Marketplace Provider Orientation



Your Extended Family.

The Molina Story

Three Decades of Delivering Access to Quality Care

Molina Healthcare's history and member-focused approach began with the vision of Dr. C. David Molina, an emergency department physician who saw people in need and opened a community clinic where caring for people was more important than their ability to pay.



Today Molina Healthcare serves the diverse needs of 1.8 million plan members and beneficiaries across the United States through government-funded programs. Molina Healthcare provides NCQA-accredited care and services that focus on promoting health, wellness and improved patient outcomes. While the company continues to grow, we always put people first. We treat everyone like family, just as Dr. Molina did – making Molina Healthcare your extended family.



Three Decades of Delivering Access to Quality Care

Molina Healthcare has evolved over the years, but the mission has remained the same-providing those most in need with access to high quality health care services. It is our story that makes us proud to call ourselves an extended family, to the members, partners and communities we serve.

1980

Molina Healthcare is born. Originally named Molina Medical Centers, our primary care clinics begin serving communities in southern California.



1997 110.000 MEMBERS

Molina Healthcare begins serving communities in Utah.

Molina Healthcare begins serving communities in Michigan.

1994 100,000 MEMBERS

Molina Healthcare establishes its first licensed health plan in California.

2003 500.000 MEMBERS

Molina Healthcare becomes a **publicly**traded company and is listed on the New York Stock Exchange as MOH.



2004 750.000 MEMBERS 250,000 MEMBERS Molina Healthcare

begins serving

communities in

New Mexico.

Molina Healthcare begins serving communities in Washington.

2000

2005 900.000 MEMBERS

Molina Healthcare begins serving communities in Texas.

Molina Healthcare begins serving communities in Ohio.



2008

begins operating Fairfax County clinics in Virginia.

begins serving communities in Florida.



Molina Healthcare

begins offering

services through

2006 1 MILLION MEMBERS

Molina Healthcare begins offering services to people with Medicare.



2011

Molina Medicaid Solutions' system in Maine receives full federal certification.

2014

Molina Healthcare begins serving communities in South Carolina.

Molina Healthcare

begins serving dual

eligible populations

Molina Healthcare

begins offering services through the

Health Insurance

Marketplace

and Ohio

in California, Illinois

2012

Molina Healthcare is awarded dual eligible contracts in California. Illinois and Ohio.

Molina Healthcare is named a FORTUNE 500 company.

Molina Medicaid Solutions' system in Idaho receives full federal certification.





Member numbers are approximate. 404131170414

Molina Healthcare

Molina Healthcare



2010



Quality, Innovation and Success

Molina Healthcare, Inc.



Molina Healthcare of Ohio





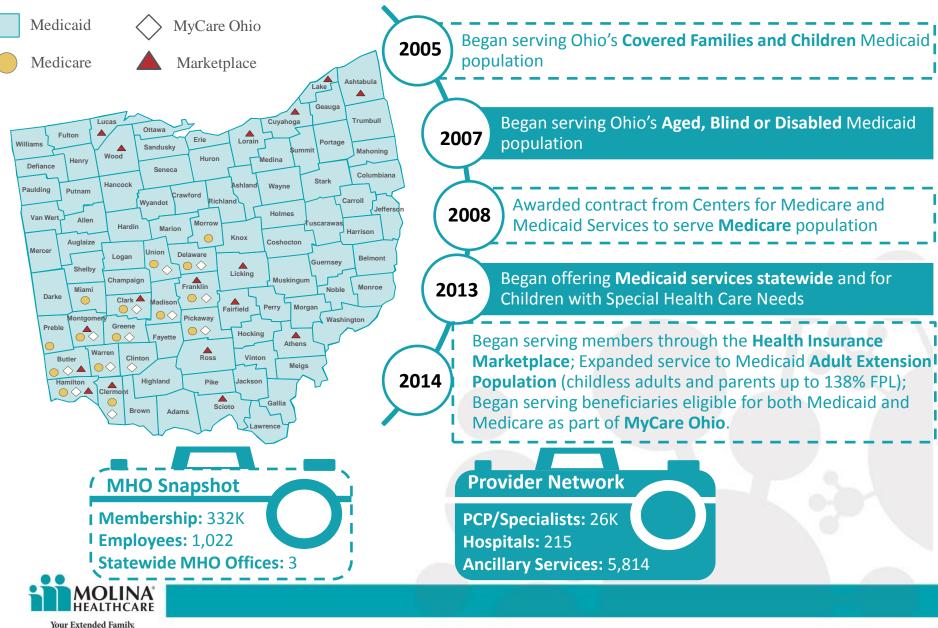
ALFRED P. SLOAN AWARD BUSINESS EXCELLENCE IN WORKPLACE FLEXIBILITY

2009: RANKED LARGEST HISPANIC-OWNED BUSINESS HISPANIC BUISNESS MAGAZINE RECOGNIZED FOR INNOVATION IN MULTI-CULTURAL HEALTHCARE ROBERT WOOD JOHNSON FOUNDATION ,

