Supplements/Forms

Note: The most current versions of the forms listed above can be found by visiting **www.caresource.com**, click the "Provider" tab, then "Provider Materials," and then "Forms."

Table of Contents

CareSource®

Breast Pump Prescription

Physician's Office:	**Patient Information:**

Duration: Duration of Need: _____ Start Date: _____

Check the Product Needed and Indicate Reason for Need:

☐ E0602 – Breast Pump, Manual

CareSource will allow E0602 (Manual Breast Pump) for purchase if the below need is indicated:

- ☐ Mother returning to work/school

OR

☐ E0603 – Breast Pump, Electric

CareSource will allow E0603 (Electric Breast Pump) for purchase if one of the below needs are indicated:

- ☐ Infant illness (specify)_____
- ☐ Difficulty with "latch on" due to physical, emotional, or developmental problems of mother or infant (specify)

  _____

  _____
- ☐ Mothers returning to work/school prior to six weeks postpartum with a plan for use approved by WIC

OR

☐ E0604 – Breast Pump, Hospital Grade Electric HG (Rental)

CareSource will allow E0604 (Lactation Pump, Hospital Grade Electric HG-Rental) for a period not to exceed six months if one of the below needs is indicated:

- ☐ Separation of infant from mother when infant is or remains hospitalized and mother has been discharged
- ☐ Any maternal illness, disease or use of medication that requires the breastfeeding mother to "pump and dump" to maintain her milk supply for a limited period of time in order to resume breastfeeding when it is safe to do so

Diagnosis Codes: (Check diagnosis code)

☐ 24.1, Lactating mother

☐ Other:_____

By my signature below, I confirm that the patient is being treated by me. All the information contained on this form accurately reflects the patient's needs. The patient/caregiver is able to follow instructions and is able to use the ordered product. For insurance requirements, I will maintain this signed original document in the patient's medical record file for post-payment review/audit purposes.

Signature:	Date:

Please fax the completed prescription to the CareSource participating Durable Medical Equipment Company of your choice. The pump will be delivered to the CareSource member.

February 2009

OH-P-160

Case Management Referral

CareSource's Case Management program is a fully integrated health management program that strives for member understanding of and satisfaction with their medical care. More importantly, it's designed to support the care and treatment you provide to your patient. If you know of a CareSource member that would benefit from case management, please complete and fax this form to 1-877-946-2273.

Date:

Patient name: DOB:

Patient address:

Patient phone number (home):
Patient phone number (cell):
Patient phone number (work):

Medicaid Identification Number (MMIS#):

Referring Physician: Office Contact:

Physician Phone Number:

Primary Diagnosis:

Secondary Diagnosis:

Reason for referral to Case Management (check all that apply):

☐ Case Manager ☐ Social Worker ☐ Home Health Care ☐ Other

Comments:

If you have comments or questions, please call us at **1-800-488-0134** (TTY: 1-800-750-0750), or fax your referral to **1-877-946-2273.**

OH-P-558

CareSource®

Return to CareSource by:
Fax: (937) 224-3388
Mail: P.O. Box 8730 Dayton, OH 45401-8730

Claims Recovery Request Form

(Please refer to the Provider Appeal Request Form to dispute payment)

REMITTANCE MUST BE ATTACHED

Provider Name:	
National Provider Identifier (NPI):	
Remittance Address *(as it appears on the EOP)**:***	
Contact Person Name:	**Phone Number:** ( )

Reason for Adjustment Request: Overpayment ____ Primary Insurance ____ Other _____

Total Number of Claims: _____

Check Enclosed: Yes ____ No ____ **If yes,** Check Number _____ Check Amount _____

Claim Type: Physician ____ Hospital ____ Home Health ____ Dental ____ Vision ____ Other _____

Member Name	Member ID	Begin Date of Service	End Date of Service	Claim Number	Reason for Adjustment

Member Name	Member ID	Begin Date of Service	End Date of Service	Claim Number	Reason for Adjustment

APPOINTMENT OF REPRESENTATIVE

NAME OF PARTY	MEDICARE OR NATIONAL PROVIDER IDENTIFIER NUMBER

SECTION I: APPOINTMENT OF REPRESENTATIVE

To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier):

I appoint this individual: _____ to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the "Act") and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my appeal, wholly in my stead. I understand that personal medical information related to my appeal may be disclosed to the representative indicated below.

SIGNATURE OF PARTY SEEKING REPRESENTATION		DATE
STREET ADDRESS		PHONE NUMBER *(with Area Code)*
CITY	STATE	ZIP

SECTION II: ACCEPTANCE OF APPOINTMENT

To be completed by the representative:

I, _____, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services; that I am not, as a current or former employee of the United States, disqualified from acting as the party's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an_____
(PROFESSIONAL STATUS OR RELATIONSHIP TO THE PARTY, E.G. ATTORNEY, RELATIVE, ETC.)

