

Contract Compliance: *Magill***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: *SV*Date: *10/10/16***DIRECTOR**

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

Signature: *Deb Gammie*Date: *10/11/2016***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: *Deb Gammie*

Date Received:

Signature: *Magill*

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: *Deb Gammie*

Date Received:

Signature: *Magill*

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 # 87487

CSF Purpose: Termination

 Priority Handling Requested

Tax ID: 582145629

**A) Business Intent:**

Discuss Business Intent

Demographic Change Only?

 YES NO

Please terminate provider from Medical contracts only at location, 182 Jefferson Pkwy, Ste A, Newnan, GA 30263. The other locations have been completed previously. He is remaining active at the locations as NON PAR (load as IDNP) on the Medical side. Correspondence attached

**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

Network Management

\* Retroactivity Reason

NM-Retro Changes due to Network management Submission Error &lt;1k claims

Responsible Party / PO

\* Retroactivity Effective Date

3/10/2016

 Retro Adjustments Requested?

Retroactivity Comments:

csi # 12606 Retro ID 16206

Estimated Dollar Amount of Adjustment:

Prompt Pay Interest Comments:

N/A

 Interest Owed?

Date Issue Identified:

Image Number 1912929878

**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: Sonia Ferris

Start Date:

10/10/2016

Actual Date Rec'd:

2/26/2016

Phone: (404) 842-8703

**E) Provider Information:**

QCare ID:

State License #:

NPI #: 1912929878

First Name: Vincent

Middle Initial: J

Last Name/Facility/Ancillary: Perciaccante

Suffix:

Title: DDS

Contact Name:

Contact #:

Ext.

Contact E-mail:

Gender:

DEA Number:

DEA Expiration Date:

Medicare Number:

Tracking # 87487

**F) Group Information:**

Attention: Provider Group Name:  Group Agreement AppliesPHO Designation: Blanket Agreement  Requires New Pricing Grid Are the Mid-Level Providers Included in this Agreement Not Eligible To Reapply**G) Tax Information:**Tax ID:  582145629Tax Name: South OMS NPI #:  1720274798

2nd

Tax ID: 

2nd

Tax Name: 

2nd

NPI #: **H) ProviderType:** SpecialistProvider Type  
Comments: **I) Location Information:**Address Type:  PhysicalAddress1:  406 Stevens EntryAddress2: City  Peachtree CityState:  GAZip:  30269Market: County: Phone: Fax:  PrimaryAddress Type:  PhysicalAddress1:  288 Hwy 314Address2: City  FayettevilleState:  GAZip:  30214Market: County: Phone: Fax:  PrimaryAddress Type:  PhysicalAddress1:  182 Jefferson PkwyAddress2:  Suite ACity  NewnanState:  GAZip:  30263Market: County: Phone: Fax:  Primary**J) Covering Physician:****K) Specialty:**Specialty:  ORAL SURGERYBoard 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 ApplicationCAQH 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:  CMS1500Existing Contract ID: Contract Status:  Affiliated With An Existing Contract?**Q) Contract Type: (Professional/Facility/Ancillary)**

Type	Network	ID Type	ID
Professional	PPO	SPEC	2842

 Use Current Date -->

Contract Dates		
Effective	Termination	Expire
<input type="text"/> 3/10/2016	<input type="text"/>	<input type="text"/>

 Is Contract Evergreen

- Regardless Of Billed
- Lesser Of Charges
- Site Of Service
- Drugs Reimbursed at Corporate Methodology
- If Capitated, Over & Above

Blanket Agreement		
Effective Date	Termination Date	
<input type="text"/>	<input type="text"/>	

<input type="checkbox"/> Medicare Based Fee	Year <input type="text"/>	<input type="checkbox"/> RBRVS
<input type="checkbox"/> Update With Medicare	A1 <input type="text"/> %	A2 <input type="text"/> %

Timeliness Of Filing  180 DaysTermination Reason: 

Type	Network	ID Type	ID
Professional	Traditional (PAR)	SPEC	3400

 Use Current Date -->

Contract Dates		
Effective	Termination	Expire
<input type="text"/> 3/10/2016	<input type="text"/>	<input type="text"/>

 Is Contract Evergreen

- Regardless Of Billed
- Lesser Of Charges
- Site Of Service
- Drugs Reimbursed at Corporate Methodology
- If Capitated, Over & Above

Blanket Agreement		
Effective Date	Termination Date	
<input type="text"/>	<input type="text"/>	

<input type="checkbox"/> Medicare Based Fee	Year <input type="text"/>	<input type="checkbox"/> RBRVS
<input type="checkbox"/> Update With Medicare	A1 <input type="text"/> %	A2 <input type="text"/> %

Timeliness Of Filing  365 DaysTermination Reason:

Tracking # 87487

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

### Chargemaster Adjustment Comments

Discuss intent of reimbursement structure if Non-Standard:

- 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/Injectables

## 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

Tracking # 87487

Submitted

Date Submitted: 10/10/2016 3:14:31 PM

## **Ferris, Sonia**

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**From:** Lawrence, Deborah  
**Sent:** Friday, October 14, 2016 2:27 PM  
**To:** Sood, Pawan; Ferris, Sonia  
**Subject:** Retro 16206 Approvals Complete

Retro 16206 approvals are complete.

