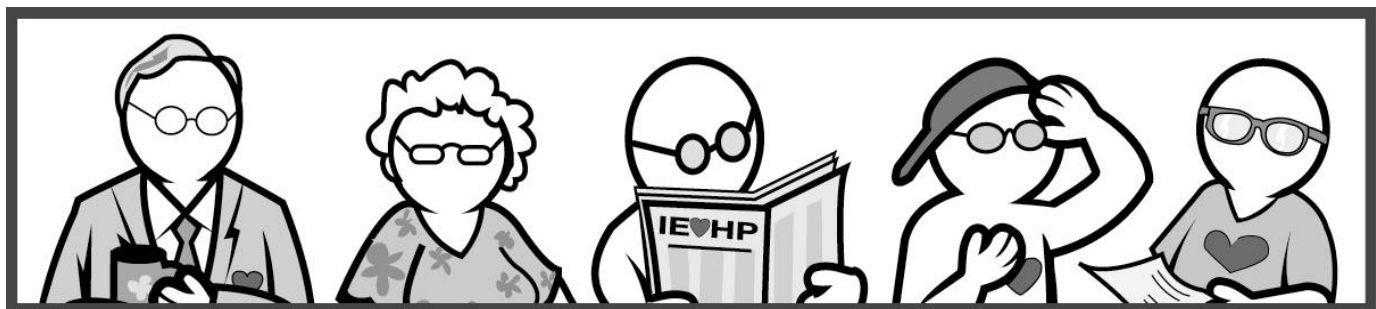


# IEHP Vision Quick Reference Guide 2011

Revised Date: July 2011



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## NEW VISION PROVIDER PACKET

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## 1. How to Log into the Vision Provider Website:

### Steps:

- 1) Open Microsoft Internet Explorer
- 2) In the address bar, type in <http://www.iehp.org>
- 3) Click on the **Providers** button.

**PROVIDERS** ▶

- 4) Click on the **Secure Site Login** button.

#### ● **Secure Site Login**

This will bring you to the login screen.

- 5) Type in your **Login ID and Password** and click submit.

Login ID:   
Password:   
**NEW!...Effective November 17, 2009**  
**Passwords are case sensitive**

- 6) Once you have successfully logged into the IEHP Provider Website, click the appropriate button (**Eligibility & Rosters, Vision or Authorization Status**) on the toolbar located on the left-hand side of the page.

**PROVIDERS** ▼  
**HOME**  
**Eligibility & Rosters**  
**Vision**  
**Authorization Status**  
**Log Out**

## 2. Eligibility & Authorization

- Eligibility must be verified on the DOS. There are many options to verify eligibility:
  - 1) IEHP website ([www.iehp.org](http://www.iehp.org))
  - 2) IEHP's Interactive Voice Response (IVR): (888) 355-2234
  - 3) Automated Eligibility and Verification System (AEVS): (800) 456-2387
- A valid authorization does not guarantee eligibility
- Authorizations are only valid for the month in which they are obtained
- If the authorization is not used in the month for which it was obtained, **an extension must be requested prior to rendering services.**

If an authorization is not utilized, the authorization needs to be cancelled. Please call IEHP's IVR or IEHP Provider Team at (909) 890-2054 to cancel an unused authorization.

### 3. Eligibility and Member Medical History

- Did you know that using **Online Member Eligibility verification** also allows you to view and print **Member's Medical History**? It's easy and useful! Here's how it works:

- 1) Log on to [www.iehp.org](http://www.iehp.org)
- 2) Proceed to the **Secure Provider Website Login**
- 3) Enter your **login ID** and **password** then click **"submit"**
- 4) Click on **Eligibility & Rosters**
- 5) Select by **SSN/CIN** or by **IEHP ID** or by **Last Name**
- 6) Enter the **SSN/CIN** or **IEHP ID** or **Last Name** then click **"submit"**
- 7) This takes you to the eligibility screen as seen below which provides you detailed information if a Member is eligible or not

**Welcome Providers!** **IEHP**  
INLAND EMPIRE HEALTH PLAN  
A PUBLIC ENTITY

**PROVIDERS** ▾  
Provider Home  
SSN/CIN  
IEHP ID  
Last Name  
Roster  
Log Out

IEHP Eligibility Provided On:  
Thursday, June 05, 2008 12:03:09 PM  
Verification Number: 123926

Member Name:	MORNING, GLORY	Status:	Member Eligible On 06/05/2008
Gender/DOB:	Female -- 04/30/1995	Assigned PCP:	Dr. Brad Pitt
IEHP ID:	20091234567801	PCP ID:	J201234
Aid Code/City:	3N / SBC (36)	PCP Phone:	(760)245-9363
Plan/Co-Pay:	Medi-Cal / \$0.00	Eff. Date WPCP:	03/01/2007
		Thru:	//
		Assigned IPA:	<a href="#">Inland Empire Health Plan</a>
		Assigned Hospital:	<a href="#">Victor Valley Comm Hosp</a>

MEMBERS ► WHO WE ARE ►

[\[View Medical History\]](#) [\[Print Medical History\]](#)

\*\*\* Billing Disclaimer \*\*\*

- Eligibility Information Provided Is Current As Of 6/5/2008.
- This Information Does **Not** Constitute Approval Or Authorization Of Any Service. Please Contact The Member's PCP For Authorization.

- From the eligibility screen above, click on **"View Medical History"** or **"Print Medical History"**
- It will take you to the **Member's Medical History** page as shown below. Be sure to keep a printed copy in the Member's chart for future reference.

**Welcome Providers!** **IEHP**  
INLAND EMPIRE HEALTH PLAN  
A PUBLIC ENTITY

**PROVIDERS** ▾  
Provider Home  
SSN/CIN  
IEHP ID  
Last Name  
Roster  
Log Out

MEMBERS ► WHO WE ARE ►

**Member Demographics**

Name: MORNING, GLORY  
IEHP ID: 20091234567801  
Date Of Birth: 04/30/1995  
Address: 123 Happy Day St, Victorville, CA 90000  
Phone No: (760) 123-4567  
Language: English

**Reminders/Alerts**

- Immunizations Are Not Up To Date

**Medical Visits**

**Medical Visits (Past 6 Months)**

Date	Primary ICD9
<a href="#">04/21/2008</a>	272.0
<a href="#">04/19/2008</a>	272.0

**Hospital Visits (Past 6 Months)**  
No Records

**RX History**

**Pharmacy Information (Past 6 Months)**

Date Filled	Brand Name	QTY
12/07/2007	Pain Reliever Plus Tablet	100
12/09/2004	Promethazine/Codaine Syru	120
12/09/2004	Triamcinolone 0.1% Cream	30

**Lab Results**

**Lab Information (Past 6 Months)**

Date	Labs Ordered
<a href="#">12/12/2007</a>	Labs Ordered
<a href="#">12/11/2007</a>	Labs Ordered

**Immunizations**

Date	Immunization
06/29/1999	33 MMR 2
09/13/2000	39 Polio (IPV) 4
06/29/1999	45 DTaP 5
03/16/1999	46 Varicella 1
11/13/2007	53 Influenza 1
07/20/2001	65 Hep A 1
08/16/2002	65 Hep A 2
08/28/2007	72 Tdap 1