SIGNATURE OF REPRESENTATIVE		DATE
STREET ADDRESS		PHONE NUMBER *(with Area Code)*
CITY	STATE	ZIP

SECTION III: WAIVER OF FEE FOR REPRESENTATION

Instructions: This section must be completed if the representative is required to, or chooses to waive their fee for representation. (Note that providers or suppliers that are representing a beneficiary and furnished the items or services may not charge a fee for representation and **must** complete this section.)

I waive my right to charge and collect a fee for representing _____ before the Secretary of the Department of Health and Human Services.

SIGNATURE	DATE

SECTION IV: WAIVER OF PAYMENT FOR ITEMS OR SERVICES AT ISSUE

Instructions: Providers or suppliers serving as a representative for a beneficiary to whom they provided items or services must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, or could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.)

I waive my right to collect payment from the beneficiary for the items or services at issue in this appeal if a determination of liability under §1879(a)(2) of the Act is at issue.

SIGNATURE	DATE

Form CMS-1696 (10/10)

CareSource®

Confidential Fraud, Waste, and Abuse Reporting Form

Please use this form to tell us about any fraud, waste, and abuse concerns you may have. This information will be confidential. Give as much information as you can.

I am concerned that the following individual, who can be reached at the address and phone number listed below, is doing something fraudulent or abusive.

Name: _____
Address: _____
_____
Phone(s) _____

This person is a/an…: (please check the appropriate box)

Employee ☐ Member ☐ Provider ☐ Other* ☐

Describe your concern? Please attach additional pages, if needed.
*Please explain the relationship between the person you are reporting and CareSource or yourself.

_____
_____
_____
_____

You may remain anonymous and not tell us your name. If you don't want to remain anonymous, please give us the following information so that we may contact you if we need additional information.

Your Name: _____
Your Address: _____
_____
Your Phone No(s).: _____

If you have documents that we should review, please attach them or tell us where to find them:

To remain anonymous, send this form (and any other documents) by **mail** to:

CareSource
Attn: Special Investigations Unit
P. O. Box 1940.
Dayton, Ohio 45401-1940

You may also submit this form by fax or e-mail. However, sending your report this way will show the number of the fax machine or your e-mail address. If you want to be anonymous, mail the form and attachments. If you do not want to be anonymous, you may send your information using these methods:

Fax: 1-800-418-0248

E-mail: fraud@caresource.com.(copy the form information and attachments into the e-mail or attach them as documents).

If you have any questions, call us on the **Fraud Hotline at 1-800-488-0134, and selecting the appropriate menu option.**

OH-P-315

CareSource

CareSource
P.O. Box 1920
Dayton OH 454011920

010000X/

Any Name Medical Center
987654321
NA
10101010X
$0.00
Page 1 of 2

EXPLANATION OF PAYMENT

PAYMENT DATE:	10/20/2010
PAYEE ID:	987654321
CHECK NUMBER:	NA
CLAIM COUNT:	0001
TOTAL CHARGES:	$ 3,478.00
TOTAL PAYMENT:	$ 180.13
PAYMENT AMOUNT:	$ 180.13

Total number of claims contained on this EOP

0100004 01 SP 0.440 **SNGLP T1 1 0321 45404-189801 -C01-P00000-I

Any Name Medical Center
1234 Any Street
Anytown, US 09876-1234

If you have questions, please visit our Provider Portal at www.caresource.com 24 hours a day, 7 days a week

Medicaid: CFC, ABD
Medicare: SNP
Montgomery County Care, Children's Buy In

Coordination of Benefits Amount Paid by Primary

CLAIM SUMMARY

SERVICE DATES FROM	TO	PROCEDURES (MODIFIER)	NO. OF UNITS	AMOUNT BILLED	ALLOWED	PAYMENT	PATIENT RESPONSIBILITY	OTHER INS. PAID	NOT COVERED	ADJUSTMENT REASON	REMARKS
Patient: 10203040506 Jane Q. Doe					Insured: 10203040506 Jane Q. Doe					Payer Claim: 10503070204	
Pat. Acct. #: 908070605					Product Name:					DRG:	
Provider: 0204060801 Any Name Medical Center					Status: Information Here Regarding Payment					POS: 11	
07/27/10	07/27/10	99213	1	65.00	20.00	20.00	0.00	0.00	0.00	CR-97	
07/27/10	07/27/10	36415	1	27.00	10.00	10.00	0.00	0.00	0.00	CR-97	
07/27/10	07/27/10	85024	1	27.00	10.00	10.00	0.00	0.00	0.00	CR-97	

Units field is limited to 2 digits

Claim Status

HIPAA Standard Codes — Explanation Key found at end of EOP

Claims adjusted on current or previous EOPs

PROVIDER ADJUSTMENTS

ADJUSTMENT REASON	AMOUNT
Total Adjustments	

ADJUSTMENT REASON CODES

CODE	DESCRIPTION
CR-97	Payment is included in the allowance for another service/procedure.
CR-22	Payment adjusted because this care may be covered by another payer per coordination of benefits.
CR-45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).