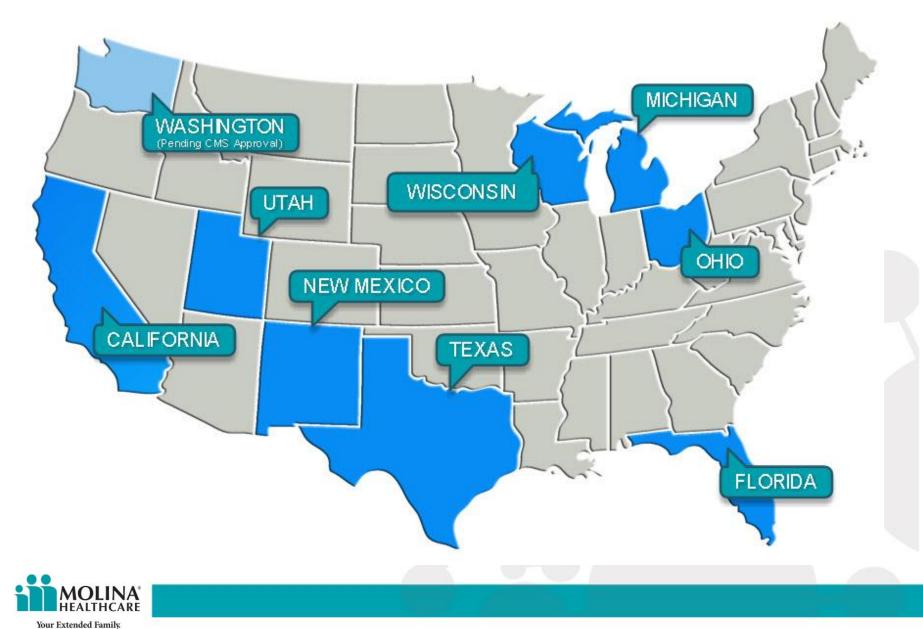




Molina Healthcare of Ohio



Molina Marketplace Plans



Introduction to HIM

Health Insurance Marketplace (HIM)

The Health Insurance Marketplace (also known as the Exchange) is a one-stop shop for low-cost health insurance.

Depending on the consumer's income, the government covers part of the cost of Marketplace insurance. Molina Healthcare offers Marketplace plans in eight states.

The Marketplace is an outcome of the Affordable Care Act – more commonly known as health care reform or Obamacare.

On the Marketplace, consumers can look at the insurance options available to them all in one place.

Marketplace was created as a simple way for individuals and small businesses to buy affordable health care coverage.



Marketplace Product Portfolio





Plans

Plans are standardized and cover the same benefits, but vary by level of co-pay, coinsurance, deductible and subsidy.

Gold Plan	 Ideal for mid- to high-earners Closely resembles employer-sponsored benefits
Silver Plan	 Ideal for low-income individuals as it is the closest to Medicaid Receives the most federal subsidy to cover the monthly premiums, co-pays, coinsurance and deductible
Bronze Plan	 Great for low-income individuals because the subsidy covers the monthly premiums Offers good first-dollar coverage, which offsets some of the impact the of the higher cost sharing

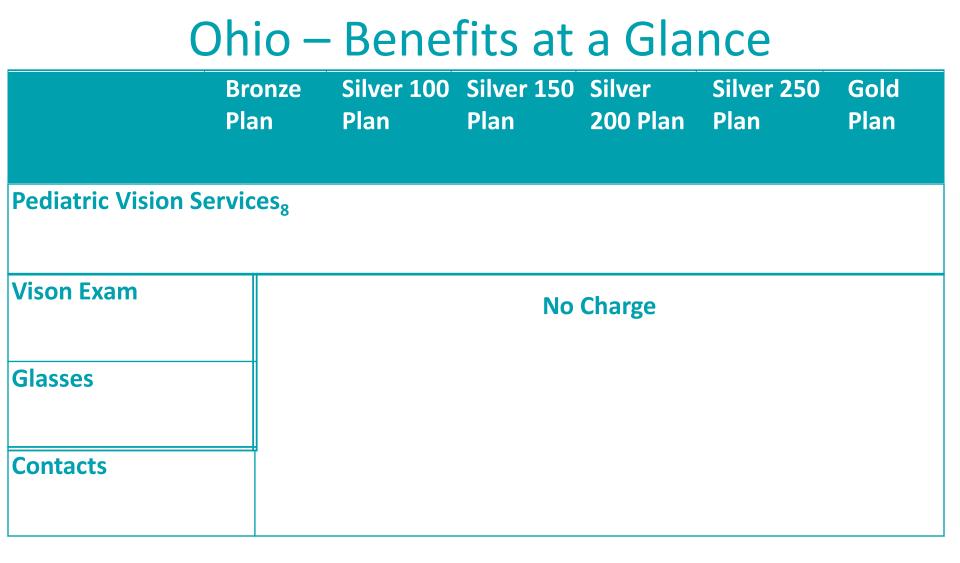


	Bronze Plan	Silver 100 Plan	Silver 150 Plan	Silver 200 Plan	Silver 250 Plan	Gold Plan
FEATURES						
Annual Deductible	\$4,500/	\$0	\$250/	\$1,700/	\$2,000/	\$500/
(Individual/Family)	\$9,000 ₂		\$5001	\$3,400 ₁	\$4,000 ₁	\$1,000 ₁
Prescription Drug Deductible (Individual/ Family)	N/A	\$0	\$0	\$0	\$200/ \$4003	\$0
Annual Out-of- Pocket Maximum (Individual/ Family)	\$6,600/ \$13,200	\$2,250/ \$4,500	\$2,250/ \$4,500	\$5,200/ \$10,400	\$6,600/ \$13,200	\$6,600/ \$13,200