## 4. Vision Benefits by Program

Benefits	Medi-Cal	Healthy Families	Healthy Kids	Medicare DualChoice
Comprehensive Eye Exam	Yes, no co-pay	Yes, \$5 co-pay ✓ VSP 800-877-7239 ✓ Safeguard 800-880-3080 ✓ Eyemed 866-723-0390	Yes, \$5 co-pay	Yes, no co-pay <sup>1</sup>
Contacts in lieu of glasses	Ages 0-21 - Only if Medically Necessary Ages 21+ Excluded	Only if Medically Necessary	Only if Medically Necessary	Yes, up to \$150 <sup>2</sup> with fitting
<u>Diabetic Retinal Exam*</u> a) Diabetic Members are eligible for a DRE once a year b) Authorization must be obtained by calling IEHP's Provider Team at (909) 890-2054 c) Once the DRE has been performed, the PCP Vision Report Form must be completed and forwarded to the Member's PCP as well as IEHP at: IEHP Claims Dept P.O. Box 10129 San Bernardino, CA 92423	Yes	Yes, refer to applicable Vision Plan for Auth: ✓ VSP 800-877-7239 ✓ Safeguard 800-880-3080 ✓ Eyemed 866-723-0390	Yes, ages 0-18 only	Yes
Frames and Lenses every 24 Months	Yes, ages 0-21 no co-pay Ages 21+ Excluded	Yes, no co-pay ✓ VSP 800-877-7239 ✓ Safeguard 800-880-3080 ✓ Eyemed 866-723-0390	Yes, no co-pay	Yes, up to \$100 <sup>2</sup> with fitting and refraction, also one pair of glasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. Corrective lenses/frames (and replacements) needed after a cataract lens implant.
Optical Labs	Order through Prison Industry Authority (PIA) by:  <b>Mail:</b> CA PIA 560 E Natoma St. Folsom, CA 95630 <b>Phone:</b> (916) 358-2733 <b>Online:</b> <a href="http://www.pia.ca.gov">www.pia.ca.gov</a>	Yes, refer to applicable Vision Plan for Auth: ✓ VSP 800-877-7239 ✓ Safeguard 800-880-3080 ✓ Eyemed 866-723-0390	<b>Express Lens Lab</b> <sup>3</sup> 17150 Newhope St. Ste 305 Fountain Valley, CA 92708-4251 Phone: (714) 545-1024 Fax: (714) 556-2026	<b>Express Lens Lab</b> <sup>3</sup> 17150 Newhope St. Ste 305 Fountain Valley, CA 92708-4251 Phone: (714) 545-1024 Fax: (714) 556-2026

<sup>1</sup> Glaucoma screening once per year for people at high risk.

<sup>2</sup> Replacement frames and lenses are not a covered benefit through the VER process.

<sup>3</sup> Please use the Lab Order Form found at [www.iehp.org](http://www.iehp.org) to complete any Lab Orders

\*Benefits that require prior authorization. If a member has exceeded the benefits available above through the IEHP Vision Program, you may submit a Vision Exception Request (VER) to IEHP.

<b>Benefits</b>	<b>Medi-Cal</b>	<b>Healthy Families</b>	<b>Healthy Kids</b>	<b>Medicare DualChoice</b>
<u>TPA Services</u> a) TPA services consist of those that require prompt diagnosis and treatment of acute eye conditions including ocular emergencies b) No prior auth is required c) The TPA benefit is only available to Members under the age of 21 effective July 1, 2009. Members age 21+ should be referred to an ophthalmologist for treatment of acute eye conditions under their medical benefits.	Yes	No**  **Available limited medical benefits. Should be referred through PCP to Specialists	Yes	Yes
<u>TPA Services Requirements</u> In order to provide TPA services a provider must: a) Be credentialed with IEHP b) Be TPA certified as verified by the CBO c) Be contracted with IEHP to provide these services	Yes	No	Yes	Yes
<u>As part of the TPA program, Providers must:</u> a) Inform the Member's PCP that services have been performed within two working days by utilizing the PCP Vision Report b) The PCP Vision Report Form must be attached to each claim c) TPA claims should be submitted on a CMS 1500 Health Insurance Claim Form to: IEHP's Claims Department – Vision P.O. Box 10129 San Bernardino, CA 92423-0129	Yes	No	Yes	Yes
<u>TPA Services include but not limited to:</u> Detailed (Quantitative) Visual Field Studies Extended Ophthalmoscope Detailed Biomicroscopy (Slit Lamp Evaluation) Gonioscopy Surgical Services such as:  Removal of foreign bodies, external eye Scraping of cornea, diagnostic for smear and/or culture, Correction of trichiasis, epliation, by forceps only Punctal plug Lacrimal Dilation	Yes	No	Yes	Yes

## 5. TPA TREATMENT PROTOCOL GUIDELINES

	Diagnosis	Treatment	Initial Visit	*Second Visit	**Additional Visit	Comments
1	Ocular Allergy	Topical Steroids	Covered	Covered 3 to 21 days after initial visit	VER Required	Consult with Ophthalmologist if present 3 weeks after diagnosis. Refer to PCP for referral to Ophthalmologist if still on topicals after 6 weeks.
2	Ocular Allergy	Oral Antihistamines	Covered	Covered 7 to 14 days after initial visit	VER Required	Refer to PCP for referral to an Ophthalmologist if not resolved in 2 weeks.
3	Staph Blepharitis Bacterial Conjunctivitis	Topical and/or oral Antibiotics	Covered	Covered 3 to 6 weeks after initial visit	VER Required	Refer to PCP for referral to an Ophthalmologist if not resolved in 6 weeks.
4	Herpes Simplex Keratitis/Conjunctivitis or Varicella Zoster Keratitis/Conjunctivitis	***Topical Antivirals and/or oral Acyclovir	Covered	Covered 3 to 6 weeks after initial visit	VER Required	Refer to PCP for referral to an Ophthalmologist if not improved within seven days. Refer to PCP for referral to an Ophthalmologist if not resolved within 3 weeks.
5	Central Corneal Ulcer	Topical and/or oral Antibiotics	Covered	Covered 1 to 2 days after initial visit	VER Required	Consult Ophthalmologist if not improved within 24 hours. Refer to PCP for referral to an Ophthalmologist if not improved within 48 hours.
6	Traumatic Iritis	Topical and/or oral Antibiotics	Covered	Covered 2 to 3 days after initial visit	VER Required	Consult Ophthalmologist if condition worsens within 72 hours. Refer to PCP for referral to an Ophthalmologist if not resolved within 1 week.
7	Peripheral Corneal Inflammatory Keratitis (Excluding Mooren's & Terrien's diseases)	Topical Steroids, Anti-Inflammatories	Covered	Covered to 14 days after initial visit	VER Required	Consult Ophthalmologist if condition worsens within 48 hours. Refer to PCP for referral to an Ophthalmologist if not resolved within 2 weeks.
8	Preseptal Cellulitis or Dacryocystitis	Topical and/or oral Antibiotics	Covered	Not Covered	Not Covered	Refer to PCP for referral to an Ophthalmologist.
9	Unilateral non-recurrent nongranulomatous. Idiopathic Iritis or Episcleritis	Topical Steroids, Anti-Inflammatories	Covered	Covered to 21 days after initial visit	VER Required	Consult Ophthalmologist if worsens within 72 hours. Refer to PCP for referral to an Ophthalmologist if not resolved within 3 weeks.
10	Ocular Inflammation	Oral nonsteroidal Anti-Inflammatory agents	Covered	Covered 1 to 3 days after initial visit	VER Required	Refer to PCP for referral to an Ophthalmologist if not resolved within 3 days.
11	Glaucoma		Covered	Not Covered	Not Covered	Coverage for initial visit applies only if patient has not been previously diagnosed. Refer to PCP for referral to an Ophthalmologist for treatment.
12	Blunt Trauma / Contusion	Examination / Observation	Covered	Covered	Not Covered	Continued suspicion of intraocular injury; i.e., retinal tear or detachment, laceration of globe, zonular dissection must be referred to PCP to arrange for ophthalmology consult.

\* "Covered" shall constitute one visit within the timeframe specified. Unless specifically indicated, third and subsequent visits not falling within the specified timeframes require prior authorization via the VER process. All VERs are reviewed by the VSM.

\*\*Additional Visits Require Prior Approval (Submission of a VER)

\*\*\*Note-In all cases topical antiviral medications shall be limited to 3 weeks, and the use of oral Acyclovir shall be limited to 10 days.

## 6. Vision Exception Requests (VERs)

- All non-routine benefits require prior authorization through the VER process. Providers must submit a completed VER form to obtain prior authorization for the following services:
  - 1) Medically necessary services not covered under routine benefits (e.g., contact lenses)
  - 2) Lost, broken or damaged frames and lenses (**not available for DualChoice**)
  - 3) Exam due to change in prescription if benefit is not available
- Failure to obtain prior authorization may result in denial of the service and/or materials.
- VER authorizations are only good for the month in which they are issued, since individual eligibility for Members is determined on a month-to-month basis.