REMARKS CODES

CODE	DESCRIPTION

For more information on HIPAA compliant codes, visit http://www.wpc-edi.com/codes

CareSource®

Healthchek Checklist

Date:_____ Patient Name: _____

Allergies: _____
Medications:_____

Medical History: ❑ Unremarkable
Family History: ❑ Unremarkable
Substance Use (drugs, ETOH, tobacco): _____
Sexual History/Contraception: _____
Pelvic Exam: ❑ Testicular Exam: ❑ _____
Height/Weight/Percentiles:_____/_____% _____/_____% _____/_____%
Head Circumference/Percentile (birth-age 2): _____/_____%
Pulse: _____ Respirations:_____ BP: _____
ENT Assessment: ❑ Normal
Gross/Fine Motor Development: ❑ Normal
Communication Skills: ❑ Normal
Social/Emotional Development: ❑ Normal
Cognitive Skills: ❑ Normal
Nutritional Assessment: ❑ Normal
Ophthalmoscopy, Internal (birth-age 3), External (age 3-20): ❑ Normal
Hearing Assessment, External (birth-age 3), Pure Tone (age 3-20): ❑ Normal
Dental Assessment - Structure, Caries Inspection: ❑ Normal
❑ Dental Appointment (age 2 and older)
❑ Immunization and Healthchek Schedule
Lead Level-Age 1: _____ mcg/Dl Lead Level-Age 2:_____ mcg/Dl
Hemoglobin-Age 1: _____ g/Dl Hemoglobin-One time, age 12-20: _____ g/Dl
Health Education Conducted: ❑ Bottle caries ❑ Healthy lifestyle
❑ Community resources ❑ Accident/Disease prevention ❑ Follow-up

Remarkable Findings/Other:

OH-P-74

CareSource®

Interpreter Service Request Form

Request Date:_____
Name of person requesting service:_____
Contact phone #:_____

Member Information

Member Name:_____
DOB:_____
Parent's name if member is a minor:_____
Phone #:_____
CareSource ID#: _____
Member's Language/Communication mode:_____

Additional Family Members

Member Name:_____
CareSource ID# & DOB:_____
Member Name:_____
CareSource ID# & DOB:_____

Appointment Information

Date of service:_____
Time of appointment:_____
Approximate length of appointment:_____
Facility Name:_____
Office/Provider Name:_____
Address 1:_____
Address 2 (Suite #, Building#/name, etc.)_____
City, State Zip:_____
Phone #:_____
Any specific directions:_____

Completed forms can be emailed or faxed for processing:
Email – CareSourceMemberInquiry@CareSource.com
Fax – (937) 226-6916

OH-P-333

CareSource®

Medical Necessity Appeal Request Form

This form is not required to submit an appeal. Please print or type all information.

Today's Date: _____

Provider's Name: _____ Participating Provider? ❑ Yes ❑ No

If yes, please provide CareSource Provider ID Number: _____

Member's Name: _____

CareSource Member ID Number: _____ Date of Birth: _____

Date(s) of Service: _____

Service(s) Not Covered: _____

Claim Number(s): _____

For DME/Orthotics, please provide code(s): _____

Reason for appeal request. Please include any relevant supporting clinical documentation:

Person Submitting Appeal: _____

Phone Number: ( ) _____ - _____

Mailing address to which response should be sent: _____

_____

April 2009

OH-P-174

Ohio Department of Job and Family Services
ABORTION CERTIFICATION FORM

I certify that, on the basis of my professional judgment, this service was necessary because (check one box only)

☐ **1** The woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would, as certified by a physician, place the woman in danger of death unless an abortion is performed; or

☐ **3** The pregnancy was a result of an act of rape and the patient, the patient's legal guardian, or the person who made the report to the law enforcement agency certified in writing that a report was filed, prior to the performance of the abortion, with a law enforcement agency having the requisite jurisdiction; or

☐ **4** The pregnancy was the result of an act of incest and the patient, the patient's legal guardian, or the person who made the report certified in writing that a report was filed, prior to the performance of the abortion, with either a law enforcement agency having the requisite jurisdiction, or, in the case of a minor, with a county children services agency established under Chapter 5153. of the Revised Code; or

☐ **5** The pregnancy was a result of an act of rape and in my professional opinion the recipient was physically unable to comply with the reporting requirement; or

☐ **6** The pregnancy was a result of an act of incest and in my professional opinion the recipient was physically unable to comply with the reporting requirement.