	Bron Plan		Silver 150 Plan		Silver 250 Plan) Gold Plan
BENEFITS ₆						
Emergency and U	Jrgent Care	Services				
Emergency	\$300 co-	\$100 co-	\$150 co-	\$250 co-	\$250 co-	\$250 co-
Room ₇	рау	рау	рау	рау	рау	рау
Urgent Care	\$75	\$15	\$30	\$60	\$75	\$60
	со-рау	co-pay	со-рау	со-рау	co-pay	co-pay







	Bronze Plan	Silver 100 Plan	Silver 150 Plan	Silver 200 Plan	Silver 250 Plan	Gold Plan				
Prescriptio	Prescription Drugs									
Formulary										
Generic	\$16	\$3	\$10	\$15	\$15	\$15				
Drugs	со-рау	со-рау	со-рау	со-рау	со-рау	со-рау				
Formulary										
Preferred	\$65	\$8	\$20	\$50	\$50	\$35				
Brand		со-рау	co-pay	со-рау	со-рау	со-рау				
Drugs										
Formulary										
Non	40%	10%	20%	30%	30%	20%				
Preferred	coinsurance	coinsurance	coinsurance	coinsurance	coinsurance	coinsurance				
Brand										
Drugs										



	Bronze Plan	Silver 100 Plan	Silver 150 Plan	Silver 200 Plan	Silver 250 Plan	Gold Plan
Specialty Drugs	40% coinsurance	10% coinsurance	20% coinsurance		30% coinsurance	20% coinsurance
Outpatient Hosp	oital / Facili	ty Services	•	· · · · · ·		
Laboratory	\$30	\$0	\$10	\$25	\$25	\$15
Services	со-рау	со-рау	со-рау	со-рау	со-рау	со-рау
Radiology	\$75	\$10	\$30	\$55	\$55	\$35
Services	со-рау	со-рау	со-рау	со-рау	со-рау	со-рау
Specialized	40%	10%	20%	30%	30%	20%
Scanning	coinsurance	coinsurance	coinsurance	coinsurance	coinsuranc	coinsurance
Services (CT,					е	
MRI, PET						
Scans)						
Medical/	40%	10%	20%	30%	30%	20%
Surgical	coinsurance	coinsurance	coinsurance	coinsurance	coinsuranc	coinsurance
Services					е	



	Bronze Plan	Silver 100 Plan	Silver 15 Plan	0 Silver 200 Plan	Silver 250 Pla	Gold n Plan
Inpatient Hosp	ital Services					
Medical/ Surgical Maternity Care, Mental Health, Substance Abuse, Skilled Nursing	40% co- insurance	10% co- insurance	20% co- insurance	30% co- insuranc e	30% co- insurance	20% co- insurance
Facility Hospice Care			No Cha	rge		



	Bronze Plan	Silver 100 Plan	Silver 150 Plan	Silver 200 Plan	Silver 250 Plan	Gold Plan
Transportation						
Assistance						
Emergency	\$100	\$100	\$150	\$250	\$250 co-	\$250
Transportation -	co-pay per	co-pay	co-pay	co-pay	pay per	pay per
Ambulance	trip	per trip	per trip	per trip	trip	trip
Non-Emergency Medical and Non- Medical			No C	harge		
Transportation to						
& from Medical						
Appointments ₅						
24-Hour Nurse			No C	harge		
Advice Line						



	Bronze Plan	Silver 100 Plan	Silver 150 Plan	Silver 200 Plan	Silver 250 Plan	Gold Plan
Weight Control Program	No Charge					
Motherhood Matters [®] , mothers-to-be program		No Charge				
Tobacco counseling, smoking cessation program			No	Charge		

- 1 Applies only to outpatient hospital / facility and inpatient hospital / facility services
- 2 Combined medical and pharmacy deductible (waived for preventive care, first three office visits, and generic drugs
- 3 Applies only to non-preferred brand name drugs and specialty drugs
- 4 Some outpatient professional services not listed require a coinsurance cost share rather than a copayment
- 5 Non-emergency medical and non-medical transportation services are limited to four (4) round trips per month
- 6 Certain benefits require prior authorization prior to obtaining services.
- 7 This cost is waived if admitted directly to the hospital for inpatient services (refer to Inpatient hospital services for applicable cost sharing information
- 8 Applicable to dependent children through age 18

This "2015 Benefits-At-A-Glance" is intended to be a summary of covered benefits that lists some features of our plan. It does not list or describe all benefits covered under a specific product or every limitation or exclusion. Please consult the Molina Healthcare of Ohio Agreement and Individual Evidence of Coverage for a detailed description of benefits, exclusions, and limitations.



Marketplace Required Benefits

All Qualified Health Plans (QHP) must include the following 10 categories of Essential Health Benefits (EHB) defined by ACA:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity & newborn care
- Mental health and substance use disorder services, including behavioral health treatment

- Laboratory services
- Pediatric services, including oral and vision care
- Prescription drugs
- Rehabilitative and habilitative services
- Preventive and wellness services, and chronic disease management



Enrollment and Coverage Dates

Date the Patient Changed Plans	Date the Patient's New Plan Began
Before Dec. 15	Jan. 1
Between Dec. 16, and Jan. 15	Feb. 1
After Jan. 15	March 1

If a patient wants to enroll with Molina Healthcare:

We can assist the patient with enrollment at (855) 882-3898 Patients can also enroll directly through the Health Insurance Exchange in their state. Go to www.HealthCare. gov or call (800) 318-2596 or TTY (855) 889-4325 to learn more.