### A. How to Submit a VER

- VERs can be submitted to IEHP through one of the following methods:
  - 1) VER online at [www.iehp.org](http://www.iehp.org). **Providers are strongly encouraged to submit online.**
  - 2) VER Form Fax. Providers may fax to (888) 860-1299.
- Providers must certify that the information on the VER form is true and correct. Without the Provider's signature, the VER will not be approved.

#### *Step(s):*

- 1) Click on the **VER** button on the toolbar once you have logged into the Vision portion of the Provider Website

#### **VER**

- 2) Enter the Member **IEHP ID** or **SSN/CIN** and the **Request Date**
- 3) Select the **Type of Services Requested** from the drop down menu.
- 4) Check the **Polycarbonate** box (as applicable)
- 5) If a Member does not qualify for Vision Benefits on the DOS, a message will indicate when a Member will be eligible for Vision Benefits/Services
- 6) Click **Clear** to start over or click **CONTINUE** to submit and view the VER form

The screenshot shows the IEHP Provider Website interface. At the top, there is a blue banner with the text "Welcome Providers!" and the IEHP logo. Below the banner, there is a navigation menu on the left with options: PROVIDERS (dropdown), HOME, Provider Home, Claims Entry, Claims Status, VER, VER Status, Diabetes Care, ICD-9 codes, Newsletters, and Log Out. The main content area features a "Vision Exception Request" heading with a person icon. Below this, it says "Welcome Happy Doc ID# 9V123456" and "Standard Vision Benefits For Member - 123456789101-01 - Will Not Be Available Until 11/01/2011. Please Submit A VER For Any Required Services." A form is displayed with the following fields: "Enter Member ID: (No Spaces Or Dashes)" with sub-fields for "IEHP ID" (123456789101-01) and "SSN/CIN", and "Request Date" (02/03/2010). Below the form, there is a "Select The Type Of Services Requested" dropdown menu set to "View Vision Benefits Available" and a "Polycarbonate" checkbox. At the bottom of the form are "CONTINUE" and "CLEAR" buttons. A footer note reads: "For Further Assistance Please Call Our Vision Response Team At (800) 890-2958."

## VER – MATERIALS FORM

(This form appears when **Materials** is selected from the **Type of Services Requested** drop down menu)

**Step(s):**

- 1) Verify **Member information**
- 2) Verify **Materials Requested** and check the applicable fields to request Vision Services
- 3) Select applicable **Diagnosis/Reason for Requested Materials** (no more than 2)
- 4) Select from applicable **Provider Verification** boxes that will justify replacement or no fraud is committed
- 5) Click **CONTINUE** to submit and process the request

The screenshot shows the 'Vision Exception Request-Materials' form for 'Happy Doc (ID# V9123456)'. The form includes a navigation menu on the left with options like HOME, Provider Home, Claims Entry, Claims Status, VER, VER Status, Diabetes Care, ICD-9 codes, Newsletters, and Log Out. The main content area contains member information (Jane Doe, IEHP ID: 123456789101-01, Address: 123 Happy Trails, Phone: (909) 123-4567, County: RIVERSIDE, Aid Code: 8R) and a 'MATERIALS REQUESTED' section with radio buttons for Frame - V2020 and Lenses (N/A, 92340 - Single Vision Lenses, 92341 - Bifocal Lenses, 92342 - Trifocal Lenses, 92784 - Polycarbonate Lenses). There is also a 'Medically Necessary Contact Lenses' section with checkboxes for V2510, V2511, V2520, and V2521. A 'DIAGNOSIS/REASON FOR REQUESTED MATERIALS' section includes checkboxes for Prescription Greater Than Or Equal To -6.00 Or +5.00 In Any Meridian, Monocular Status, Replacement Of Broken/Damaged Frames, Two Pair Of Glasses In Lieu Of Bifocals, Qualifying Change In Prescription, Replacement Of Stolen Glasses, Replacement Of Broken/Damaged Lenses, Lost Glasses, Headache/Asthenopia, High Ametropia, and Keratoconus. A 'PROVIDER VERIFICATION' section has checkboxes for Member Has Supplied The Provider With A Signed Statement, Provider Certifies That Specific Items Require Replacement, and Provider Certifies That Specific Items Require Replacement And No Obvious Fraud Or Intentional Abuse Is Evident. The form ends with 'CONTINUE' and 'CANCEL' buttons.

## VER – SERVICES FORM

(This form appears when **Services** is selected from the **Type of Services Requested** drop down menu)

**Step(s):**

- 1) Verify **Member information**
- 2) Select the appropriate **Services Requested**
- 3) Select applicable **Diagnosis/Reason for Requested Service**
- 4) Click **CONTINUE** to submit and process the request

The screenshot shows the 'Vision Exception Request-Services' form for 'Happy Doc (ID# 9V 123456)'. The form includes a navigation menu on the left with options like HOME, Provider Home, Claims Entry, Claims Status, VER, VER Status, Diabetes Care, ICD-9 codes, Newsletters, and Log Out. The main content area contains member information (Jane Doe, IEHP ID: 123456789101-01, Address: 123 Happy Trails, Phone: (909) 123-4567, County: RIVERSIDE, Aid Code: 33) and a 'SERVICES REQUESTED' section with radio buttons for 92012 - Intermediate Exam (Established), 92002 - Intermediate Exam (New Patient), and 92310 - Contact Lens (Evaluation). There is also a 'DIAGNOSIS/REASON FOR REQUESTED SERVICE' section with radio buttons for Patient Reports Change In Vision/Blurred Vision, Primary Care Physician Requested Evaluation, School Recommended Eye Exam, Headache/Asthenopia, Keratoconus, and High Ametropia. The form ends with a 'CONTINUE' button.

## B. How to Check VER Status

Step(s):

- 1) Click the **VER Status** button on the toolbar once you have logged into the Vision portion of the Provider Website to check the status of any pending and approved VERs.

**VER Status**

- 2) The **Auth #** serves as a hyperlink to view the VER-Authorization. Click on the **blue hyperlink** to view details.

Welcome Providers! **IEHP**  
INLAND EMPIRE HEALTH PLAN  
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**PROVIDERS** ▾  
HOME  
Provider Home  
Claims Entry  
Claims Status  
VER  
**VER Status**  
Diabetes Care  
ICD-9 codes  
Newsletters  
Log Out

MEMBERS ▾ WHO WE ARE ▸

**Vision Exception Request-Status**  
VERs Requested From:  
12/5/2009 THRU 2/2/2010  
[ PRINT ] [ NEW SUBMISSION ] [ BACK ]

Auth #:	Name:	IEHP ID:	Req. Date:	Service:	Status:	Det. Date:
<a href="#">V1234567</a>	Jane Doe	123456789101-01	02/01/2010	92002 92015	Approved Approved	N/A
<a href="#">V1234568</a>	John Doe	123456789202-01	01/29/2010	92012 92015	Approved Approved	N/A
<a href="#">V1234569</a>	Jennifer Doe	123456789303-01	01/20/2010	92340	Approved	N/A
<a href="#">V1234560</a>	Jack Doe	123456789404-01	01/19/2010	92340 V2020	Approved Approved	N/A

**Vision Exception Request-Authorization**  
[ PRINT ] [ NEW SUBMISSION ] [ BACK ]

The Vision Department Has Processed The Following Request:

Auth No: **V1234567**  
Request Date: 03/01/10  
Determination Date: N/A  
Expiration Date:  
Provider: HAPPY DOC ( 9V123456)  
Member: Jane Doe  
ID Number: 123456789101-01  
Aid Code/County: 3N/San Bernardino(36)  
Service/Material: 

- V2020 (1) **Approved**
- 92340 (2) **Approved**

  
Reason: 

- Lost Glasses

### **C. VER Review Process**

- IEHP reviews and responds to all VERs within three (3) working days. IEHP reviews the VER, verifies eligibility, benefit availability and previous utilization and either approves, modifies, defers, or denies the request as follows:
  - 1) Approved – A VER Response Form is faxed back to the Provider with an authorization for the requested services.
  - 2) Modified – A VER Response Form is faxed back to the Provider with an authorization that describes the modified services/materials authorized.
  - 3) Deferred – A VER that has been deferred is one that has been placed “on hold” pending additional information. A VER Response Form is faxed back to the Provider requesting additional information.
    - a) If the additional information is not received within 3 days of the initial request, a second notice is sent. If the Provider does not respond within 3 days of the second notice, the VER is denied.
    - b) Once the requested information is received, the VER is reviewed and a decision is made within 3 working days of receipt of the required information.
  - 4) Denied – A VER Response Form is faxed back to the Provider with the denial reason.

