PROVIDER*Update*

Health Net®

NEWS & ANNOUNCEMENTS | NOVEMBER 20, 2018 | UPDATE 18-842 | 3 PAGES

Upcoming Deadline for the Perinatal Notification Incentive Program Forms

Submit forms by Friday, January 11, 2019, for all services performed in 2018

Health Net Community Solutions, Inc. (Health Net) offers a Perinatal Notification Incentive Program (PNIP) for participating Medi-Cal practitioners who ensure timely access to care for pregnant and postpartum members. Eligible practitioners include obstetricians and gynecologists (OB/GYNs), other prenatal care specialists, and primary care physicians (PCPs).

Participation in the program requires filling out the attached Timely Prenatal Visit and Pregnancy Notification Form or the Postpartum Care Notification Form. Practitioners are encouraged to complete the appropriate form at the time of the visit and include it in the member's medical record.

To qualify for quarterly incentive payments of $50, PNIP forms must be submitted to Health Net prior to the close of each quarter. Members will also receive a $25 gift card from Health Net for each form submitted. Practitioners should:

- Accurately complete each section of the form and include the signature and the individual National Provider Identifier (NPI) of the practitioner who performed the prenatal or postpartum care.
- Submit PNIP forms within the required time frames via fax to 1-877-783-0287. A fax cover sheet must accompany all fax transmissions of Protected Health Information. The cover sheet must be labeled "PROTECTED HEALTH INFORMATION."

Note: The deadline to submit PNIP forms for all services performed in 2018 is Friday, January 11, 2019.

Physicians who receive PNIP supplemental payments will not be paid for the same measure under the PCP Healthcare Effectiveness Data and Information Set (HEDIS®) Improvement Program. This would create a duplicate payment.

The **minimum requirements** to qualify for an incentive payment include:

- Currently contracting with Health Net or a Health Net participating physician group (PPG) under the Medi-Cal program.
- No licensing or credentialing restrictions and in good standing with Health Net and their PPGs.
- A current W-9 form is on file. If not, fax a W-9 form to 1-877-783-0287.

For additional information about PNIP, contact your Provider Relations representative via email at HN_Provider_Relations@Healthnet.com. To download the PNIP forms, visit the provider website at provider.healthnet.com under *Working with Health Net > Quality > Maternity and Obstetrics > Perinatal Notification Incentive Program.*

THIS UPDATE APPLIES TO **CALIFORNIA** PROVIDERS:

- ● Physicians
- ● Participating Physician Groups
- ○ Hospitals
- ○ Ancillary Providers

LINES OF BUSINESS:

- ○ HMO/POS/HSP
- ○ PPO
- ○ EPO
- ○ Medicare Advantage (HMO)
- ● Medi-Cal
  - ● Kern
  - ● Los Angeles
    - ○ Molina
  - ● Riverside
  - ○ Sacramento
  - ● San Bernardino
  - ● San Diego
  - ● San Joaquin
  - ● Stanislaus
  - ● Tulare

PROVIDER SERVICES

1-800-675-6110
provider.healthnet.com

PROVIDER COMMUNICATIONS

provider.communications@healthnet.com
fax 1-800-937-6086

Health Net
COMMUNITY SOLUTIONS

TIMELY PRENATAL VISIT and PREGNANCY NOTIFICATION FORM

To qualify for the incentive:

- Complete this form for Health Net Medi-Cal members only and fax to [Health Net/PPG name] within seven days of the visit.
- This form must be signed by a primary care physician (PCP), OB/GYN, nurse practitioner, or certified nurse midwife.
- A timely prenatal visit is in the first trimester of pregnancy or within 42 days of enrollment into Health Net Medi-Cal.
- This form must be kept in the patient's medical record.

Fax to Health Net at 1-877-783-0287

Date of prenatal visit: _____

Member Information

First name:	**Last name:**
Medi-Cal ID # (CIN #):	**Date of birth:**
9	**Telephone number:**
Address:	**City:** / **ZIP code:**
Medical group name (also known as IPA or PPG):	

Primary Language

☐English ☐Spanish ☐Vietnamese ☐ Mandarin ☐Farsi ☐Korean ☐Arabic ☐Other_____

Pregnancy Information - Required

Pregnancy diagnosis confirmed: ☐Yes

LMP:_____ **or EDD:**_____

Is this a high-risk pregnancy? ☐Yes ☐ No

Gravida:	Para:	Abortions:	OR	Gestational age: weeks	Gestational age: days	Fetal heart rate: (pos. or neg.)	Fundal height: cm

Provider Information

Practitioner name:		**Clinic name:**	
Practitioner NPI:	**Specialty (OB/GYN, PCP, NP, or CNM):**	**Clinic address:**	
Office contact name:		**City:**	**County:**
Office telephone number:		**ZIP code:**	

☐ **I confirm that this document is also filed in the member's legal health/outpatient record.**

Practitioner signature:	**Date signed:**

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Health Net
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POSTPARTUM CARE NOTIFICATION FORM

To qualify for the incentive:

- Complete this form for Health Net Medi-Cal members only and fax to [Health Net/PPG name] within seven days of the visit.
- This form must be signed by a primary care physician (PCP), OB/GYN, nurse practitioner, or certified nurse midwife.
- The postpartum visit must be between three and eight weeks (21 to 56 days) after delivery.
- This form must be kept in the patient's medical record.

Fax to Health Net at 1-877-783-0287

Date of postpartum visit: _____

Member Information

First name:	**Last name:**	
Medi-Cal ID # (CIN #):	**Date of birth:**	
9	**Telephone number:**	
Address:	**City:**	**ZIP code:**
Medical group name (also known as IPA or PPG):		

Primary Language

☐English ☐Spanish ☐Vietnamese ☐ Mandarin ☐Farsi ☐Korean ☐Arabic ☐Other:_____

Postpartum Assessment

Date of delivery: _____ Hospital: _____

☐ **Confirmation of live birth** **BP: _____** **Weight: _____**

Abdomen	☐ Normal ☐ Abnormal	**Comments:**
Breasts	☐ Normal ☐ Abnormal ☐ Breastfeeding	**Comments:**

OR

Pelvic	**Uterus:_____** **Cervix: _____** **Other comments:**	**Pap test: (optional)** ☐ Normal ☐ Abnormal

Additional comments/visit notes:

Provider Information

Practitioner name:		**Clinic name:**	
Practitioner NPI:	**Specialty (OB/GYN, PCP, NP, or CNM):**	**Clinic address:**	
Office contact name:		**City:**	**County:**
Office telephone number:		**ZIP code:**	

☐ **I confirm that this document is filed in the member's legal health/outpatient record.**

Practitioner signature:	**Date signed:**

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