PLEASE NOTE: **The number indicators besides the empty boxes are for departmental use only.**

Patient's Name
Patient's Address
City, State, and Zip Code
Patient's Medicaid Billing Number

Physician's Name (Please Type)	
Physician's Medicaid Provider Number	
Physician's Signature	Date

OAC 5101:3-17-01 required completion of this form in order to receive Medicaid reimbursement.

JFS 03197 (Rev. 3/2005)

Guidelines for completing the ODJFS ACKNOWLDGEMENT OF HYSTERECTOMY INFORMATION

JFS 03199 (Rev 4/2011)

Section I: Patient Information – *always complete*

1. Patient's first and last name
2. Name of patient's representative (if any)
3. Patient's Medicaid number (this is the MMIS12-digit number listed on CareSource ID card)
4. Date of hysterectomy

Section II: Provision of hysterectomy information prior to hysterectomy procedure(s) – *complete when Section III is NOT completed*

5. Patient or representative signature acknowledging that they were informed both orally and in writing, prior to surgery
6. Date of signature
7. Name of physician representative providing procedural outcomes information (to the patient)
8. Signature of person providing information
9. Date of signature

Section III: Physician Certification of reason for not providing hysterectomy information prior to the hysterectomy procedure – *complete **only** if the member was sterile prior to surgery or was in a life-threatening emergency situation. If Section III is completed then Section II does not need to be completed.*

10. Physician indicates that the patient was already sterile before surgery
    - If this box is checked, briefly explain cause of the sterility (no attachments).
11. Physician indicates that surgery was performed under a life-threatening emergency situation
    - If this box is checked, briefly describe the nature of the emergency (no attachments).
12. Name of physician who performed the surgery (please type or print clearly)
13. Signature of physician who performed the surgery
    - This must be a signature and NOT a stamped signature.
14. Date of signature

The form must be accurately completed before CareSource can consider the claim for payment. Page **_____(#)** is a blank ODJFS Acknowledgement of Hysterectomy Information Form that can be reproduced and used. This form can also be accessed on our website at www.caresource.com.

April 2012

Ohio Department of Job and Family Services

ACKNOWLEDGMENT OF HYSTERECTOMY INFORMATION

Instructions: Complete Section I and either Section II or Section III.

Section I: Patient Information *(REQUIRED: please type or print clearly)*

Patient's Name 1
Name of Patient's Representative *(if any)* 2
Patient's 12 Digit **Medicaid** Number 3
Date of Hysterectomy 4

Section II: Provision of hysterectomy information prior to hysterectomy procedure(s)

Patient acknowledgement of receipt of hysterectomy information:

I understand that a hysterectomy (surgical removal of the uterus), whether performed as a single procedure or together with other procedures, is medically necessary and will not be/has not been performed solely for the purpose of making me incapable of reproducing (sterile).

Prior to the hysterectomy, I have been/was informed, both orally and in writing,that the hysterectomy would make me permanently incapable of reproducing (sterile).

Patient/Representative Signature 5	Date of Signature 6

Provider acknowledgement of provision of hysterectomy information:

Prior to the hysterectomy, I informed this patient *(and her authorized representative, if applicable)* both orally and in writing, that the hysterectomy would make her permanently incapable of reproducing (sterile).

Name of Person Providing Information 7	Signature of Person Providing Information 8	Date of Signature 9

Section III: Physician certification of reason for not providing hysterectomy information prior to the hysterectomy procedure.

Prior to the hysterectomy, the patient was not informed that the hysterectomy would make her permanently incapable of reproducing (sterile) because: *(check all that apply, please type or print clearly, do not provide additional attachments)*

10 ☐ she was already sterile before the hysterectomy (*please briefly explain cause of the sterility*):

_____

11 ☐ the hysterectomy was performed under a life-threatening emergency situation in which prior provision of information was not possible (*please describe the nature of the emergency*):

_____

Name of the physician who performed the hysterectomy *(please type or print clearly)* 12	Signature of the physician who performed the hysterectomy 13	Date of Signature 14

FOR REIMBURSEMENT, EACH PROVIDER MUST INCLUDE A COPY OF THIS COMPLETED FORM WITH CLAIM FOR SERVICES

Distribution: One copy to patient; one copy retained by facility; one copy retained by physician; one copy retained by anesthesiologist.

JFS 03199 (Rev. 4/2011)

Ohio Department of Job and Family Services

ACKNOWLEDGMENT OF HYSTERECTOMY INFORMATION

Instructions: Complete Section I and either Section II or Section III.