### **7. Vision Claims Process**

- Please use IEHP’s website to bill for all standard Vision Authorizations and Vision Exception Requests (VER) – please see attached online claims submission instructions.
- Claims for TPA (Therapeutic Pharmaceutical Agents) Services and the Diabetic Retinal Exam (DRE) must be billed on a CMS 1500. Please mail these claims to:

IEHP Claims Department  
P.O. Box 10129  
San Bernardino, CA 92423

## A. Online Claims Submission Instructions:

### Steps:

- 1) Click the **Claims Entry** button on the toolbar once you have logged into the Vision Provider Website.

### Claims Entry

- 2) Enter the **Authorization Number** that you received for the claim that you plan to submit
- 3) Enter the actual **Date of Service** in this format (mm/dd/yyyy)
- 4) Click the **Clear** to start over or the **CONTINUE** button.

- 5) Verify the **Member's Information** and enter the **Patient Account Number**. If you do not use account numbers, simply enter "1" because this field cannot be left blank.
- 6) The **Visit Information** on the claim will automatically populate the service codes that were authorized. You must enter your "usual and customary" fees in the **Charges** and **Units** fields only for services that you have performed.
- 7) From the drop-down list select the **ICD-9 Diagnosis Code** that corresponds to the service and/or materials.
- 8) Click the **Submit/Print HCFA-1500** button

Date of Service:	Service	POS:	TOS:	Procedure:	*Charges:	*Units:
01/08/2010	Exam	11	01	92004	.00	1
	Refraction	11	01	92015	.00	1
	Frame	11	01	V2020	.00	1
	Lens	11	01	92340	.00	2

- 9) Upon pressing the **Submit** button, the following will occur:
- A completed CMS 1500 form will be displayed that will print to your default printer.
  - You have transmitted the claim for payment on-line.

Submitted to IEHP via the website on 2/8/2010

**HEALTH INSURANCE CLAIM FORM**

PLEASE DO NOT STAPLE THESE AREAS

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA ELK LUNO Other  
 (Medicare #)  (Medicaid #)  (Sponsor SSN)  (VA File #)  (Sponsor ID #)  (SSN)  (ID)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S DOB SEX  
 M  F

4. INSURED'S NAME (Last Name, First Name, Middle Initial) 5. INSURED'S ADDRESS (No. Street) CITY  
 ZIP CODE TELEPHONE

6. PATIENT RELATIONSHIP TO INSURED  
 Self  Spouse  Child  Other

7. PATIENT STATUS  
 Employed  PT Student  PT Student

8. PATIENT'S DATE OF BIRTH SEX  
 mm dd yy M  F

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PATIENT CONDITION RELATED TO:  
 a. EMPLOYMENT? (Current or Previous) YES  NO   
 b. AUTO ACCIDENT? YES  NO  PLACE (State)  
 c. OTHER ACCIDENT? YES  NO

11. INSURED'S POLICY GROUP OR FECA NO. 12. INSURED'S DATE OF BIRTH SEX  
 mm dd yy M  F

13. EMPLOYER'S NAME OR SCHOOL NAME 14. INSURANCE PLAN OR PROGRAM NAME  
 104. RESERVED FOR LOCAL USE

15. IS THERE ANOTHER HEALTH BENEFIT PLAN?  
 YES  NO (Yes, return to end, complete Item 9a-d.)

16. AUTHORIZED PERSON'S SIGNATURE  
 I, the undersigned, authorize the release of any medical or other information necessary to process this claim. I do not request payment of government benefits either to myself or the party who accepts assignment.

17. DATE mm dd yy 18. DATE mm dd yy 19. DATE mm dd yy  
 20. DATE mm dd yy  
 21. DATE mm dd yy

22. MEDICATED Prescription Code Original Ref No. Code  
 23. PRIOR AUTHORIZATION NO.

24. DATE OF SERVICE From MM/DD/YY To MM/DD/YY	25. PLACE OF SERVICE	26. TYPE OF SERVICE	27. PROCEDURE/SERVICES OR SUPPLIES (Bypass Usual Circumstances) CPT/HCPCS	28. MODIFIER	29. DIAGNOSIS CODE	30. CHARGES	31. Days Report Under	32. or Family Plan	33. ID	34. Reverting Provider ID#
10/21/2009	10/21/2009	11	01	92004		110.00	1		MDI	1052339145
10/21/2009	10/21/2009	11	01	92015		35.00	1		MDI	1052339145
						35.00	1		MDI	1052339145

**B. Daily Transaction Report**

**Steps:**

- Click the **Claims Entry** button on Vision Provider Website  
**Claims Entry**
- Click the **Daily Transaction Report** button at the bottom of page to have a log of claims that you have submitted that day.

[Daily Transaction Report.](#)

- Click on the **red arrow** to expand the Claim Detail and view a printable list of transactions submitted

Welcome Providers!

PROVIDERS ▾  
 HOME  
 Provider Home  
 Claims Entry  
 Claims Status  
 VER  
 VER Status  
 Diabetes Care  
 ICD-9 codes  
 Newsletters  
 Log Out

MEMBERS ▸ WHO WE ARE ▸

Vision Claims

Welcome Happy Doc ID# (000009V12345)

Authorization Number: [input field]

Date of Service: (mm/dd/yyyy)  
 02/08/2010

CONTINUE CLEAR

For further assistance please call our Vision Response Team at (909) 890-2958.  
 Click here to view and print the [Daily Transaction Report.](#)

Welcome Providers!

PROVIDERS ▾  
 HOME  
 Provider Home  
 Claims Entry  
 Claims Status  
 VER  
 VER Status  
 Diabetes Care  
 ICD-9 codes  
 Newsletters  
 Log Out

MEMBERS ▸ WHO WE ARE ▸

Vision Claims

WEB BASED TRANSACTION REPORT BY THE OFFICE OF:  
 Happy Doc

TOTAL VISION CLAIMS SUBMITTED ON MONDAY, FEBRUARY 08, 2010: 4 ↓

\*\*\*ALL ENTRIES ARE SUBJECT TO VALIDATION.\*\*\*  
 IEHP RECOMMENDS THAT YOU PRINT THIS REPORT AT THE END OF EACH DAY.  
 CLICK THE RED ARROW ABOVE TO VIEW CLAIM DETAIL.

- 4) Click on the blue hyperlink – **IEHP ID** to regenerate the completed CMS form.

**Welcome Providers!**

**IEHP**  
INLAND EMPIRE HEALTH PLAN  
A PUBLIC ENTITY

**PROVIDERS** ▾

HOME  
Provider Home  
Claims Entry  
Claims Status

VER  
VER Status  
Diabetes Care

ICD-9 codes  
Newsletters  
Log Out

MEMBERS ▶ WHO WE ARE ▶

**Vision Claims**

WEB BASED TRANSACTION REPORT BY THE OFFICE OF:  
Happy Doc

**TOTAL VISION CLAIMS SUBMITTED ON MONDAY, FEBRUARY 08, 2010: 5 ↑**

PROVIDER	DOS	IEHP ID	NAME	PT. ACCT.	CHARGES
Happy Doc	02/08/2010	<a href="#">123456789101</a>	Jane Doe	N/A	145.00
Happy Doc	02/08/2010	<a href="#">456789123654</a>	John Doe	N/A	255.00
Happy Doc	02/08/2010	<a href="#">789456321456</a>	Jack Doe	N/A	110.00
Happy Doc	02/08/2010	<a href="#">456321456789</a>	Jill Doe	N/A	110.00
Happy Doc	02/08/2010	<a href="#">987654321456</a>	John Smith	N/A	255.00

\*\*\*ALL ENTRIES ARE SUBJECT TO VALIDATION\*\*\*  
IEHP RECOMMENDS THAT YOU PRINT THIS REPORT AT THE END OF EACH DAY.  
CLICK THE RED ARROW ABOVE TO VIEW CLAIM DETAIL.

