HEALTH OHIO NETWORK, LLC.
HON

An Ohio Preferred Provider Network

Physician/Provider's Manual

Health Ohio Network, LLC.
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Introduction

Health Ohio Network, LLC. (HON) is a Preferred Provider Organization (PPO) created to address clients' healthcare needs through a network of quality doctors, hospitals, and other healthcare professionals, in Ohio and adjacent states, and throughout the country.

In this managed care setting, HON's client/employers guarantee that they will encourage their participating employees to receive care from HON network providers. In return, the HON providers agree to accept the HON fee schedule for their services to patients.

HON is the only independent PPO in Ohio. HON clients and their employees are accessing the Health Ohio Network for a reason: quality providers, delivering quality healthcare, made available to all eligible participants, at a reasonable price.

THIS MANUAL IS INTENDED FOR THE USE OF HEALTHCARE PROVIDERS, AND THEIR STAFF. IT IS A REFERENCE FOR THEM, TO ACT AS A PRACTICAL GUIDE IN WORKING WITH HON AND IT'S CLIENTS.

PLEASE KEEP THIS MANUAL FOR FUTURE REFERENCE

IDENTIFICATION CARD

Covered persons are given an Identification Card from their Health Plan (Payor).

HON will use its best efforts to ensure that all Covered Persons will carry a card with the HON designation.

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TO VERIFY ELIGIBILITY AND BENEFITS, contact the Covered Person's Payor or Administrator, whose telephone number and address will appear on the identification card.

UTILIZATION MANAGEMENT. Consistent with quality patient care, Physician/Provider has agreed to accommodate Utilization Management criteria and advice, as confirmed by the name, telephone number and/or address that will appear on the identification card.

CLAIMS. Should be prepared on standard forms, and mailed to the designated Payor at address shown on the identification card. Electronic claims processing instructions will be provided by the claims Payor listed on the ID Card.

PROMPT PAYMENT MAY BE EXPECTED. Payment of a claim submitted to a Payor should be received by you within 30 days of repricing.

If the claim Payor establishes a pattern of sending payments exceeding the 30 day requirement, please notify your HON Provider Relations Representative. HON will contact the Payor and explain that claims must be paid within 30 days of the process date to remain in compliance with the HON Payor contract.

FEE SCHEDULE. Should there be questions regarding the HON fee schedule, please call the HON Provider Relations Department at (234) 380-5700.

PAYMENT AMOUNT. Physician/Provider has agreed to accept compensation derived from the OPN fee schedule, as payment in full.

PAYMENT INQUIRY PROCESS. If Physician has a question regarding reimbursement or any claim issue, please contact the claims payor.

PAYMENT APPEALS PROCESS. If the Physician is dissatisfied with the resolution of the Payment Inquiry Process, above, the Physician may institute a Payment Appeals Process. Physician has 60 days from the determination date of the Inquiry Process, to submit an Appeal.

During the Inquiry and Appeal Process, the Physician agrees not to bill the Covered Person.

All supporting documentation should be submitted in writing to the **Health Ohio Network Attn: Provider Relations Representative, P.O. Box 848, Hudson, Ohio 44236**, with the Provider Appeal Form (See attached Provider Appeal Form). Supporting documents include, but are not limited to, claim copies, operative reports, laboratory or radiology results, hospital or patient records.

If Physician is dissatisfied with the Appeal determination, Physician can submit an additional Appeal only if there is additional evidence or documentation, not previously submitted as part of the First Appeal.

Questions regarding the kind and scope of covered (or non-covered) services, Health Plan exclusions, and Health Plan limitations must be taken to the Payor not to Health Ohio Network, LLC.

PARTICIPATING PROVIDER REFERRALS. HON's Agreements with its Physicians/Providers require that, within the dictates of good practice and the best interest of the Covered Person under care, if a referral is deemed necessary, that such a ***referral be made to other HON participating Physician/Providers whenever possible.***

Referrals to other HON participating Physician/Providers is also important to the Covered Person, as such a provider may provide a considerable reduction in the Covered Person's out-of-pocket expense, in comparison with a non-participating Provider.

The addition of Physician/Providers to HON may occur faster than Provider Directories/Web Site are updated and distributed. HON maintains a referral service to accommodate Physician/Providers, Covered Persons, and Payors. The referral service may be accessed by calling HON at (234) 380-5700.

HOSPITAL ADMISSIONS. For Pre-Admission Certification, please call the Covered Person's Payor or Administrator, whose telephone number and address will appear on the identification card.

Pre-Admission Certification is not verification of covered medical expenses.

ADDITIONAL CONSIDERATIONS.

Patient and diagnostic services should be done on an outpatient basis when possible.

Where prudent, outpatient surgical procedures (at surgery centers, or in the Physician/Provider's office) are encouraged.

Inpatient admissions should be discharged as soon as medically prudent, with use of home healthcare to shorten the length of inpatient stay.

Inpatient diagnostic procedures should be recommended, consistent with high quality care to the patient.

CHANGES IN PHYSICIAN/PROVIDER STATUS. Physician/Provider should notify HON of any changes (or additions) in address, hospital or clinic affiliations, accreditation, levels of insurance or litigation, and/or any and all significant changes in the status of Physician/Provider's practice. Notification of such changes (See attached Provider Update Form), with copies of supporting documents as appropriate, should be mailed to **Health Ohio Network, LLC. Attn: Provider Relations Representative, P.O. Box 848, Hudson, OH 44236.**

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PROVIDER APPEAL FORM

Date: ______________________

Please provide HON with a reason for an Appeal, and attach a copy of the Claim, Explanation of Benefit Form, Post Operative Report, and any other relevant documentation, as applicable.

REASON FOR APPEAL:

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Physician/Provider Name: ____

Physician/Provider Signature:____

Tax ID Number: ____

Physician/Provider Address: ____

City: _______________________ State: __________________ Zip Code: ____________

Phone Number: ______________________________

Contact Person, if different from Physician/Provider: ______________________________

Email Contact Address: ____

Please return this form with copies of claim and additional documents to:

ATTN: Health Ohio Network, LLC. Provider Relations Representative,

P.O. Box 848, Hudson, OH 44236

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PROVIDER INFORMATION UPDATE FORM

Date: ____________________________

Information Now On Record With HON:

Physician/Provider Name: ____

Tax ID Number: ____

Physician/Provider Address: ____

City: ____________________ State: ____________________ Zip Code: ____________

Phone Number: ____

Contact Person, if different from Physician/Provider: ______________________________

Email Address: ____

CHANGES/ADDITIONS/DELETIONS:

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Please return this form with copies of changes in insurance, accreditation, affiliation, and additional relevant documents to:

**ATTN: Health Ohio Network, LLC. Provider
Relations Representative,
P.O. Box 848, Hudson, OH 44236**