Special Enrollment - Exceptions

The Marketplace must allow qualified individuals to enroll in a QHP or change from one QHP to another as a result of a qualifying event





Special Enrollment - Exceptions

Special Enrollment Event

Loss of minimum essential coverage

Gaining or becoming a dependent

Gaining lawful presence

Enrollment errors of the Marketplace

Material contract violations by QHP

Gaining or losing eligibility for premium tax credits or cost sharing reductions

Relocation resulting in new or different QHP selection

American Indians and Alaska Natives (AI/AN) may enroll in a QHP or change from one QHP to another one time per month

Exceptional circumstances



Molina Marketplace ID Card

Molina Marketplace ID #: 00000000 Member: JOHN SMITH	MOLINA HEALTHCARE	This card is for identification purposes only and does not prove eligibility for see Member: Emergencies (24 hrs): when a medical emergency might lead to disability of call 911 immediately or get to the nearest emergency room. No prior authorization is r
DOB: 10/18/1963 Subscriber Name: Fred Flints Subscriber ID: 123456789 Provider: JANE DOE	Plan: OH Marketplace tone	for emergency care. Miembro: Emergencias (24 horas): cuando una emergencia puede resultar en muerte disabilidad, llame al 911 imediatamente o vaya a la sala de emergencia mas cercana. No requiere autorización para servicios de emregencia. Remit claims to: Molina Healthcare Riverside/San Bernadino
Provider Phone: (000)000-00 Provider Group: PCPGRP0	000	P.O. Box 22712, Long Beach, CA 90802 Customer Support Number: (888)123-4567
Medical Cost Share Primary Care: \$0 Specialist Visits: \$0 Urgent Care: \$0 ER Visit: \$0	Prescription Drugs Rx Deductible: \$50 Generic Drugs: \$5 Preferred Brand Drugs: \$0 Non-Preferred Brand Drugs: \$0 Specialty Drugs: \$40	24 Hour Nurse Advice Line: (800)000-0000 Para Enfermera En Español: (866) 648-3537 CVS Caremark Pharmacy Help Desk: Provider: Notify the health plan within 24 hours of any inpatient admission at the hosp admission notification phone number. Prior Authorization/Notification of Hospital Admission and Covered Services: (8 322-4079
Molina Healthcare of Ohio, Inc.	Rx Bin: 004336 Rx PCN: ADV Rx Group: RxGroup(MHO01012014 - MHO-1366 www.MolinaHealthca

Front

Back



Member Cost Sharing

Cost sharing is the deductible, copayment, or coinsurance that members must pay for covered services provided under their Molina Marketplace plan.

Cost Sharing applies to all covered services, except preventive services, included in the Essential Health Benefits (as required by the Affordable Care Act).

It is the provider's responsibility to collect the copayment and cost share from the member to receive full reimbursement for a service.

The amount of the co-payment and other cost sharing will be deducted from the Molina Healthcare payment for all claims involving cost sharing.



Binder Payment and Restrictions

The first month premium is referred to as their binder payment.

If a member does NOT make the binder payment, the coverage will not be effective.

There will be a binder restriction placed on every Marketplace member record.

Additional restrictions may also be added.

The restriction is visible on the eligibility page, below the enrollment line table.



Grace Period

<u>APTC Member:</u> A member who receives Advanced Premium Tax Credits (premium subsidy), which helps to offset the cost of monthly premiums for the member.

Non-APTC Member: A member who is not receiving any Advanced Premium Tax Credits and is therefore solely responsible for the payment of the full monthly premium.



Grace Period Timing

Non-APTC members are granted a 1-month grace period, and can access some or all services covered under their benefit plans. If the full pastdue premium is not paid by the end of the grace period, the Non-APTC Member will be retroactively terminated to the last paid day of the last month.

SUN	MON	TUE	WED	тн	FRI	SAT
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31



Grace Period Timing

APTC members are granted a three-month grace period. During the first month, claims and authorizations will continue to be processed. Services, authorization requests and claims may be denied or have certain restrictions during the second and third months.

If the APTC member's full pastdue premium is not paid by the end of the third month of the grace period, the APTC Member will be retroactively terminated to the last paid day of the first month of the grace period.

SUN	MON	TUE	WED	тн	FRI	SAT
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31



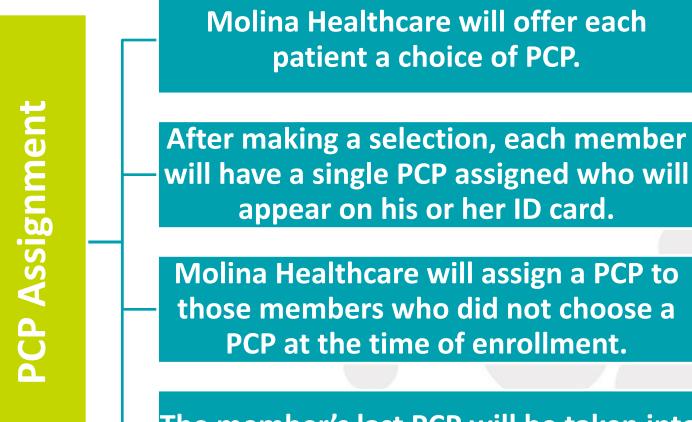
Grace Period

Service Alerts

- When a member is in the grace period, Molina Healthcare will have a service alert on the Web Portal, Interactive Voice Response (IVR) and in the call center. This alert will provide more specific detail about where the member is in the grace period (first month vs. second and third) as well as information about how authorizations and claims will be processed during this time.
- Providers should verify the eligibility status and any service alerts when checking the eligibility of a member.
- For additional information about how authorizations and claims will be processed during this time, please refer to the Member Evidence of Coverage or contact our Provider Services department at (855) 322-4079.



