

Contract Compliance: Maggie Seal**Contract Review and Certification**

I attest that this CSF, Contract(s)/Amendment(s) have been reviewed in full  
and the information is accurate and complete.

**CONTRACTOR/NETWORK MANAGEMENT CONSULTANT/REPRESENTATIVE**Signature: [Signature]Date: 10-10-16**DIRECTOR**

I attest that the contract has been reviewed, and the information is accurate and complete.

Signature: [Signature]Date: 10-10-2016**LEGAL DEPARTMENT**

I have reviewed and approved the non-standard language used in this contract.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**HEALTHCARE ANALYTICS**

I have received and approved the fee schedule/rates.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**REGIONAL VICE PRESIDENT**

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**MEDICAL DIRECTOR (as necessary)**

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**PROVIDER OPERATIONS (PO)**Date Routed to PO: October 14, 2016

Date Received: \_\_\_\_\_

Signature: Maggie Seal

Date: \_\_\_\_\_

Retroactive Effective Date? Y/N Approved? \_\_\_\_\_

M \_\_\_\_\_

R \_\_\_\_\_

RA \_\_\_\_\_

Effective Date: \_\_\_\_\_

Date Returned to CC \_\_\_\_\_

**PROVIDER REIMBURSEMENT (PR)**

Date Routed to PR: \_\_\_\_\_

Date Received: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Date Loaded: \_\_\_\_\_

Date Routed to PDO \_\_\_\_\_

Date Returned to CC: \_\_\_\_\_

**PROVIDER DATABASE OPERATIONS (PDO)**

Date Routed to PDO: \_\_\_\_\_

Date Received: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Date Loaded: \_\_\_\_\_

Date Routed to PDO \_\_\_\_\_

**CONTRACT COMPLIANCE (CC)**

Date Routed to CC: \_\_\_\_\_

Date Received: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



# Common Submission Form

New Contract Or Amendment

☐ N/A ☒ This Is A New Contract ☐ This Is An Amendment

Tracking # 10000

CSF Purpose: Add Provider

☒ Priority Handling Requested

Tax ID: 385345286

## A) Business Intent:

Discuss Business Intent

Demographic Change Only?

☐ YES

☒ NO

This provider has recently joined the practice and needs to be added.

## B) Retroactivity:

Will this CSF result in retroactivity? (REQUIRED)

☐ YES

☒ NO

\* If this CSF is a New Contract or an Amendment, is it the result of a:

☐ Not Result of Contract or Amendment

☒ Negotiation

☐ Quality Issue

\* Responsible Party / Market

nent

\* Retroactivity Reason

Responsible Party / PO

Network Management

\* Retroactivity Effective Date:

Retro Adjustments Requested?

Retroactivity Comments:

Estimated Dollar Amount of Adjustment:

☐ Interest Owed?

Prompt Pay Interest Comments:

Date Issue Identified:

Image Number 1912998936

## C) PDO Updates:

Are PDO Updates Required?

☐ YES

☒ NO

Number of Individual Providers =

1

Number of QCare Records To Be Updated =

1

## D) Completed By Information:

Name: Susan Hayes

Start Date:

9/1/2017

Actual Date Rec'd:

8/15/2017

Phone: 617-270-4000

## E) Provider Information:

QCare ID:

State License #:

NPI #: 1712983465

First Name: Janet

Middle Initial: K.

Last Name/  
Facility/Ancillary: Lawrence

Suffix: Title: DDS

Contact Name:

Contact #: 617-270-4000

Ext. 3122

Contact E-mail: jlance@massgeneral.org

Gender: F

DEA Number:

DEA Expiration Date:

Medicare Number:

Tracking # 10000

## F) Group Information:

<b>Attention:</b> _____	<b>Provider Group Name:</b> _____
<input checked="" type="checkbox"/> Group Agreement Applies	
<b>PHO Designation:</b> _____	
Blanket Agreement _____	<input checked="" type="checkbox"/> Requires New Pricing Grid
<input checked="" type="checkbox"/> Are the Mid-Level Providers Included in this Agreement	<input checked="" type="checkbox"/> Not Eligible To Reapply

**G) Tax Information:**

Tax ID: 583111789	Tax Name: Mass General	NPI #: 1712983465
2nd Tax ID: _____	2nd Tax Name: _____	2nd NPI #: _____

**H) ProviderType:**

Cardiac Specialist	
<b>Provider Type Comments:</b> Dr. Lawrence is focused specifically on cardiology for pediatric patients.	