Section I: Patient Information *(REQUIRED: please type or print clearly)*

Patient's Name
Name of Patient's Representative *(if any)*
Patient's 12 Digit **Medicaid** Number
Date of Hysterectomy

Section II: Provision of hysterectomy information prior to hysterectomy procedure(s)

Patient acknowledgement of receipt of hysterectomy information:
I understand that a hysterectomy (surgical removal of the uterus), whether performed as a single procedure or together with other procedures, is medically necessary and will not be/has not been performed solely for the purpose of making me incapable of reproducing (sterile).

Prior to the hysterectomy, I have been/was informed, both orally and in writing,that the hysterectomy would make me permanently incapable of reproducing (sterile).

Patient/Representative Signature	Date of Signature

Provider acknowledgement of provision of hysterectomy information:
Prior to the hysterectomy, I informed this patient *(and her authorized representative, if applicable)* both orally and in writing, that the hysterectomy would make her permanently incapable of reproducing (sterile).

Name of Person Providing Information	Signature of Person Providing Information	Date of Signature

Section III: Physician certification of reason for not providing hysterectomy information prior to the hysterectomy procedure.
Prior to the hysterectomy, the patient was not informed that the hysterectomy would make her permanently incapable of reproducing (sterile) because: *(check all that apply, please type or print clearly, do not provide additional attachments)*

☐ she was already sterile before the hysterectomy (*please briefly explain cause of the sterility*):
_____

☐ the hysterectomy was performed under a life-threatening emergency situation in which prior provision of information was not possible (*please describe the nature of the emergency*):
_____

Name of the physician who performed the hysterectomy *(please type or print clearly)*	Signature of the physician who performed the hysterectomy	Date of Signature

FOR REIMBURSEMENT, EACH PROVIDER MUST INCLUDE A COPY OF THIS COMPLETED FORM WITH CLAIM FOR SERVICES

Distribution: One copy to patient; one copy retained by facility; one copy retained by physician; one copy retained by anesthesiologist.

JFS 03199 (Rev. 4/2011)

Guidelines for completing the HHS CONSENT FOR STERILIZATION

HHS-687 (05/10)

*Complete **all** fields unless optional is indicated.*

Consent to Sterilization:

1. Name of physician or clinic providing the patient with the form
2. List the name of the surgical procedure to be performed (e.g. tubal ligation, vasectomy, etc.)
3. Patient's date of birth
4. Patient's first and last name
5. Name of physician who will be performing the surgical procedure
6. List the name of the surgical procedure to be performed (e.g. tubal ligation, vasectomy, etc.)
7. Patient's signature
8. Date patient signed
   ***Note:** The procedure cannot be performed until at least 30 days after this date and must be performed within 180 days of this date.*
9. Optional: patient can check the box of their race and ethnicity

Interpreters Statement (Optional):

10. Optional: The interpreter defines the language used in the interpretation
11. Optional: The interpreter signs their name
12. Optional: The interpreter enters the date they read the statement to the patient

Statement of Person Obtaining Consent:

13. Patient's first and last name
14. Specify type of surgical procedure performed
15. Signature of person obtaining informed consent (physician or physician representative)
16. Date consent was obtained
17. List the name of the facility (hospital, surgery center, etc.) where the procedure will be performed or the practice name of the physician performing the surgery
18. List the complete address (including city, state and zip code)

Physician's Statement:

19. First and last name of patient to be sterilized
20. Date the surgical procedure was performed
21. List the name of the surgical procedure performed
22. This is not required unless the surgical procedure is performed less than 30 days after the patient's signature date (in #8 above). One of the following boxes **must** be checked:
    - ☐ Premature delivery – indicate the expected date of delivery
    - ☐ Emergency abdominal surgery – describe circumstances
23. Signature of physician performing surgery. This must be the physician's actual signature. Do Not Use a Signature Stamp.
24. Date the physician signs

The form must be accurately completed before CareSource can consider the claim for payment. Page _____(#) is a blank ODJFS Consent for Sterilization Form that can be reproduced and used. This form can also be accessed on our website at www.caresource.com.

Form Approved: OMB No. 0937-0166
Expiration date: 12/31/2012

CONSENT FOR STERILIZATION

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from

1 _____
Doctor or Clinic

. When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Temporary Assistance for Needy Families (TANF) or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a

2 _____
Specify Type of Operation

. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on: 3 _____
Date

I, 4 _____, hereby consent of my own free will to be sterilized by 5 _____
Doctor or Clinic

by a method called 6 _____. My consent expires 180 days from the date of my signature below.
Specify Type of Operation

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Human Services, or Employees of programs or projects funded by the Department but only for determining if Federal laws were observed.

I have received a copy of this form.