Primary Care Provider (PCP) Assignment



The member's last PCP will be taken into consideration.



Primary Care Provider (PCP) Changes

PCP Changes

Patients can change their PCP at any time. All changes completed by the 25th of the month will be in effect on the first day of the following calendar month.

Any changes requested on or after the 26th of the month will be in effect on the first day of the second calendar month.



Prior Authorizations

Molina Healthcare requires PA for specified services as long as the requirement complies with Federal or State regulations and the Molina Healthcare Hospital or Provider Services Agreement. The list of services that require PA is available in narrative form, along with a more detailed list by CPT and HCPCS codes.

Services performed without authorization may not be eligible for payment. Services provided emergently (as defined by Federal and state law) are excluded from the PA requirements. Molina Healthcare does not "retroactively" authorize services that require PA.



Prior Authorizations

Molina Healthcare will process any non-urgent requests within 14 calendar days of receipt of request. Urgent requests will be processed within 72 hours of receipt of the request.

Providers who request PA approval for patient services and/or procedures may request to review the criteria used to make the final decision. Molina Healthcare has a full-time medical director available to discuss medical necessity decisions with the requesting provider at (855) 322-4079.



Services that Require Prior Authorization

An example of some of the services that require prior authorization include:

- Behavioral Health
- Experimental
- Durable Medical Equipment
- Home Health/Infusion
- Non Participating Providers
 or Facilities

- Cosmetic Services
- General Dental Anesthesia
- Durable Medical Equipment
- Imaging Services
- s Inpatient Admissions
 - Pain Management Procedures

For a complete list of services that require PA please see our codified list at http://www.molinahealthcare.com/providers/common/PDF/Ohio/p rior-authorization-codification-list.pdf



Prior Authorization Form

You can submit PAs in two different ways:

- Submit Online: Via our Provider Web Portal at <u>https://eportal.MolinaHealth</u> <u>care.com/Provider/login</u>
- Or fax: Medicaid (866) 449-6843

Medicare (877) 708-2116



Molina Healthcare Medicaid and Medicare

Prior Authorization/Pre-Service Review Guide . Effective: 01/01/2015

Contact Provider Services for details ***Reterrals to Network Specialists and office visits to contracted (par) providers do not require Prior Authorization/*** This Prior Authorization/Pre-Service Guide applies to all Molina Healthcare Medicaid and Medicaiere Members – excludes Marketpla Refer to Molina's website or portal for specific codes that require authorization Only covered services are eligible for reimbursement			
		 Behavioral Health: Mental Health, Alcohol and Chemical Dependency Services: Inpatienti, Residential Treatment, Partial hospitalization Electroconvulsive Therapy (ECT) Applied Behavioral Analysis (ABA) – for treatment of Antism Spectrum Disorder (ASD) Cosmetic, Plastic and Reconstructive Procedures (in any setting) Dental General Anesthesia: > 7 years old or per state benefit (Not a Medicare covered benefit) Dialysis: one time only notification Durable Medical Equipment: Refer to Molina's website or portal for specific codes that require authorization. Medicare Hearing Supplemental benefit: Contact Avesis at 800-327-4462 Experimental/Investigational Procedures (In any setting) Genetic Counselling and Testing except for prenatal diagnosis of congenital disorders of the unborn child through aminocentesis and genetic test screening of newborns mandated by state regulations Habilitative Therapy – After initial evaluation plus six (6) visits for outpatient and home settings (per state benefit) Home Healthcare and Home Infusion: After initial evaluation plus six (6) visits (Hospiter equires authorization and put the Admission Actuate hospital, Skilled Nursing Facilities (SNF), Rehabilitation, Long Term Acute Care (UTAC) Facility, Hospice (Hospice requires notification only: Hyperbaric Therapy Long Term Services and Supports: Refer to Molina's website or portal for specific codes that require authorization or portal for specific codes that require authorization on a Medicare covered benefit (reprise authorization). Not a Medicare Covered benefit (reprise authorization). Not a Medicare Covered benefit (reprise authorization). Not a Medicare Covered benefit (reprise) (SITE) (SIT	 Occupational Therapy: After initial evaluation plus six (6) visits for outpatient and home settings Office-Based Procedures do not require authorization (unless otherwise noted) Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures: Refer to Molina's website or portal f apecific codes that require authorization Pain Management Procedures (In any setting): except trigger point injections (Acupuncture is not a Medicare covered benefit) Physical Therapy: After initial evaluation plus six (6) visits for outpatient and home settings Pregnancy and Delivery: notification only Prosthetics/Orthotics: Refer to Molina's website or portal for specific codes that require authorization Radiation Therapy and Radiosurgery (for selected services only): Refer to Molina's website or portal for specific codes that require authorization Rachaiton Therapy and Radiosurgery (for selected services only): Refer to Molina's website or portal for specific codes that require authorization Rehabilitation Services Including Cardiac, Pulmonary and Comprehensive Outpatient Rehab Facility (CORF). CORF Services for Medicare only Respite Care Sleep Studies Specialty Pharmacy drugs (oral and injectable): Refer Molina's website or portal for specific codes that require authorization Speech Therapy: After initial evaluation plus six (6) visi for outpatient and home settings Transplants including Solid Organ and Bone Marrow (Cornea transplant does not require stuthorization) Transportation: non-emergent ambulance (ground and air) Unlisted, Miscellaneous and T (Temporary) Codes (In any setting): Molina requires standard codes when requesting authorization. Should an unlisted or miscellaneous code be requested, medical necessity documentation and rationale must be submitted with the prior authorization request. Wo

(Medicaid benefit only

MolinaHealthcare.com



Hospitals

Emergency Care

A medical screening exam performed by licensed medical personnel in the emergency department and subsequent emergency care services rendered to the member do not require PA from Molina Healthcare.

