Form: 7/1/2014
Form to Submit Changes to a **Institutional** Claim Paid or Denied (Adjustment)

<table>
<thead>
<tr>
<th>Section 1 – Information to identify the claim that you want to adjust</th>
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</thead>
<tbody>
<tr>
<td>* Identifier (Internal Control Number)</td>
</tr>
<tr>
<td>* Provider Number (NPI)</td>
</tr>
<tr>
<td>* Provider Name</td>
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</table>

<table>
<thead>
<tr>
<th>Section 2 – Indicate the information that you want to change</th>
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<tbody>
<tr>
<td>Insurer’s Number</td>
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<tr>
<td>Type of Bill</td>
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<tr>
<td>Statement cover from (MM/DD/YYYY)</td>
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<tr>
<td>Statement covers to (MM/DD/YYYY)</td>
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<tr>
<td>Admission Date (MM/DD/YYYY)</td>
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<td>Principal Diagnostic</td>
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<td>Admission Diagnostic</td>
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<td>Other Diagnostic</td>
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<td>B</td>
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<tr>
<td>Preauthorization Number</td>
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<tr>
<td>Principal Procedure</td>
</tr>
<tr>
<td>Principal Procedure Date (MM/DD/YYYY)</td>
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<tr>
<td>Other Procedure</td>
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<tr>
<td>Other Procedure Date (MM/DD/YYYY)</td>
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<tr>
<td>Referral Number</td>
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<td>Provider NPI</td>
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<table>
<thead>
<tr>
<th>Section 3 – Indicate the information that you want to change by line</th>
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<tbody>
<tr>
<td>Line</td>
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<table>
<thead>
<tr>
<th>Section 4 – Other types of adjustment</th>
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</thead>
<tbody>
<tr>
<td>*Process Note</td>
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<tr>
<td>*Process Note</td>
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<tr>
<td>Total documents included</td>
</tr>
<tr>
<td>Check if you submit other adjustment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section 5 – Comments:</th>
</tr>
</thead>
</table>

Institutional Adjustment Form: 7/1/2014
Form to Submit Changes to a Professional Claim Paid or Denied (Adjustment)

Section 1 – Information to identify the claim that you want to adjust

- CN Number (Internal Control Number)
- Alpha Prefix
- Insurer's Number
- Provider Number (NPI)
- Provider Name:

Section 2 – Indicated the information that you want to change

- Insurer's Number
- Preauthorization number or Referral

Section 3 – Indicate the information that you want to by lines

<table>
<thead>
<tr>
<th>Line</th>
<th>Date of Service - From (MM/DD/YYYY)</th>
<th>Date of Service - To (MM/DD/YYYY)</th>
<th>Place of Service Procedure Code</th>
<th>Modifiers</th>
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Section 4 – Other types of adjustments

- Process Note
- Process Note
- Total documents included

Section 5 – Comments:

Professional Adjustment Form: 7/1/2014
PATIENT’S BILL OF RIGHTS AND RESPONSIBILITIES

Public law # 94 of August 25, 2000, known as the “Patient’s bill of rights and responsibilities” states the rights and responsibilities of patients and users of health care medical services and hospitals in Puerto Rico.

- All patients have the right to receive medical services of the highest quality, consistent with principles generally accepted in the practice of medicine.
- Has the right to receive correct and reliable information easy to comprehend about their health plan such as:
  - Payment of premiums and deductibles
  - Facilities and health care professional that will provide care
  - Access to specialists and emergency services
  - The experience and studies of the physician who will provide care
  - Medical-hospital facilities where health care services will be provided
- All patients have the right to an adequate selection of health plans and an adequate and sufficient selection of service providers to guarantee access without undue delay to all services including specialists, under the health plan.
- In case of a cancellation or termination for any reason, the patient must be notified of said cancellation with at least 30 days prior notice. If it is a cancellation, the patient has the right to continue receiving services for the 90 day transition period in exchange for a premium.
- If the cancellation during the second trimester of a woman’s pregnancy, the transition period shall be extended until the woman is discharged after the birth of the child or the discharge of the baby, whatever happens last. For terminal patients, the transition period shall be extended to the rest of the life of the patient in exchange for a premium.
- Has the right and unrestricted access to emergency services and facilities when and where the need arises and without prior authorization from the insurer.
- Has the right to participate or a person of their trust to participate completely in the medical care decisions.
- The health care service provider shall supply all necessary information and available options and the costs, risks, and probabilities of success of said options.
- The service provider must respect and carry out treatment preferences and decisions.
- No insurance plan can impose gag rules, penalties, or other mechanisms to interfere with communicating the provider's options available for patients.
- All physician or health care professional must provide the medical order for laboratories, X-rays, or medications so the patient can choose the facility where they want to receive services.
• The patient has the right to receive equal treatment from any health care service provider at all moments, regardless of the race, gender, color, age, religion, origin, ideology, incapacity, medical information, genetics, social condition, sexual preference, or capacity or method of payment.

• Can communicate freely and without fear with the medical service provider

• Trust that their medical records shall be kept in strict confidentiality and shall not be divulged without their authorization and only for medical or treatment purposes, unless required by court order or authorized by law.

• The right to access and copy medical files if needed.

• All health care service providers or health insurance providers must have available a way to resolve any complaint patients presents in a fast and fair way and must also have a way to appeal said decision.

Patient responsibilities are:

To provide information in a complete and precise manner about their health conditions including prior diseases, medications, etc.

• Report any unexpected changes in your condition.

• Let it known that you understand the course of action recommended by the health care provider.

• Provide copy of advance directives, if they exist, of you desire to receive or not medical treatment to prolong life.

• Inform the health care provider if you anticipate problems with the prescribed treatment.

• Know the obligation of the provider to be efficient and just when providing care for other patients.

• Make arrangements needed for the hospital needs, the other patients needs, the medical faculty and others are not affected by particular actions.

• Provide necessary information regarding medical insurance plans and payment of the account.

• Realize the impact of your life style on your health.

• Participate in All decisions regarding care.

• Report any fraud or fund misuse.

• Resolve any difference by means of insurance established procedures.

• Know the risks and limits of medicine

• Know the coverage, options and benefits and other details of the health plan.

• Comply with health plan, provider, and government health care administrative procedures.

• Remain certified in order to receive services offered by the Health Reform.