**I) Location Information:**

Address Type: Physical	Address1: 55 Fruit St	Address2: _____	City: Boston	State: MA	Zip: 02114	Market: _____	County: Suffolk	
Phone: 617-270-4000 ext. 3122	Fax: _____	<input checked="" type="checkbox"/> Primary						

  

Address Type: Physical	Address1: 30 Longwood Ave	Address2: Suite 500	City: Cambridge	State: MA	Zip: 02139	Market: _____	County: Middlesex
Phone: _____	Fax: _____	<input checked="" type="checkbox"/> Primary					

  

Address Type: _____	Address1: _____	Address2: _____	City: _____	State: _____	Zip: _____	Market: _____	County: _____
Phone: _____	Fax: _____	<input checked="" type="checkbox"/> _____					

  

Address Type: _____	Address1: _____	Address2: _____	City: _____	State: _____	Zip: _____	Market: _____	County: _____
Phone: _____	Fax: _____	<input type="checkbox"/> _____					

**J) Covering Physician:****K) Specialty:**

Specialty: Cardiology	Board Status: _____	Age - Low: _____	Age - High: _____
	Panel Size: _____	Accepting New Patients: _____	

Waiver Indicator

Waiver Update:

☐ YES☒ NO

**L) Hospital Privilege:****M) Language:**

Staff Language:

Practitioner Language:

**N) Contract Status:**☐ Credentialed Application

CAQH

Current Panel Size:

Date Sent to Andover

Date Returned from Andover

Credentialing Date Approved

**O) Member Move:**

Indicate where to move members if it is required

**P) Billing/Contract Information :**

Billing Format:

CMS1500

Existing Contract ID:

Contract Status:

☐ Affiliated With An Existing Contract?**Q) Contract Type: (Professional/Facility/Ancillary)**

Type	Network	ID Type	ID	Contract Dates		
Professional	PPO	SPEC	3847	Effective	Termination	Expire
<input checked="" type="checkbox"/> Regardless Of Billed <input type="checkbox"/> Lesser Of Charges <input type="checkbox"/> Site Of Service <input type="checkbox"/> Drugs Reimbursed at Corporate Methodology <input type="checkbox"/> If Capitated, Over & Above				<input type="checkbox"/> Use Current Date -->> 9/1/2017 <input type="checkbox"/> Is Contract Evergreen		
<input type="checkbox"/> Medicare Based Fee Year <input type="text"/> <input type="checkbox"/> Update With Medicare A1 <input type="text"/> % A2 <input type="text"/> %				<b>Blanket Agreement</b> Effective Date <input type="text"/> Termination Date <input type="text"/>		
				Timeliness Of Filing <input type="text"/>		
Termination Reason: <input type="text"/>						

Type	Network	ID Type	ID	Contract Dates		
Professional	Traditional (PAR)	SPEC	3403	Effective	Termination	Expire
<input type="checkbox"/> Regardless Of Billed <input type="checkbox"/> Lesser Of Charges <input type="checkbox"/> Site Of Service <input type="checkbox"/> Drugs Reimbursed at Corporate Methodology <input type="checkbox"/> If Capitated, Over & Above				<input checked="" type="checkbox"/> Use Current Date -->> <input checked="" type="checkbox"/> Is Contract Evergreen		
<input checked="" type="checkbox"/> Medicare Based Fee Year <input type="text"/> <input checked="" type="checkbox"/> Update With Medicare A1 <input type="text"/> % A2 <input type="text"/> %				<b>Blanket Agreement</b> Effective Date <input type="text"/> Termination Date <input type="text"/>		
				Timeliness Of Filing <input type="text"/>		
Termination Reason: <input type="text"/>						

Tracking #

Contract Other Comments

Medicare Advantage-HMO-Facility  
Medicare Advantage-HMO-Professional  
Medicare Advantage-PPO-Facility  
Medicare Advantage-PPO-Professional

Medicare Advantage-HMO-Facility-2  
Medicare Advantage-HMO-Professional-2  
Medicare Advantage-PPO-Facility-2  
Medicare Advantage-PPO-Professional-2

IRF	NST / GNT	Pricing Code

**R) Contract Language:**

Contract Language

☒ Red Line Attached

Contract Language Comments

Specify contract intent if Non-Standard:

**S) Contract Reimbursement:**

Date Fee Schedule Requested From HCA

Standard

Discuss intent of reimbursement structure if Non-Standard:

Chargemaster Adjustment Comments

- ☒ Do reimbursement terms change mid-contract
- ☐ Automatic Rate Increase
- ☐ Index Adjustment
- ☐ Chargemaster Adjustment
- ☐ Change in Capitation Reporting Requirements
- ☐ Includes withhold on risk pool

- ☐ Does this contract qualify as an INC under the terms of the Managed Care Settlement
- ☐ Custom Reimbursement (higher than region standard)
- ☐ Termination Not For Cause (Other than 120 days)
- ☐ Fee Schedule can be reduced more than once per year
- ☐ Non-Standard reimbursement for Vaccines/Injectibles

Default Pricing

PA Exceptions

Add Provider

Add Tax ID

Tax Effective Date

Reason for  
Additional Tax ID

Change Tax ID

Reason for Tax ID change

Should the CURRENT Tax Affiliation be terminated? (Applies only if the Tax info is changing)