Members accessing the emergency department inappropriately will be contacted by Molina Healthcare Care Managers whenever possible to determine the reason for using emergency services. Care Managers will also contact the primary care provider (PCP) to ensure that members are not accessing the emergency department because of an inability to be seen by the PCP.



Hospitals

Admissions

Hospitals are required to notify Molina Healthcare within 24 hours or the first working day of any inpatient admissions, including deliveries, in order for hospital services to be covered. PA is required for inpatient or outpatient surgeries. Retroactive authorization requests for services rendered will normally not be approved.

Claims Submissions

Claims must be submitted in accordance with the guidelines and processes set forth in the "Claims" section of the provider manual.



Non-emergent Transportation

Molina Healthcare provides coverage for non-emergent transportation for Molina Marketplace Silver plan members who meet certain requirements.

- Non-emergent, non-medical transportation is available to members who have non-emergent transportation as a covered service and are recovering from a serious injury or medical procedure that prevents them from driving to a medical appointment. The member must have no other form of transportation available.
- Non-emergent, non-medical transportation for members to medical services can be supplied by a passenger car, taxi cabs or other forms of public/private transportation.
- PA is required to access these services.
- Members should call the transportation vendor at least two to three business days before the appointment to arrange this transportation.
 To find out if this is a covered service for your patient, please contact Molina Healthcare at (855) 322-4079.



Access to Care Standards

Providers will not discriminate against any member on the basis of age, race, creed, color, religion, sex, national origin, sexual orientation, marital status, physical, mental or sensory handicap, place of residence, socioeconomic status, or status as a recipient of Medicaid benefits. Members' medical (physical or mental) condition or the expectation of frequent or high-cost care may not negatively affect the care received. Providers must give Molina Healthcare 30 days written notice if closing a panel to new members.

Office Wait Times

- Not to exceed 30 minutes
- Primary Care Providers (PCPs) are required to monitor waiting times and adhere to standard

After Hours Care

- Providers must have backup (on call) coverage 24/7
 - It may be an answering service or recorded message
 - It must instruct members with an emergency to hang up and call 911 or go to the nearest emergency room

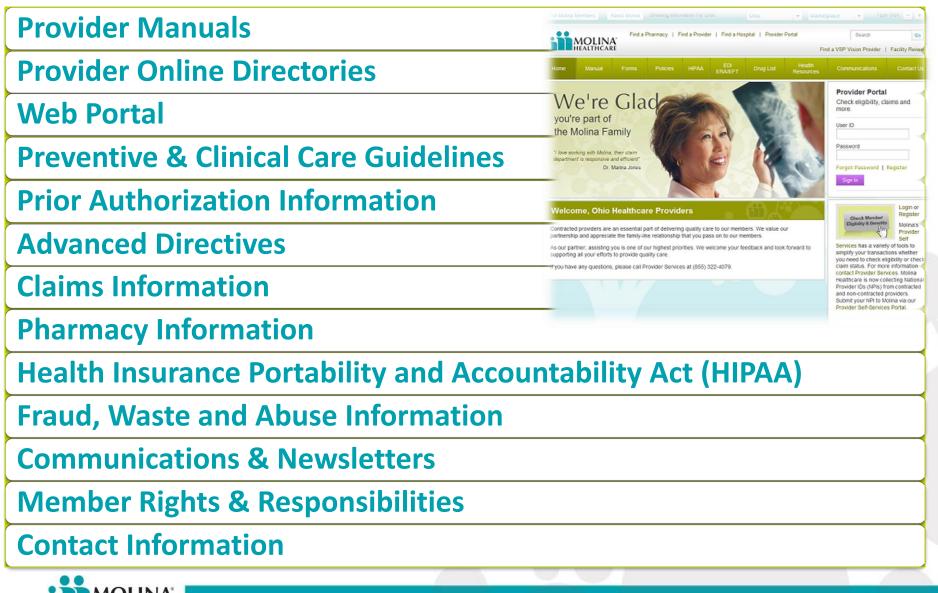


Access to Care Standards

Category	Type of Care	Access Standard	
Primary Care Provider	Preventive/routine care	Within six weeks	
(general practitioners,	Urgent care	By the end of the following work day	
internist, family	Emergent care	Triaged and treated immediately	
practitioners, pediatricians)	After hours	Available by phone 24 hours a day, seven days a week	
OB/GYN	Pregnancy (initial visit)	Within two weeks	
	Routine visit	Within six weeks	
Orthopedist	Routine visit	Within eight weeks	
Otolaryngologist	Routine visit	Within six weeks	
Dermatologist	Routine visit	Within eight weeks	
Dental	Routine visit	Within six weeks	
Endocrinologist	Routine visit	Within eight weeks	
Neurologist	Routine visit	Within eight weeks	
Behavioral health	Routine care	Within 10 business days	
	Urgent care	Within 48 hours	
	Non-life threatening	Within six hours	
Other non-primary care	Routine care	Within eight weeks	
All	Office wait time	Maximum of 30 minutes	



Provider Online Resources



Your Extended Family

Provider Web Portal

The Web Portal is secure and available 24 hours a day, seven days a week. Register for access to our Web Portal for self-services, including:

Member eligibility verification and history	Claims status inquiry
Coordination of benefits (COB)	Member Nurse Advice Line call reports
Update provider profile	Healthcare Effectiveness Data and Information (HEDIS [®]) missed service alerts for members
View Primary Care Provider (PCP) member roster	Status check of authorization requests
Online chat with Care Manager	Secure emailing with Molina Healthcare
Clear Coverage [™] - submit online service and prior authorization requests	Submit claims, corrected claims, and voided claims



Register for Web Portal

Register at <u>www.MolinaHealthcare.com/Providers/OH</u>. You will need the TIN and your Provider Identification number or three of the following: NPI, State License Number, Medicaid Number, or DEA Number.