- 5) The submitted **CMS 1500 Form** will then appear

PLEASE DO NOT STAPLE IN THIS AREA

Submitted to IEHP via the website on 2/8/2010


**HEALTH INSURANCE CLAIM FORM**

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> Other <input type="checkbox"/>		2. PATIENTS NAME (Last Name, First Name, Middle Initial)		3. PATIENTS DOB		4. INSURED'S ID NUMBER (For Program in Item 1)	
5. PATIENTS ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED		7. INSURED'S ADDRESS (No., Street)		8. PATIENT STATUS	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NO.		12. PATIENTS OR AUTHORIZED PERSON'S SIGNATURE	
13. DATE OF CURRENT Illness (First symptom or Injury/Accident or Pregnancy/LMP)		14. DATE OF REFERRING PHYSICIAN OR OTHER SOURCE		15. DATE OF REFERRING PHYSICIAN		16. DATE(S) OF SERVICE	
17. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY		18. MEDIC AID Reimbursement Code		19. PRIOR AUTHORIZATION NO		20. PROCEDURE(S) OF SERVICE	
21. DATE(S) OF SERVICE		22. PLACE OF SERVICE		23. TYPE OF SERVICE		24. PROCEDURE(S) OF SERVICE	
25. DATE(S) OF SERVICE		26. PLACE OF SERVICE		27. TYPE OF SERVICE		28. PROCEDURE(S) OF SERVICE	

DATE(S) OF SERVICE	PLACE OF SERVICE	TYPE OF SERVICE	PROCEDURE(S) OF SERVICE	DIAGNOSIS CODE	CHARGES	Days	ESSTD	ID	Bandwidth	Provider ID#
10/21/2009	11	01	92004		110.00	1		NPI	1952339145	
10/21/2009	11	01	92015		35.00	1		NPI	1952339145	
					35.00	1		NPI	1952339145	


## 8. Prescription Medications

- All prescription medications prescribed to IEHP Members must comply with IEHP's formulary.
- TPA Providers must use the Prescription Exception Request (PER) Forms for the following:
  - 1) Medication or dosage not included in the IEHP formulary
  - 2) Code 1 medications used for treatment of conditions or criteria other than those specified by their restrictions
  - 3) Branded medications when generic is available
  - 4) Prescriptions for formulary medications that do not comply with Dose/Duration/ or Quantity guidelines (as outlined in the IEHP formulary).

<b>Please Print</b>	 <small>INLAND EMPIRE HEALTH PLAN</small>	PER #: _____ <small>(For IEHP Use Only)</small>
<b>PHARMACY EXCEPTION REQUEST (PER) FORM</b>		
<b>FAX TO: IEHP</b>		<b>FAX #: (909) 890-2058</b>
<b>IEHP MEMBER</b>		
Member Name: _____	ID#: _____	DOB: _____ M F
	SSN#: _____	
<b>PHYSICIAN</b>		
Prescribing Physician: _____	MD State License #: _____	MD Specialty: _____
Contact Name: _____	Phone #: _____	Fax #: _____
<b>PHARMACY</b>		
Pharmacy Name: _____	Pharmacy NABP #: _____	
Contact Name: _____	Phone #: _____	Fax #: _____
<b>FORM</b>		
Form Completed By: _____	Today's Date: _____	
<b>PRESCRIPTION</b>		
Rx #: _____	Date of Original Rx: _____	
Medication: _____		
Strength: _____	Quantity: _____	Refills Remaining: _____
NDC #: _____	SIG: _____	
Diagnosis: _____		
Previous Therapy: _____		
Medical justification for non-formulary drug:		
Your request is: <input type="checkbox"/> Approved <input type="checkbox"/> Modified <input type="checkbox"/> Request for More Information <input type="checkbox"/> Misdirected <input type="checkbox"/> Denied		
Valid from: _____	Expires on: _____	Decision by: _____ Date: _____
<b>Request for Expedited Review (For IEHP Medicare DualChoice Members Only)</b>		
<input type="checkbox"/> REQUEST FOR EXPEDITED REVIEW (24 HOURS)		
▶ BY CHECKING THIS BOX AND SIGNING ABOVE, I CERTIFY THAT APPLYING THE 72 HOUR STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION		
Please submit Request promptly to avoid any delays in patient care. IEHP will respond to the request within one working day. Providers should exercise appropriate clinical judgment in dispensing medication pending PER approval.		
<small>Notice: This facsimile contains confidential information that is being transmitted to and is intended only for the use of the recipient named above. Reading, disclosure, discussion, dissemination, distribution or copying of this information by anyone other than the named recipient or his or her employees or agents is strictly prohibited. If you have received this facsimile in error, please immediately destroy it and notify IEHP Pharmaceutical Services Department by telephone at (888) 860-1297. P.O. Box 19026, San Bernardino, CA 92423-9026 Tel (888) 860-1297 Fax (909) 890-2058 Visit our web site at: <a href="http://www.iehp.org">www.iehp.org</a></small>		
<small>A Public Entity</small>		

## 9. Updates and Reminders

- Please click on the **Updates** tab on the toolbar under **Vision Providers** of the Provider Website at [www.iehp.org](http://www.iehp.org) for any Vision Provider Updates.



The screenshot shows the IEHP website interface. At the top, there are language options for ENGLISH and ESPAÑOL, and a TEXT-ONLY VERSION link. The IEHP logo is prominently displayed. A navigation menu on the left lists various categories, with 'VISION PROVIDERS' expanded to show 'FORMS', 'UPDATES', and 'SITE HELP'. The 'UPDATES' link is circled in red. The main content area shows a breadcrumb trail: Home >> Providers >> Vision Providers >> Updates. Below this, the heading 'Vision Updates' is followed by a notice about Adobe Acrobat Reader. A list of updates follows, including dates and descriptions of changes or reminders.

ENGLISH ESPAÑOL  
TEXT-ONLY VERSION

**IEHP**  
A Public Entity  
Inland Empire Health Plan

**PROVIDERS** ▼

- BEHAVIORAL HEALTH ▶
- CLINICAL PRACTICE GUIDELINES ▶
- EDUCATIONAL OPPORTUNITIES ▶
- FLU UPDATES
- FORMS ▶
- IEHP UNIVERSITY
- INFORMATION RESOURCES ▶
- NEWSLETTERS ▶
- P4P PROGRAM ▶
- PHARMACEUTICAL SERVICES ▶
- VISION PROVIDERS** ▼
  - FORMS ▶
  - UPDATES** ▼
  - SITE HELP ▶

MEMBERS ▶ WHO WE ARE ▶

SEARCH

Home >> Providers >> Vision Providers >> Updates

**Vision Updates**

You will need Adobe Acrobat Reader 4 or later to view the PDF files. You can download a free copy by clicking below.