7 _____ 8 _____
Signature *Date*

You are requested to supply the following information, but it is not required: *(Ethnicity and Race Designation) (please check)*

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race (mark one or more):
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in 10 _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

11 _____ 12 _____
Interpreter's Signature *Date*

HHS-687 (05/10)

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before 13 _____ signed the consent form, I explained to him/her the nature of sterilization operation
Name of Individual

14 _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.
Specify Type of Operation

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

15 _____ 16 _____
Signature of Person Obtaining Consent *Date*

17 _____
Facility

18 _____
Address

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon

19 _____ on 20 _____
Name of Individual *Date of Sterilization*

I explained to him/her the nature of the sterilization operation

21 _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.
Specify Type of Operation

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(**Instructions for use of alternative final paragraph**: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- ☐ Premature delivery
  22 Individual's expected date of delivery: _____
- ☐ Emergency abdominal surgery *(describe circumstances)*:

_____

_____

23 _____ 24 _____
Physician's Signature *Date*

Form Approved: OMB No. 0937-0166
Expiration date: 12/31/2012

CONSENT FOR STERILIZATION

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from _____ (*Doctor or Clinic*). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Temporary Assistance for Needy Families (TANF) or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____ (*Specify Type of Operation*). The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on: _____ (*Date*)

I, _____, hereby consent of my own free will to be sterilized by _____ (*Doctor or Clinic*) by a method called _____ (*Specify Type of Operation*). My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Human Services, or Employees of programs or projects funded by the Department but only for determining if Federal laws were observed.

I have received a copy of this form.

_____ (*Signature*) _____ (*Date*)

You are requested to supply the following information, but it is not required: *(Ethnicity and Race Designation) (please check)*

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race (mark one or more):
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____ (*Interpreter's Signature*) _____ (*Date*)

HHS-687 (05/10)

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____ (*Name of Individual*) signed the consent form, I explained to him/her the nature of sterilization operation _____ (*Specify Type of Operation*), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

_____ (*Signature of Person Obtaining Consent*) _____ (*Date*)

_____ (*Facility*)

_____ (*Address*)

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon _____ (*Name of Individual*) on _____ (*Date of Sterilization*) I explained to him/her the nature of the sterilization operation _____ (*Specify Type of Operation*), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(**Instructions for use of alternative final paragraph**: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- ☐ Premature delivery
  Individual's expected date of delivery: _____
- ☐ Emergency abdominal surgery *(describe circumstances)*:

_____

_____

_____ (*Physician's Signature*) _____ (*Date*)

CareSource®

Phone: 1-800-488-0134
Fax: 1-888-752-0012

Ohio Provider Medical Prior Authorization Request Form

❑ Routine ❑ Urgent (72 hours)

PATIENT INFORMATION

Date of Request _____ Member ID # _____

Member's Last Name _____ First Name _____

Member Address _____

DOB _____ Phone Number _____

ATTACH CLINICAL NOTES WITH HISTORY AND PRIOR TREATMENT

❑ **Inpatient** ❑ **Outpatient**

Ordering Provider Name _____

Tax ID _____ NPI _____

Phone _____ Fax _____

Ordering Provider Address _____

Date of Service(s) Requested _____

Facility / Service Provider (First and Last Name) _____

Provider Address _____

Phone _____ Fax _____

Tax ID _____ NPI _____ DX Codes (ICD-9) _____

DX Description _____

Additional Information _____

Requested Procedures / Services / Surgery _____

Procedure Codes (CPT/HCPCS) _____

Qty.	HCPCS Code	Durable Medical Equipment/Orthotics/Prosthetics/Vision, Make & Model, etc.	U&C Charge

NUMBER OF VISITS

(Circle) 1 2 3 4 5 6 Other _____ visit(s); Refer back to PCP with report

❑ Update Authorization Number _____ # of Visits _____ Requested Extension Date _____

OTHER LIABILITY

❑ Work / Auto / Other Insurance _____

This Form Completed by: _____

THIS SECTION CARESOURCE USE ONLY

AUTHORIZATION INFORMATION

Authorization ❑ Approved ❑ Denied ❑ Pended ❑ Duplicate Request

Authorization Number _____ # of Visits / Treatments _____

Authorization To/From (Date) _____

CareSource Staff Signature _____ Date _____

All non-par providers must have an authorization PRIOR to services rendered. Approved Prior Authorizations payment is contingent upon the eligibility of the member at the time of service, services billed must be within the provider's scope of practice as determined by the applicable fee/payment schedule and the claim timely filing limits. Authorizations are not a guarantee of payment, but are based on medical necessity, appropriate coding and benefits. Benefits may be subject to limitation and/or qualifications and will be determined when the claim is received for processing.

