A close up of a sign

Description automatically generated

***NOTE: Please sign and return all pages within three days of receipt to avoid claims issues.***

|  |  |  |  |
| --- | --- | --- | --- |
| *To:* |  | *Fax/Email* |  |
| *From* |  | *Date:* |  |
| *Re:* |  | *Pages* |  |
| *For:* |  | | |

It is the participant's responsibility to familiarize oneself with regards to the Plan's

**provisions. Participant is responsible for copayments and out-of-pocket co-insurance if appl ic able. Thank you.**

►*Please provid e/ con f ir m information if applicable:*

►

►

►

►

►

►

*Physical Address Mailing Address State* License

*DEA* License *Malpractice Insurance W9 form* to *verify TIN NPI*

*PLEASE RETURN AGREEMENT WITHIN 3 DAYS*

All Autism/ **ABA/IBT** Claims must be submitted on a CMS-1500 claim form and

**Faxed to dedicated processing team: Fax: 1-855-835-6130; Attn: Autism Claims Processing**

***Claim forms submitted without NPI will* be rejected.**

***For all claims questions please call*** *1-800-333-8724*

***For all authorization questions please call*** *1-800-548-6549 ext. 37983*

***IMPORTANT:*** *This transmission contains confidential information intended only for the parties specifically identified on the cover page. Disclosure, distribution or reproduction of sensitive information to third parties* is *prohibited . If this fax* is *received in error, please notify the sender by telephone and return the original to the sender at the address listed .*

A close up of a sign

Description automatically generated

ACCOMMODATION AGREEMENT

FOR OFFICE USE ONLY:

# FACETS:

# STATE:

**Clinician/Facility Name:**

**Tax ID# NPI#**

### Medicare/Medicaid #

Patient:

DOB:

Subscriber ID:

#### Dear Provider,

**Thank you** for accepting our request to become a temporary "accommodation or single case agreement (SCA) provider" for the above named Patient ("Patient"), who is covered by XXXX Behavioral Solutions ("XXXXX"). XXXX is the behavioral health services contractor managing behavioral health funding for this Patient.

This letter serves as the formal agreement ("Agreement") between XXXX and the undersigned healthcare professional or facility, whose name and identifying information appear above and on the signature portion of this agreement. The terms of this Agreement are as follows:

Provider will provide medically necessary behavioral health services consistent with community standards as required by the Patient and as authorized by XXXX Insurance company. Provider shall be qualified by law and have the capacity to provide such services. XXXX Insurance company will provide compensation for such services as noted below and in compliance with applicable federal or state law(s). Provider shall maintain, and demonstrate upon request by XXXX Insurance company, that the Provider is licensed to provide behavioral health services in the state where they practice and that Provider is in compliance with all other applicable Federal and State regulations. Provider further warrants that Provider holds and maintains in full force and effect sufficient malpractice insurance according to state mandated levels of coverage for applicable services to be rendered by Provider to Patient.

Provider shall abide by all operating policies and procedures of XXXX Insurance company, which include but are not limited to, Case Management, Utilization Review and Quality Improvement Programs of XXXX Insurance company. Provider specifically acknowledges and agrees to the following:

* Provider shall comply with XXXX Insurance company Utilization Management requirements including contacting a Utilization Manager for any additional authorization(s) or any different type of treatment not otherwise indicated below (OR ANY SERVICE CODE WHICH IS NOT LISTED BELOW) as necessary . An authorization is required for all services rendered and is subject to Patient eligibility at the time of service. Prior authorizations/authorizations are not a guarantee of payment. Please review and validate current eligibility with Patient.
* Provider shall ensure that a valid consent for disclosure form is signed by the assigned XXXX Insurance company Patient receiving behavioral health services from Provider in order to permit XXXX Insurance company, or its designee, to review claims and treatment records related to the services provided by Provider under this Agreement.
* Provider shall maintain and provide to XXXX Insurance company or any applicable state or federal regulatory agencies all records relating to services provided to each Patient as required by state and federal law. Such records shall be retained by Provider for either a period of not less than five (5) years following the provision of behavioral health services or such greater length of time Provider may be required to maintain patient records under applicable state or federal law.

###### Provider agrees to submit complete clean claims and all supporting information necessary to process such claims to the address on the back of the Member's plan identification card no later than ninety (90) days from the date of completion of the services or the authorized treatment episode whichever occurs first. XXXX Insurance company, or its designee, shall make payments of compensation for services to Provider at the rates outlined below as payment in full for all covered behavioral health services provided to member pursuant to this Agreement. Please note that failure to execute this Agreement may not prevent XXXX Insurance company from reimbursing Provider at the rate(s) reflected below as payment in full as XXXX Insurance company recognizes its responsibility to reimburse Provider for services appropriately authorized and/or approved for XXXX Insurance company Patients.

###### **All Autism/ ABA/IBT Claims must be submitted on a CMS-1500 claim form and Faxed to dedicated processing team: Fax: 1-855-835-6130; Attn: Autism Claims Processing**

* With the exception of applicable copayments, coinsurance, deductibles or non-covered services delivered on a fee-for-service basis to Patient, with the Patient's written consent, ***Provider shall in NO event,*** including, but not limited to insolvency of XXXX Insurance company, bill, charge or collect any form of payment from Patient for covered behavioral health services provided by Provider pursuant to this Agreement.

Either party may terminate this Agreement without cause at any time by providing thirty (30) days prior written notice of termination to the other party. Upon termination of Agreement, Provider shall continue to provide covered behavioral health services until the effective date of transfer of Patient to another Provider.

**This Agreement shall be interpreted and governed by any and all applicable federal and state laws and regulations.**

**EFFECTIVE DATE:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Unit** | **CPT** / **Rev Code** | **Authorization** | **Reimbursement** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

*\*The per diem rates/ or psychiatric, dual diagnosis and substance abuse services include the following treatment components. Provider will not receive additional or separate reimbursement when billing multiple levels of care or included treatment components on the same day- ajiercare, anesthesiology, discharge planning, ER, ECT, EEG, EKG, Family Therapy, In dividual Therapy, Initial Evaluation/Assessment,*

*Laborato1y /Pathology, Medical and Surgical Supplies, Medica l His tory & Physical (including professional fees), Medications, Nurs ing, Neuropsycho logical Testing, Primary Therapist (non-MD), Ambulance, Psychosocial Programs/Services, Psychological Testing, Radiology, Recreational/Occupational Therapy, Room and Board Charges, Team Meetings.*

###### Note: The above-referenced reimbursement rate(s) may reflect verbal agreement(s) that occurred between Provider and XXXX Insurance company Accommodations Staff.

**Please acknowledge your Agreement** with the above rate and terms by signing this document where indicated and return to my attention **within five (5) business days of receipt.** If XXXX Insurance company does not receive the signed Agreement within five (5) business days of verifiable receipt, XXXX Insurance company will assume acceptance of this Agreement. Additionally, XXXX Insurance company will move forward and reimburse Provider at the rate(s) reflected above as payment in full.

Should you have any questions or concerns regarding this Agreement, please do not hesitate to contact me at (415) 547-5016. **For questions regarding claims or authorizations,** please contact the designated phone number(s) indicated on the cover sheet as I do not have access to claims or clinical information.

**Sincerely,**

#### Acknowledged and Agreed :



Date:

***Please complete and sign the following:***

|  |
| --- |
| **Clinician License Type:** |
| **Clinician License Number:** |
| **Expiration Date:** |

##### DEA Number (MD's/RN's only):

**Expiration Date:**