Get ADOBE READER

- 2010/01/20 - Termination of Miller Optical Services
- 2009/12/28 - Reminder Vision Benefit for DualChoice
- 2009/06/22 - Vision Letter regarding Medi-Cal Cuts
- 2009/12/04 - DualChoice New Vision Benefit
- 2009/11/13 - Kaban Optical Lab Relocation
- 2009/08/24 - Polycarbonate Lenses
- 2008/12/02 - Miller Optical & PCP Vision Form Online
- 2006/06/19 - New PIA Codes
- 2006/03/03 - Vision Provider Phone Number

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Legal Notice | Privacy Policy | Site Help | Contact Us

## 10. Vision Forms & Description

All Vision forms are available online at <http://ww2.iehp.org/IEHP/Providers/Vision/Forms>


### A. PCP Vision Report Form

- This form is used to communicate to the Member's PCP:
  - 1) Vision Services such as Diabetic Retinal Exams
  - 2) TPA Services
  - 3) Bi-focals/Trifocals request for Medi-Cal Members under the age of 38
  - 4) Examination findings and/or treatment provided that require further evaluation or follow up by the Member's PCP
  - 5) Send to PCP file in Member's chart for verification or audit purposes

IEHP INLAND EMPIRE HEALTH PLAN PCP VISION REPORT		
<b>TO BE COMPLETED BY THE VISION PROVIDER</b>		
Member's Name: <u>SPICY SALTY</u>	Exam Date: <u>12/01/2008</u>	
Member's IEHP ID#: <u>123456789000-01</u>	DOB: <u>10/17/2000</u>	
<input checked="" type="checkbox"/> CHECK HERE IF MEMBER WAS REFERRED BY THE PCP		
<b>FROM:</b>		
Vision Provider: <u>Dr. Vision</u>	Phone: <u>909 123-3456</u>	
Address: <u>000 Cauliflower St.</u>	City: <u>San Bernardino</u> Zip: <u>92407</u>	
<b>TO:</b>		
PCP: <u>Dr. Primary</u>	Forwarded by: MAIL <input type="checkbox"/> FAX <input checked="" type="checkbox"/>	
Address: <u>123 McDonald Ave</u>	Phone: <u>909 789-1011</u>	
	City: <u>San Bernardino</u> Zip: <u>92407</u>	
	Phone: <u>909-121-1415</u> Fax: <u>(909) 151-8171</u>	
<b>EXAMINATION FINDINGS</b>		
<b>CHECK ALL THAT APPLY:</b>		
<input checked="" type="checkbox"/> This was a dilated <i>Diabetic Retinal Examination (DRE)</i> using a binocular indirect ophthalmoscope to rule out diabetic eye disease. Examination results are as follows:		
<input checked="" type="checkbox"/> Normal Findings <input type="checkbox"/> Other      ( <i>please complete section below</i> )		
<input type="checkbox"/> This was a medical eye visit for evaluation, treatment and management of an acute ocular condition: <i>( please complete section below )</i>		
Symptoms (detail): <u>Blurry vision, nausea</u>		
Diagnosis: <u>Cataract</u> ICD Code: <u>V70.0</u>		
Procedures / Treatment Plan: <u>Needs Cataract Surgery</u>		
Recommendations: <u>Asap</u>		
Vision Provider: <u>Dr. Vision</u> (signature)	Date: <u>12/01/2008</u> Next Visit: <u>12/17/08</u>	
<small>NOTICE: This facsimile contains confidential information that is being transmitted to and is intended only for the use of the recipient named above. Reading, disclosure, discussion, dissemination, distribution, or copying of this information by anyone other than the named recipient or his or her employees or agents is strictly prohibited. If you have received this facsimile in error, please immediately destroy it and notify us by telephone at (800) 899-2064.</small>		
White Copy Attach to Claim Form	Yellow Copy To PCP	Pink Copy Vision Provider File <small>Revised 2005/03</small>

## B. Ophthalmologist Referral Form


- This form is used to:
  - 1) Refer Members to an Ophthalmologist for assessment, diagnosis, and treatment as needed.
  - 2) Vision Providers, with the assistance of IPA Utilization Management (UM) staff, are responsible for referring Members to an Ophthalmologist for assessment, diagnosis and treatment as needed. Please refer to the Ophthalmologist Referral Form and submit the completed referral to the Member's assigned IPA within 24 hours of the encounter with the Member.
  - 3) Please refer to the Vision Provider Referrals Policy in IEHP's Policy and Procedure Provider Manual for more detailed information:
    - a) Section 12, M.2 Vision Provider Referrals for Medi-Cal
    - b) Section 12, H.2 Vision Provider Referrals for HF/HK
    - c) Section 12, G.2 Vision Provider Referrals for Medicare DualChoice

OPHTHALMOLOGIST REFERRAL FORM				DATE: _____
<b>1A. OPTOMETRY TO OPHTHALMOLOGY REFERRALS ONLY</b>		<b>1B. REFERRAL TYPE</b>		
1. Fax a copy to the Member's IPA. 2. Place a copy in Member's medical record. 3. Fax a final copy back to the referring Optometrist.		<input type="checkbox"/> GENERAL OPHTHALMOLOGY <input type="checkbox"/> RETINA SPECIALIST <input type="checkbox"/> PEDIATRIC OPHTHALMOLOGY <input type="checkbox"/> MEDICALLY URGENT <input type="checkbox"/> ROUTINE – Decision in five (5) working days <input type="checkbox"/> Patient Request		
<b>2. GENERAL INFORMATION</b>				
Member Name (please print)		DOB	ID #	
Plan (select one)	<input type="checkbox"/> Medi-Cal <input type="checkbox"/> DualChoice	<input type="checkbox"/> Healthy Kids	Parent/Guardian/Caretaker name (REQUIRED)	
Address		City	Zip	Phone
Diagnosis		ICD-9 Code (REQUIRED)		
Clinical justification for referral (and description of procedure requested if any) *REQUIRED				
Referring Provider (please print)		Phone	Fax	
Address		City	Zip	
Referring Provider Signature (REQUIRED)		Office Contact Person		
<b>3. COMPLETED BY IPA</b>				
Ophthalmologist Referred (please print)		Appointment Date	Phone	
Address		City	Zip	Fax
<input type="checkbox"/> Office	<input type="checkbox"/> Outpatient	CPT Code (REQUIRED)		
Date Additional Information Requested:		Date Additional Information Received:	<input type="checkbox"/> Approved	<input type="checkbox"/> Modified
Medical Reviewer Comments				
<b>IF YOU WOULD LIKE TO DISCUSS THIS DECISION WITH THE PHYSICIAN REVIEWER, PLEASE CONTACT THE IPA:</b>				
IPA NAME:		Phone: (     ) -     -		
Medical Reviewer Signature (Circle Title: MD, DO, OD, RN, LVN, Coordinator)		Date/Time	Criteria utilized in making this decision are available upon request by calling IEHP – Provider Relations at (909) 890-2054.	
UPON ACCEPTANCE OF REFERRAL AND TREATMENT OF THE MEMBER, THE PHYSICIAN/PROVIDER AGREES TO ACCEPT IPA CONTRACTED RATES. This referral/authorization verifies medical necessity only. Payments for services are dependent upon the Member's eligibility at the time services are rendered. NOTICE: This facsimile contains confidential information that is being transmitted to and is intended only for the use of the recipient named above. Reading, disclosure, discussion, dissemination, distribution, or copying of this information by anyone other than the named recipient or his or her employees or agents is strictly prohibited. If you have received this facsimile in error, please immediately destroy it and notify us by telephone at (909) 890-2054.				
<b>FAX COMPLETED REFERRAL FORMS TO THE MEMBER'S IPA.</b>				

**\*\*For a list of IPA fax numbers, contact the IEHP Provider Team at (909) 890-2054  
Or see Important IPA Fax Numbers on page 27 of this guide\*\***


**C. Vision Exception Request (VER) Form**

- This form is used to request:
  - 1) Services such as eye exams and lens evaluations
  - 2) Replacement Materials such as frames and lenses (**not applicable for DualChoice**)
  - 3) Polycarbonate Lenses
  - 4) Medically Necessary Contact Lenses