CareSource®

PCP Change Request Form

Provider/Facility: _____ **OR Stamp:**_____

Tax ID#: _____ **Phone:** _____

Member Information:

Member name: (required) _____

Member Phone# (required):_____ **Member ID# OR DOB** (required): _____

Other Family Members:

Member name: _____ **Member ID# or DOB:** _____

Member name: _____ **Member ID# or DOB:** _____

Member name: _____ **Member ID# or DOB:** _____

Reason for Change (required):

- ☐ No Reason - I just want different doctor on my card
- ☐ More convenient location/hours
- ☐ Referral by family/friend
- ☐ I am an existing patient with this doctor. I did not request this doctor when I enrolled with CareSource.
- ☐ Dissatisfaction - A CareSource representative will contact you upon receipt of request.
- ☐ I requested this PCP when I enrolled, but CareSource assigned a different doctor on my CareSource ID card.

☐ I want to be contacted by a CareSource representative to discuss the change.

The **required** fields must be completed for the change to be processed. Members can continue to be treated by the requested PCP until the change is complete. The member should continue to use their current ID card until the new ID card is received. All requests will be processed within 3-5 business days of receipt.

Member/Member Representative Signature _____ Date:_____

Provider (staff) Signature _____ Date:_____

Fax requests to CareSource Member Services at (937) 226-6916

OH-P-183b

CareSource®

Prenatal Risk Assessment Form

(Please print or type)

Patient/Member Name:		Provider Name:	Expected Date of Delivery (EDD): (mo/day/yr)
Member ID #:	Patient Age:	Provider Telephone:	Date of First Prenatal Visit:
Patient Address:		Provider Billing Number: NPI (National Provider Identifier):	Social Service Referral? Date: Agency:
Patient Telephone: Cell Phone:		**Please complete and fax to 1-866-573-0013 (this is for PRAF forms only) or mail to CareSource, Attn: Case Management, P.O. Box 8738, Dayton, OH 45401-8738.** Forms must be received within four weeks of date of service.	

At Risk of Pre-term Birth

Please check all that apply. If at least one factor is checked, patient is at risk of pre-term birth – V23.8

Obstetrical History

- ☐ 1. Abortion, elective
- ☐ 2. Abortion, spontaneous
- ☐ 3. Cone biopsy
- ☐ 4. Eclampsia or severe pre-eclampsia
- ☐ 5. Incompetent cervix
- ☐ 6. Low birth weight, less than 2500g
- ☐ 7. Pre-term delivery/labor
- ☐ 8. Other (please specify): _____

Current Pregnancy

- ☐ 9. Abdominal surgery
- ☐ 10. Age, less than 21 years
- ☐ 11. Age, 35 years or older
- ☐ 12. Alcohol Abuse
- ☐ 13. Anemia, less than 11 hgb or less than 33% hct
- ☐ 14. Asthma, on medication
- ☐ 15. Bleeding, if significant after 12 weeks
- ☐ 16. Cervix dilated, more than 1.5 cm before 29 weeks
- ☐ 17. Cervix effaced, more than 50% before 29 weeks
- ☐ 18. Chronic bronchitis
- ☐ 19. Diabetes, insulin dependent
- ☐ 20. Diabetes, non-insulin dependent
- ☐ 21. Domestic Violence
- ☐ 22. Drug Abuse
- ☐ 23. Eclampsia or pre-eclampsia
- ☐ 24. Heart disease
- ☐ 25. Hypertension
- ☐ 26. Irritable uterus
- ☐ 27. Kidney disease
- ☐ 28. Late initial visit, after 14 weeks of pregnancy
- ☐ 29. Malignancy or leukemia
- ☐ 30. Missed prenatal appointments
- ☐ 31. Multiple gestation
- ☐ 32. Oligohydramnios
- ☐ 33. Placenta previa
- ☐ 34. Pneumonia
- ☐ 35. Polyhydramnios
- ☐ 36. Poor nutrition
- ☐ 37. Prenatal care noncompliance, most recent pregnancy
- ☐ 38. Pre-term labor
- ☐ 39. PROM, confirmed
- ☐ 40. Sickle cell or other hemoglobinopathy
- ☐ 41. Smoking
- ☐ 42. Trauma
- ☐ 43. Underweight, less than 15% weight for height
- ☐ 44. Uterine anomaly or fibroids
- ☐ 45. UTI
- ☐ 46. Weight loss
- ☐ 47. Other (please specify): _____

At Risk of Poor Pregnancy Outcome

Please check all that apply. If at least one factor is checked, patient is at risk of poor pregnancy outcome – V23.9

Obstetrical History:

- ☐ 48. Congenital anomaly, major
- ☐ 49. Infant death - stillborn, neonatal, post-neonatal