Add Other

Change Other

**T) Special Instructions:**

Comments

☒ Submitted

Date Submitted: 8/31/2017

CSF # 87489

## Georgia Provider Solutions CSF Verification List

Question #	Question	Response		Additional Instructions
#1	Did you include the CSF Purpose?	YES	N/A	
#2	Did you include the applicable Tax id(s)?	YES	N/A	If this update applies to multiple tax id's, please indicate multiple and use the special instructions field to indicate what documentation is provided to indicate the tax id's; i.e. a spreadsheet or roster.
#3	Has the Business Intent been completed?	YES	N/A	
#4	Is this a retro?	YES	N/A	
#5	Do you have a signed LOA?	YES	N/A	
#6	Does the end date on your LOA meet the processing time requirements?	YES	N/A	
#7	Does your retro require adjustments?	YES	N/A	
#8	Did you include the retro # and copy of approval?	YES	N/A	
#9	Did you include the retro reason?	YES	N/A	
#10	Did you include the prompt pay form?	YES	N/A	
#11	Did you include the Image/File Net Number?	YES	N/A	
#12	Did you indicate if PDO updates are required?	YES	N/A	
#13	Did you indicate the number of individual providers and records to be updated?	YES	N/A	
#14	Have you included the name of the Provider (First and Last) or the name of the Group/Facility?	YES	N/A	
#15	Did you include the NPI?	YES	N/A	
#16	Is this a group agreement?	YES	N/A	
#17	Does PHO designation apply?	YES	N/A	
#18	Does your Agreement/Amendment include mid-level providers?	YES	N/A	
#19	Should a center record be created?	YES	N/A	
#20	Did you include the provider's telephone number?	YES	N/A	
#21	Have you included the Tax name of the Provider, Group or Facility?	YES	N/A	
#22	Have you included the Tax NPI for the Provider, Group or Facility?	YES	N/A	
#23	Did you indicate the Provider type?	YES	N/A	
#24	Did you include all applicable physical and mailing locations?	YES	N/A	
#25	Did you include the Specialty?	YES	N/A	
#26	Did you include the Credentialing sheet or Non-Cred application (applies to new providers)?	YES	N/A	
#28	Did you indicate the Contract type?	YES	N/A	

  

Question #	Question	Response		Additional Instructions
#29	Did you indicate all applicable Networks and the Contract ID for each Network?	YES	N/A	
#30	Did you indicate effective date?	YES	N/A	
#31	Is this an Individually Negotiated Contract?	YES	N/A	If N/A, skip to #46
#32	Does Lesser of Language Apply?	YES	N/A	
#33	Does Site of Service Language Apply?	YES	N/A	
#34	Are Drugs reimbursed at Corporate Methodology?	YES	N/A	
#35	Is this a Medicare Based Fee? What Year?	YES	N/A	
#36	If not priced by Medicare, is the fee based on RBRVS (Resource Based Relative Value Schedule)?	YES	N/A	
#37	Did you include the Medicare Rate Sheet?	YES	N/A	
#38	Did you include the Medicare Advantage GNT(s)?	YES	N/A	
#39	Did you include the Medicare Advantage iRF(s)?	YES	N/A	
#40	Does Lab Pricing apply (applies only to HMO)?	YES	N/A	
#41	Does the Statewide In office lab list apply (applies only to HMO)?	YES	N/A	
#42	Did you include the Reimbursement Attachment/Rate Sheet?	YES	N/A	
#43	Did you include a Fee Schedule (for new contract or newly negotiated contract; if there are more than 20 codes)?	YES	N/A	
#44	Did you include the QHIP Scorecard (only for QHIP rate increases)?	YES	N/A	
#45	If the Contract has to be built, is the effective date more than 25 days from current date? (if not it is a retro)	YES	N/A	
#46	Did you indicate TOF for all Networks?	YES	N/A	
#47	Does this request include Medicare? Did you provide the Medicare Advantage Contract Code?	YES	N/A	
#48	Do you have Special Instructions? If so, they should be aligned to the Business Intent.	YES	N/A	
#49	Is Network Management Director Signature Required?	YES	N/A	
#50	Is Healthcare Analytics Signature required?	YES	N/A	
#51	Is Legal's Signature required?	YES	N/A	
#52	Did you include the signed Contract or Amendment?	YES	N/A	
#53	Did you include the PCS (Plan Compensation Schedule) and PCS Attachment?	YES	N/A	
#54	Should this CSF go to Contract Compliance?	YES	N/A	

Completed by: **SONIA FERRIS**

## Ferris, Sonia

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**From:** Lawrence, Deborah  
**Sent:** Thursday, October 13, 2016 9:37 AM  
**To:** Sood, Pawan; Ferris, Sonia  
**Subject:** Retro 16202 Approvals Complete

Retro 16202 approvals are complete.

Provider: Schultz, Jeffrey  
Anthem Id(s): 52027437  
Contract Manager: Ferris, Sonia  
Provider Type: Professional  
Market: Georgia  
Business Unit:  
Impact (Estimated claims): 100  
Name of Requestor: Ferris, Sonia

Type: Request

Reason: PS-Retro Changes due to Network Management Submission Error =<1K Claims

[View Retro Details](#)