 <small>INLAND EMPIRE HEALTH PLAN</small>	<small>MAIL TO: P.O. Box 19026 San Bernardino, CA 92408-9026</small>	<small>FAX TO: (888) 860-1299</small>
<b>VISION EXCEPTION REQUEST (VER) FORM</b>		
Date of Request: _____		
Member Name: _____	Member ID#: _____	DOB: _____
Member Address: _____	City: _____	Zip: _____ Phone: (____) _____
Provider Name: _____	Provider ID#: 9V _____	
<i>Please Check All That Apply</i>		
<b>REQUEST FOR SERVICES</b>		
Examination (within 24 months of last benefit)	<input type="checkbox"/> 92012 Intermediate – Estab	<input type="checkbox"/> Z2706 Contact Lens Evaluation
	<input type="checkbox"/> 92002 Intermediate – New	<input type="checkbox"/> Other CPT: _____
Reason: _____		
<b>REQUEST FOR MATERIALS</b>		
<b>Replacement of Materials</b> (within 24 months of previous benefit):		
	<input type="checkbox"/> Frame	<input type="checkbox"/> Bifocal
	<input type="checkbox"/> Single Vision	
Reason:	<input type="checkbox"/> Broken/Damaged Frames	<input type="checkbox"/> Replacement of Lost Glasses
	<input type="checkbox"/> Broken/Damaged Lenses	<input type="checkbox"/> Replacement of Stolen Glasses
	<input type="checkbox"/> Change in Prescription (Meets minimum criteria as listed on Page III.C.3 of IEHP Vision Provider Handbook)	
<i>* Both items below must be satisfied and checked to qualify for approval of Replacement Frames and/or Lenses:</i>		
<input type="checkbox"/> Member has supplied the Provider with a signed statement under penalty of perjury that describes the circumstances of the loss or destruction, the steps taken to recover the lost item and that the loss, breakage or damage was beyond the Member's control.		
<input type="checkbox"/> Provider certifies that specific items require replacement and no obvious fraud or intentional abuse is evident.		
<b>Request for Polycarbonate Lenses:</b>		
	<input type="checkbox"/> Single Vision	<input type="checkbox"/> Bifocal
	<input type="checkbox"/> Prescription greater than or equal to -6.00 or +5.00 in any meridian?	
	<input type="checkbox"/> Monocular Status (One eye BCVA worse than 20/70)	
	<input type="checkbox"/> Other _____	
<i>* Polycarbonate lenses require prior VER approval and must be fabricated by an IEHP Contract Optical Lab.</i>		
<b>FOR MEDICALLY NECESSARY CONTACT LENSES ONLY</b>		
<input type="checkbox"/> Bilateral <input type="checkbox"/> Right Only <input type="checkbox"/> Left Only <b>Contact Lenses Type:</b> <input type="checkbox"/> RGP Sphere <input type="checkbox"/> RGP Toric <input type="checkbox"/> Soft Sphere <input type="checkbox"/> Soft Toric <input type="checkbox"/> Other		
<b>Proposed CL Specifications:</b>	Right: Base Curve: _____ Diameter: _____ Power: _____ Type/Mfg: _____	
	Left: Base Curve: _____ Diameter: _____ Power: _____ Type/Mfg: _____	
<b>Keratometry Reading:</b>	<b>Grade of Mire Distortion:</b>	<b>BCVA with Diagnostic CLs (if available)</b>
Right: _____ D/_____ D X _____	0 +1 +2 +3 +4	Distance _____/_____ Near _____/_____
Left: _____ D/_____ D X _____	0 +1 +2 +3 +4	Distance _____/_____ Near _____/_____
Diagnosis & Medical Justification: _____		
I certify, under penalty of perjury, that the information contained herein is true, current, correct and complete to the best of my knowledge. I understand all claims are subject to retrospective review. I verify that the above specifications meet minimum Medical prescription requirements.		
_____ <i>Provider Signature</i>		_____ <i>Date</i>
<b>FOR IEHP USE ONLY</b> <input type="checkbox"/> Denied <input type="checkbox"/> Approved <input type="checkbox"/> Approved/Modified <input type="checkbox"/> Need More Information		
Comments: _____		

### D. IEHP Lab Order Form

- This form is used to:
  - 1) Order lab materials through IEHP's designated contracted labs such as Kaban Optical or Express Lens for Healthy Kids and DualChoice Members. For Medi-Cal Members, Providers can order materials through the PIA Optical Website at [www.pia.ca.gov](http://www.pia.ca.gov).

<b>IEHP Lab Order Form</b>							
			<b>Claims Remittance To:</b> IEHP Claims Department – Vision P.O. Box 10129 San Bernardino, CA 92423				
<b>INLAND EMPIRE HEALTH PLAN</b> A Public Entity							
Member Name:		Member ID#:		Auth#:		Order Date:	
Date of Birth:		Tray#:			Date Received:		
	SPHERE	CYLINDER	AXIS	PD		PRISM	BASE
				FAR	NEAR		
R							
L							
<b>CHECK APPROPRIATE LENS STYLE</b>							
SINGLE VISION		BIFOCAL		TRIFOCAL		MATERIAL	
<input type="checkbox"/> SINGLE VISION V2100		<input type="checkbox"/> ROUND 22 V2200-28		<input type="checkbox"/> FLAT 28 V2200-28 <input type="checkbox"/> FLAT 35 V2200-35		<input type="checkbox"/> FLAT 7X28 50% Intermed V2300 <input type="checkbox"/> CR-39 <input type="checkbox"/> GLASS	
ADD		SEG HEIGHT		TINT: *Must include medical justification in special instructions			
R				<input type="checkbox"/> UV V2755	<input type="checkbox"/> PNK 1 2 V2740	<input type="checkbox"/> BRN 1 2 3 V2740	<input type="checkbox"/> GRY 1 2 3 V2740
L				<input type="checkbox"/> PGX V2799-SV <input type="checkbox"/> V2799-BI <input type="checkbox"/> Frame Enclosed <input type="checkbox"/> New Frame <input type="checkbox"/> Used Frame			
Frame Manufacturer	Frame Style	Eye Size	Bridge Size	Temple	Color		
<b>Add Ons (VER REQUIRED)</b>				<b>Special Instructions:</b> (Include medical justification for tint and/or special instructions for lab)			
<input type="checkbox"/> VIP X/L Progressives V2781		<input type="checkbox"/> Scratch Resist V2760		<input type="checkbox"/> Spectralite S0590-SV/S0590-BI			
<input type="checkbox"/> Multi-Layer Anti-Glare V2750		<input type="checkbox"/> Plastic Photochromic V2744		<input type="checkbox"/> 1.60 S0581-SV/S0581-BI			
<input type="checkbox"/> Polycarbonate S0580-SV/S0580-BI		<input type="checkbox"/> Other _____					
* Do not send case, straps, or specialty attachments with frame(s)							
PROFESSIONAL SIGNATURE:			DATE OF SERVICE:		TELEPHONE: (     )		
White – Lab Copy  Yellow – Lab Billing Copy  Pink – Packing Slip/Mailing Label  Goldenrod – Doctor's Copy			<b>SHIP TO:</b>				

***E. Non-Covered Services Waiver Forms (English & Spanish)***

- These forms should be completed by the Member when they request Non-Covered Services and/or Materials such as:
  - 1) Cosmetic contact lenses and fitting services
  - 2) Non-benefit frames
  - 3) Cosmetic tints/lens coatings
  - 4) Lenses, other than CR39 and Glass

These forms help to ensure that the Member understands the services requested are not covered under their vision benefits and they are responsible for payment.



**NON-COVERED SERVICES / MATERIALS WAIVER FORM**

MEMBER NAME: \_\_\_\_\_ MEMBER DOB: \_\_\_\_\_

MEMBER IEHP ID#: \_\_\_\_\_

PROVIDER NAME: \_\_\_\_\_

Requested Non-Covered Service(s) and/or Materials (check all that apply):

- |   | FEE      |
|---|----------|
| <input type="checkbox"/> Cosmetic contact lenses and fitting services | \$ _____ |
| <input type="checkbox"/> Non-benefit frames                           | \$ _____ |
| <input type="checkbox"/> Cosmetic tints/lens coatings                 | \$ _____ |
| <input type="checkbox"/> Lenses, other than CR39 and Glass            | \$ _____ |
| <input type="checkbox"/> Other _____<br>(specify)                     | \$ _____ |

Total Charges: \$ \_\_\_\_\_

I request the specified service(s)/materials. I understand that the service(s)/materials are not covered by IEHP and/or Medi-Cal and are unavailable as a benefit to me. I understand that I am under no obligation to purchase any non-covered service or that in requesting such services or materials, I accept full responsibility of payment for all charges as indicated above.

This waiver does not apply to any IEHP/Medi-Cal covered benefits. All standards regarding covered benefits are unaffected by the provisions of this waiver.