Home	manual	forms	policies	HIPAA	EDI ERA/EFT	Rx info	health resources	communications	contact us
you're the N	e part of lolina Fa king with Molina, it is responsive a Dr.	amily their claim	d					Provider Portal Check eligibility, cla more. User ID I Password Forgot Password I Sign In	aims and



Registration Instructions

1. Begin registration

- Click "New Registration Process"
- Select "Other Lines of Business"
- Select state
- Select role type "Facility or Group"
- Click "Next"

3. Username and Password

- Create a user ID using 8-15
 characters
- Create a unique password with 8-12 characters
- Select three security questions and answers

2. Required Fields

- Enter first name
- Enter last name
- Enter email address
- Enter email address again to confirm

4. Complete Registration

- Accept "Provider Online User Agreement" by clicking on the check box
- Enter the code in the textbox as shown in the image
- Click "Register"



Member Eligibility Search

Provider Portal	Member Search Enter Member ID or First and Last Name and Date of Birth.
Member Eligibility	Member ID:
Claims	Or First Name: Last Name:
Service Request/Authorization	Date of Birth:
Member Roster	(mmddyyyy)
HEDIS Profile New!	Search Options
Reports	Gender: Select Zip Code:
Links	Line of Business: Select
Forms	
Account Tools	o see member eligibility from certain date enter date here: 02/04/2015 (mmddyyyy)

Click *Member Eligibility* from the main menu. Search for a Member using Member ID, First Name, Last Name and/or Date of Birth. When a match is found, the Web Portal will display the member's eligibility and benefits page.



Verifying Member Eligibility

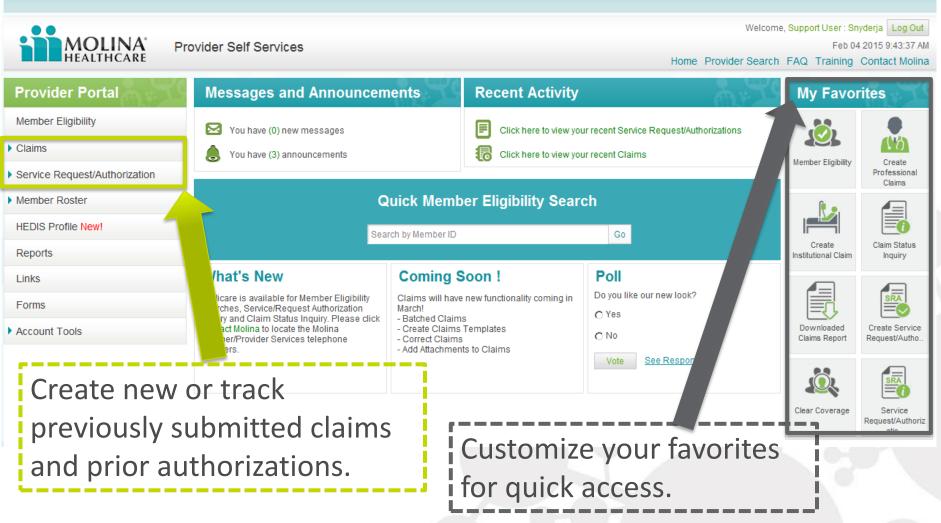
Molina Healthcare offers various tools to verify member eligibility. Providers may use our online self-service Web Portal, integrated voice response (IVR) system, eligibility rosters or speak with a customer service representative.

Please note: At no time should a member be denied services because his or her name does not appear on the eligibility roster. If a member does not appear on the eligibility roster, please contact Molina Healthcare for further verification.

Web Portal: https://eportal.molin ahealthcare.com/ Provider/login Provider Services/24hour IVR Automated System: (855) 322-4079



Web Portal





Provider Portal

Member Eligibility

Claims

Claims Status Inquiry

- Create Professional Claim (CMS 1500)
- Create Institutional Claim (UB04)

Open Incomplete Claim

Export Claims Report to Excel

- Service Request/Authorization
- Member Roster

HEDIS Profile New!

Reports

Links

Forms

Account Tools

Web Portal

You can also build claims and submit a batch of claims all at once.

- Complete a claim following the normal process.
- Then, instead of submitting, select "Save for Batch."
- Claims saved for a batch can be found in the "Saved Claims" section in the side menu.
- Ready-to-batch claims need to be selected and then can be submitted all at once.





Web Portal

Next >>		Save for Later Cancel
Member Prov	ider Summary	*- Required Field Help FAO
What would you like to do?* O Create Claim Prior Claim ID#:* Eligibility Check	Correct Claim O Void Claim Enter	
Enter Claim ID number here.	claim through select "Create "Correct Claim	ed claims or void a the Web Portal. First Claim," then select the " or "Void Claim" ter the previously ID number.