Current Pregnancy

- ☐ 50. Anesthesia-related allergies
- ☐ 51. Behavioral Health condition
- ☐ 52. Deep venous thrombosis
- ☐ 53. Diabetes, gestational, diet-controlled
- ☐ 54. Diabetes, gestational, on medication
- ☐ 55. Epilepsy or on anticonvulsant
- ☐ 56. Familial genetic disorder, confirmed
- ☐ 57. Grand multipara, more than five of 20 weeks or more
- ☐ 58. Group B Streptococcal disease
- ☐ 59. Height, less than five feet
- ☐ 60. Hepatitis or chronic liver disease
- ☐ 61. HIV/ARC/AIDS
- ☐ 62. Illiteracy
- ☐ 63. Isoimmunization associated with fetal disease
- ☐ 64. Language barrier
- ☐ 65. Mental Retardation
- ☐ 66. Obesity, more than 20% weight for height
- ☐ 67. Prior C-section and/or previous uterine scar
- ☐ 68. Recent delivery, less than one year
- ☐ 69. Sexually transmitted disease, any
- ☐ 70. Thyroid disease, confirmed
- ☐ 71. Other (please specify): _____

Provider's Signature:	**Date:**

June 2009

OH-P-159a

CareSource®

Provider Clinical / Claim Appeal form

Include supporting documentation • Incomplete submission will be returned for additional information • Applicable timely filing limits apply

Member Name_____

Member ID Number_____

Date of Service_____

Code / Service not covered_____

Place of Service_____

Provider Name_____

Provider NPI Number _____

Provider Telephone Number (_____)_____

CareSource Provider ID_____

Claim Number_____

Requestor Name_____

❒ **Claims Appeal** — An adverse decision regarding payment for a submitted claim or a denied claim for services rendered to a CareSource member.	• **Appeal Form** • **Supporting Documentation** • **Original Remittance Advice** The provider / Facility rendering services has 365 days from the date of service to file a claim appeal.
❒ **Clinical Appeal** — A request to review a determination not to certify an admission, extension or stay, or other health care service conducted by a peer review who was not involved in any previous adverse determination / non-certification decision pertaining to the same episode or care.	• **Appeal Form** • **Records supporting medical necessity** • **Original Remittance Advice** The provider / facility rendering services has 180 days from the date of service to file a clinical appeal.
❒ **Corrected Claim** — Any correction of the date of service, procedure / diagnosis code, incorrect unit count, location code and / or modifier to a previously processed claim. ■ Resubmit the entire claim with updated information as a **Corrected Claim**. If you disagree with the amount paid on a claim line, you will need to submit an appeal.	STOP **Please send Corrected Claims to:** CareSource ATTN: Claims Dept. P.O. Box 8730 Dayton, OH 45401-8730

Claims Appeals Department **P.O. Box 2008** **Dayton, OH 45401-8730**	**Clinical Appeals Department** **P.O. Box 1947** **Dayton, OH 45401-8730**	**Fax to: Provider Claims Appeal Coordinator** **Fax Number: 937-531-2398**

OH-P-182d

CareSource®

Request for Reconsideration

Instructions: *Please type or print. Leave the block empty if you cannot answer it.*

Mail to: CareSource Advantage® (HMO SNP), P.O. Box 1947, Dayton, OH 45401-1947

1. Member Name	2. Identification Number

3. Representative Name (if applicable): ☐ Relative ☐ Attorney ☐ Other Person ☐ Provider Filing

4. **Please attach a copy of the notice(s) you received about your claim to this form.**	5. Social Security Number _____-_____-_____

6. This claim is for: ☐ Hospital ☐ Physician ☐ Skilled Nursing Facility (SNF) ☐ Emergency Room ☐ Home Health Agency (HHA) ☐ Other

7. Name of Provider (Physician, Hospital, SNF)	Provider Address, City & State
8. Date of Admission or Start of Services	9. Date(s) of the Notice(s) you received

10. I do not agree with the determination on my claim. Please reconsider my claim because:

_____

_____

_____

11. **You must obtain any evidence you wish to submit**. (Example: A letter from a doctor.) ☐ I have attached the following evidence: ☐ I will send the evidence within 10 days. ☐ I have no additional evidence or information.	12. Only one signature is needed. Signed by: ☐ Member ☐ Representative* ☐ Provider Rep **Sign Here** _ _____ ***If representative authorization needed**
13. Is this request filed within 60 days of your notice? ☐ Yes ☐ No If you checked "No", please attach an explanation.	14. Street Address: City, State Zip Code Phone: **Date**:

15. If this request is signed by mark (X), TWO WITNESSES who know the person requesting the reconsideration must sign in the space provided. **Witnesses are ONLY required if this request has been signed by a mark (X).**

Witness #1 _____	Witness #2 _____
Address _____	Address _____
City, State Zip _____	City, State Zip _____

DO NOT FILL IN BELOW THIS LINE, THANK YOU

16. Routing	18. Date Stamp
17. Additional Information	