\_\_\_\_\_  
Member's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Provider's Signature

\_\_\_\_\_  
Date



**FORMULARIO DE EXENCIÓN DE SERVICIOS/MATERIALES SIN COBERTURA**

NOMBRE DEL MIEMBRO: \_\_\_\_\_

FECHA DE NACIMIENTO DEL MIEMBRO: \_\_\_\_\_

# DE IDENTIFICACIÓN DE IEHP DEL MIEMBRO: \_\_\_\_\_

NOMBRE DEL PROVEEDOR: \_\_\_\_\_

Servicio(s) y/o materiales sin cobertura solicitado(s) (marcar todas las opciones que correspondan):

- |  | TARIFA   |
|--|----------|
| <input type="checkbox"/> Lentes de contacto cosméticos y servicios de ajuste | \$ _____ |
| <input type="checkbox"/> Armazones que no forman parte de sus beneficios     | \$ _____ |
| <input type="checkbox"/> Tintes cosméticos/recubrimientos para lentes        | \$ _____ |
| <input type="checkbox"/> Lentes, que no sean de CR39 ni de vidrio            | \$ _____ |
| <input type="checkbox"/> Otros _____   | \$ _____ |
| (especifique)  |          |

Importe total: \$ \_\_\_\_\_

Solicito el servicio(s)/material(es) especificado(s). Comprendo que el servicio(s)/material(es) no está cubierto por IEHP y/o por Medi-Cal y que no están disponibles para mí como un beneficio. Comprendo que no estoy obligado a adquirir ningún servicio sin cobertura y que, al solicitar dichos servicios o materiales, acepto la responsabilidad total del pago de todos los importes indicados arriba.

Esta exención no se aplica a ninguno de los beneficios cubiertos de IEHP/Medi-Cal. Ninguno de los estándares relacionados con los beneficios cubiertos se verá afectado por las disposiciones de esta exención.

\_\_\_\_\_  
Firma del miembro

\_\_\_\_\_  
Fecha

\_\_\_\_\_  
Firma del proveedor

\_\_\_\_\_  
Fecha

## **11. IEHP Vendor Direct Deposit**

### 1) Frequently Asked Questions (FAQs)

- What is a direct deposit payment?
  - Direct deposit is a method of payment where your funds are deposited directly into your bank account. No paper check is issued.
- How do I sign up for direct deposit payments?
  - You will need to complete the IEHP Application and Authorization for Vendor Direct Deposit Payments form. If the forms are completed correctly, IEHP will set up your record within two business days. IEHP will then request verification of the bank account information from your financial institution. This verification takes approximately two weeks. When the verification has been completed, you can then be paid by direct deposit.
- Do I need any special software to receive direct deposit payments?
  - No. All you need is a valid account at any United State bank or credit union that participates in direct deposit.
- What format is used to transmit the direct deposit payment?
  - IEHP currently makes direct deposit payments using the CCD (Cash Concentration or Disbursement) format.
- How will I know that I have received a direct deposit payment?
  - You will receive a direct deposit notification, either by e-mail or US mail, detailing the payor, all invoice/claims numbers, the dollars amounts in each day's deposit, and the date of the deposit. Notification is mailed two days before the deposit is made.
- Will my bank notify me that I have received a direct deposit payment?
  - Each bank has its own internal procedures. Please contact your bank to find out its process.
- How soon will the direct deposit be in my account?
  - The funds become available three business days or sooner, depending on your banking institution, after the payment has been processed by IEHP.
- Is my bank account information secure?

- Yes. IEHP has only a few designated staff that has access to update and read vendor bank account information.
- How do I notify IEHP of changes to my bank account?
  - To update your account, call IEHP's Provider Team at (909) 890-2054. Please provide a week's notice before you close an account and provide us with a replacement account.
- Can I get my claims remittance advice electronically?
  - Due to HIPAA regulations, we are not offering this service at this time.
- Can I get my claims remittance advice faxed to me?
  - We do not offer that service at this time. We will consider adding it if enough vendors request it.
- Who do I contact if I have additional questions?
  - You can contact IEHP's Provider Team at (909) 890-2054.

- 2) It is convenient and easy to sign up to receive payment directly into your account. All you have to do is fill out an Application and Authorization for Vendor Direct Deposit Payments Form.

**INLAND EMPIRE HEALTH PLAN  
ACCOUNTS PAYABLE**

**Application and Authorization for Vendor Direct Deposit Payments**

Directions: Read Frequently Asked Questions. Complete all information and attach a voided check to this form. Mail to Accounts Payable, PO Box 19026, San Bernardino, CA 92423-9026.

**Transaction Type:**

<input type="checkbox"/> New Setup	<input type="checkbox"/> Change financial institution
<input type="checkbox"/> Cancellation	<input type="checkbox"/> Change account number

**Payee Identification:**

Provider ID \_\_\_\_\_

Provider/Vendor Name \_\_\_\_\_

Provider/Vendor TIN (Tax Identification Number) \_\_\_\_\_

Provider/Vendor E-Mail \_\_\_\_\_

Contact Name \_\_\_\_\_

Contact Phone Number \_\_\_\_\_

**Bank Information** (see sample check on page 2)

Depository Name	Transit/ABA number (9 digits)
Address	Account Number
City, State, Zip	Checking Account

I authorize Inland Empire Health Plan to initiate credit entries, and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my account indicated below and the depository institution named below hereinafter called Depository, to credit and/or debit the same to such account. It is my responsibility to notify IEHP Provider Services department at (909) 890-2054 immediately if I become aware of any changes in status or banking information. It is my responsibility to notify Provider Services immediately if I believe there is a discrepancy between the amount deposited directly to my bank account and the amount of the invoices/claims paid.

This authority is to remain in full force and effect until IEHP has received written notification from me of its termination in such time and in such manner as to afford IEHP and Depository a reasonable opportunity to act on it.

**Authorized Name** \_\_\_\_\_ **Title** \_\_\_\_\_

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**INLAND EMPIRE HEALTH PLAN  
ACCOUNTS PAYABLE**

**Application and Authorization for Vendor Direct Deposit Payments**

**Please attach Voided Check Here**

John Smith 123 Your Street Anywhere, USA 12345	<del>63-88</del> 0555 670 _____ 20 _____
PAY TO THE ORDER OF _____ \$ <span style="border: 1px solid black; display: inline-block; width: 80px; height: 20px; vertical-align: middle;"></span>	_____ DOLLARS
YOUR BANK 000-001 123 Main Street Anywhere, USA 12345	SAMPLE (NON-NEGOTIABLE)
FOR _____   : 063000471   : 1234567890	0555 _____

\_\_\_\_\_ ABA Number      \_\_\_\_\_ Account Number      \_\_\_\_\_ Check Number  
 (Do not include as part of your Bank Account number)

## 12. Important Contacts & Phone/Fax Numbers

<b>Phone and Fax Numbers</b>	
IEHP Provider Team Phone	(909) 890-2054
IEHP Website	<a href="http://www.iehp.org">www.iehp.org</a>
Vision Authorizations IVR	(888) 355-2234
Vision Exception Requests (VER) Online	<a href="http://www.iehp.org">www.iehp.org</a>
Fax	(888) 860-1299
IEHP Member Services Department	(800) 440-4347
Claims	<a href="http://www.iehp.org">www.iehp.org</a>
Claims Appeals Address	IEHP-Claims Department P.O. 10129 San Bernardino, CA 92423-0129
(Standard Vision Claims should be submitted on IEHP's website – <a href="http://www.iehp.org">www.iehp.org</a> )	

## 13. Important IPA – UM Fax Numbers

IPA Name	IPA Code	Fax Number
Alpha Care Medical Group	A	(626) 401-1672
Inland Health Care Group	B	(909) 335-7147
Vantage Medical Group	C	(951) 778-1364
LaSalle Medical Associates	E	(323) 257-7637
Inland Faculty Medical Group	F	(323) 257-7637
IEHP Direct	J	(909) 890-5751
McKinley Medical Group	K	(951) 689-6644
Physicians Health Network	N	(951) 689-6644
Physicians Healthways	P	(626) 388-2336
Riverside Family Health Medical Group	Q	(818) 702-9128