Provider Online Directory

Home	Find A Pharmacy	Find A Provider	Find A Hospital/Facility
Find A Provider			Aug 06 2015 3:14:36 PM
*Required			
Enter Your Location			Quick Name Search
			State* OH 🔽
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Molina Healthcare providers are encouraged to use the Online Provider Directory on our website to find a network provider or specialist.

To find a Molina Healthcare provider, visit

<u>www.MolinaHealthcare.com /Providers/OH</u> and click "Find a Doctor or Pharmacy."



Claims Submission Options

Clearinghouse

EDI or electronic claims are processed faster than paper claims. Providers may use any clearinghouse. Note that fees may apply. Emdeon is the outside vendor used by Molina Healthcare. Use payer ID: 20149 Emdeon phone: (877) 469-3269

Provider Web Portal

Online submission through the Web Portal at www.MolinaHealthcare.com/provider/login

Paper claims directly to Molina Healthcare

Attn: Molina Marketplace Claims, P.O. Box 22712, Long Beach, CA 90801



Corrected Claims

Use the Corrected Claims Form on our website. Providers have 120 days from the date of original remittance advice.

Mail completed form and corrected claim to:

P.O. Box 22712, Long Beach CA 90801



EDI Submission Issues





Claims Reconsiderations

Call the EDI customer service line at (866) 409-2935. Requests must be received within 120 days from the date of original remittance advice. Fax (800) 499-3406 Mail to: Provider Services P.O. Box 349020 Columbus, OH 43234-9020

For help with any claims related process, contact Provider Services at (855) 322-4079.



Electronic Payments

Molina Healthcare partners with our payment vendor, **FIS Change Healthcare**, for Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA). Access to Change Healthcare is **FREE** to our providers. Providers are encouraged to register after receiving their first check from Molina Healthcare. Here's how:

Change Healthcare Access

- **1. Register for Change Healthcare online**
- 2. Verify your information
- 3. Enter your user account information
- 4. Verify payment information



Electronic Payment Instructions

- Go to: https://providernet.adminisource.com
- Click "Register"
- Accept the terms
- Select Molina Healthcare from the payers list
- Enter your primary NPI
- Enter your primary tax ID
- Enter recent claim and/or check number
- Use your email address as username
- Strong passwords are enforced (eight or more characters of letters and numbers)
- Bank account and payment address
- Changes to address may interrupt EFT process
- Add additional addresses, accounts, & tax IDs after login



Benefits of Change Healthcare

Ability to associate new providers within your organization to receive Electronic Fund Transfer (EFT)/835s

Administrative rights to sign-up/manage your own EFT account

View/print/save PDF versions of your explanation of payment (EOP)

Historical EOP search by various methods (i.e. claim number, member name)

Ability to route files to your file transfer protocol (FTP) and/or clearinghouse



HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) requires providers to implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability, and integrity of a member's **protected health information (PHI)**. Providers should recognize that identity theft is a rapidly growing problem and that their patients trust them to keep their most sensitive information private and confidential.

Molina Healthcare strongly supports the use of electronic transactions to streamline health care administrative activities. Providers are encouraged to submit claims and other transactions using electronic formats. Certain electronic transactions are subject to HIPAA's Transactions and Code Sets Rule including, but not limited to, the following:

- Claims and encounters
- Member eligibility status inquiries and responses
- Claims status inquiries and responses
- Authorization requests and responses
- Remittance advices

Molina Healthcare is committed to complying with all HIPAA Transaction and Code Sets standard requirements. Providers who wish to conduct HIPAA standard transactions with Molina Healthcare should refer to: <u>HIPAA Transactions</u>



Fraud, Waste and Abuse

Molina Healthcare seeks to uphold the highest ethical standards for the provision of health care services to its members, and supports the efforts of federal and state authorities in their enforcement of prohibitions of fraudulent practices by providers or other entities dealing with the provision of health care services.

Do you have suspicions of member or provider fraud? The **Molina Healthcare AlertLine** is available 24 hours a day, seven days a week, and even on holidays at (866) 606-3889. Reports are confidential, but you may choose to report anonymously.



Fraud, Waste and Abuse

Abuse

Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the Medicare and Medicaid programs, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicare and Medicaid programs. (42 CFR § 455.2)

Fraud

An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. (42 CFR § 455.2)



Examples of Fraud, Waste and Abuse

Health care fraud includes, but is not limited to, the making of intentional false statements, misrepresentations or deliberate omissions of material facts from, any record, bill, claim or any other form for the purpose of obtaining payment, compensation or reimbursement for services.



Examples of Fraud, Waste and Abuse

Member

- Lending an ID card to someone who is not entitled to it
- Altering the quantity or number of refills on a prescription
- Making false statements to receive medical or pharmacy services
- Using someone else's insurance card
- Including misleading information on or omitting information from an application for health care coverage or intentionally giving incorrect information to receive benefits
- Pretending to be someone else to receive services
- Falsifying claims



Examples of Fraud, Waste and Abuse

Provider

- Billing for services, procedures or supplies that have not actually been rendered
- Providing services to patients that are not medically necessary
- Balance billing a Medicaid member for Medicaid covered services
- Double billing or improper coding of medical claims
- Intentional misrepresentation of benefits payable, dates rendered, medical record, condition treated/diagnosed, charges or reimbursement, provider/patient identity, "unbundling" of procedures, non-covered treatments to receive payment, "upcoding," and billing for services not provided
- Concealing patients misuse of ID card
- Failure to report patient's forgery/alteration of a prescription