Provider: Vincent Perciaccante, Vincent Perciaccante

Anthem Id(s): NA

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](#)

CSF # 87487

## Georgia Provider Solutions CSF Verification List

Question #	Question	Response	Additional Instructions	Question #	Question	Response	Additional Instructions
#3	Did you include the CSF Purpose?	YES	N/A				
#2	Did you include the applicable Tax id(s)?	<input checked="" type="checkbox"/>	N/A				
#3	Has the Business Intent been completed?	<input checked="" type="checkbox"/>	N/A				
#4	Is this a retro?	<input checked="" type="checkbox"/>	N/A				
#5	Do you have a signed LOA?	YES	<input checked="" type="checkbox"/>				
#6	Does the end date on your LOA meet the processing time requirement?	YES	N/A				
#7	Does your retro require adjustments?	<input checked="" type="checkbox"/>	N/A				
#8	Did you include the retro ID and copy of approval?	<input checked="" type="checkbox"/>	N/A				
#9	Did you include the retro reason?	<input checked="" type="checkbox"/>	N/A				
#10	Did you include the prompt pay form?	YES	<input checked="" type="checkbox"/>				
#11	Did you include the Image/Files Net Number?	YES	<input checked="" type="checkbox"/>				
#12	Did you indicate if PPO updates are required? Did you indicate the number of individual providers and records to be updated?	<input checked="" type="checkbox"/>	N/A				
#13	Have you included the name of the Provider (First and Last) or the name of the Group/Facility?	<input checked="" type="checkbox"/>	N/A				
#15	Did you include the NPI?	<input checked="" type="checkbox"/>	N/A				
#16	Is this a group agreement?	<input checked="" type="checkbox"/>	N/A				
#17	Does PPO designation apply?	YES	<input checked="" type="checkbox"/>				
#18	Does your Agreement/Amendment include mid-level providers?	YES	<input checked="" type="checkbox"/>				
#19	Should a center record be created?	YES	<input checked="" type="checkbox"/>				
#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?	<input checked="" type="checkbox"/>	N/A				
#22	Have you included the Tax NPI for the Provider, Group or Facility?	<input checked="" type="checkbox"/>	N/A				
#23	Did you indicate the Provider type?	<input checked="" type="checkbox"/>	N/A				
#24	Did you include all applicable physical and mailing locations?	<input checked="" type="checkbox"/>	N/A				
#25	Did you include the Specialty?	<input checked="" type="checkbox"/>	N/A				
#26	Did you include the Credentialing sheet or Non-Cred application (applies to new providers)?	<input checked="" type="checkbox"/>	N/A				
#28	Did you indicate the Contract type?	<input checked="" type="checkbox"/>	N/A				
#29	Did you indicate all applicable Networks and the Contract ID for each Network?	<input checked="" type="checkbox"/>	N/A				
#30	Did you indicate effective date?	YES	N/A				
#31	Is this an individually Negotiated Contract?	YES	N/A				
#32	Does Lesser of Language Apply?	YES	N/A				
#33	Uses 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 (Reference 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 DRG(s)?	YES	N/A				
#40	Does Lab Pricing apply (applies only to HMO)? Does this statement in office lab test apply (applies only to HMO)?	YES	N/A				
#41	Did you include the Reimbursement Attachment/Rate Sheet?	YES	N/A				
#42	Did you include a Fee Schedule [for new contract or newly negotiated contract; if there are more than 70 codes]	YES	N/A				
#43	Did you include the CHIP Scorecard [only for CHIP rate increases]	YES	N/A				
#44	If the Contract has to be bolted, is the effective date more than 25 days from current date? (if not it is a retag)	YES	N/A				
#45	Did you indicate TOF for all Networks?	<input checked="" type="checkbox"/>	N/A				
#46	Does this contract include Medicare? Did this provide the Medicare Advantage Contract code?	YES	<input checked="" type="checkbox"/>				
#47	Do you have Special instructions? If so, they should be aligned to the Business Intent?	YES	<input checked="" type="checkbox"/>				
#48	Is Network Management Director Signature required?	<input checked="" type="checkbox"/>	N/A				
#49	Is Healthcare Analytics Signature required?	YES	<input checked="" type="checkbox"/>				
#50	Is Legal's Signature required?	YES	<input checked="" type="checkbox"/>				
#51	Did you include the signed Contract or Amendment?	YES	<input checked="" type="checkbox"/>				
#52	Did you include the signed PCS Attachment?	YES	<input checked="" type="checkbox"/>				
#53	Did you include the PCS (Plan Compensation Schedule) and PCS Attachment?	YES	<input checked="" type="checkbox"/>				
#54	Should this CSF go to Contract Compliance?	YES	N/A				

Completed By: SONIA FERRIS