4665 Business Center Drive
Fairfield, CA 94534
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www.partnershiphp.org

New Provider Education for Partnership HealthPlan of California Providers

Revised 06/2021

This document highlights some of Partnership HealthPlan of California's (PHC) programs and requirements and meets the new provider training requirements set forth by the Department of Healthcare Services (DHCS). **This document is for training purposes only, and does not replace or change contractual obligations between Providers and PHC**. More details are available in the PHC Provider Manual and on the PHC web site at www.partnershiphp.org/providers. Should you find any discrepancies between this document and the Provider Manual, please follow the Manual's specifications. PHC also has specific policies and procedures for each subject highlighted in this document. If you have any questions regarding the information following, please contact PHC's Provider Relations Department at (707) 863-4155.

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Welcome to the Partnership HealthPlan of California Provider Network

Partnership HealthPlan of California (PHC) is a non-profit community based health care organization that contracts with the State to administer Medi-Cal benefits through local care providers to ensure Medi-Cal recipients have access to high-quality comprehensive cost-effective health care. PHC provides quality health care to over 560,000 lives. Beginning in Solano County in 1994, PHC now provides services to 14 Northern California counties - Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity and Yolo. PHC's Mission is to help our members, and the communities we serve be healthy.

Contact Information

Provider Relations Department

Please contact the Provider Relations department for any questions or concerns about provider issues, network and contracting, credentialing, payment disputes, etc.

Hours of Operation: Monday - Friday, 8:00 am to 5:00 pm
Telephone: (800) 863-4155
Email: esystemssupport@partnershiphp.org

Claims Department

PHC Claims Department supports providers with general claims information; denied claims; Remittance Advice (RAs); claims submission process; and Claims Inquiry Form (CIF).

The billing limit is 365 days and clean claims are processed within 30 days of receipt. Please visit PHC website at www.partnershiphp.org/Providers/Claims for more information on coding tips, Electronic (EDI) claims submission and Important Provider Notices.

PHC Claims Contact Information:
Hours of Operation: Monday - Friday, 8:00 am to 5:00 pm
PHC Claims Telephone: (707) 863-4130
Address for Paper Claims, CIFs and Appeals:
PO Box 1368, Suisun City, CA 94585-1368

Health Services Department

Health Services handles Utilization Management of Referral Authorization Forms (RAFs) and Treatment Authorization Requests (TARs).

Other departments within Health Services are Care Coordination for Complex Case Management; Population Health for member Health Education; and Quality Improvement that works with providers on HEDIS measures and Quality Incentive Programs (QIP).

Hours of Operation: Monday - Friday, 8:00 am to 5:00 pm
Utilization Management Telephone: (707) 863-4133
Care Coordination Telephone: (800) 809-1350
Population Health: (800) 809-1350
Quality Improvement: (707) 863-4213

Member Services

Primary Care Providers (PCPs) and clinics are always the first point of contact for our members' medical care. Member Services is responsible for PCP assignments, eligibility verification and member related issues.

Hours of Operation: Monday - Friday, 8:00 am to 5:00 pm
Member Services Telephone: (800) 863-4155

Our Program

Welcome to PHC. PHC providers must promptly notify PHC of any changes in their practice location, hours of operation, or if they plan to terminate their relationship with their medical group or PHC. It is especially important for a Primary Care Provider (PCP) to provide at least 90 calendar days' notice of termination to PHC as PHC is required by law to re-assign patients to another PCP and to provide 30-day advance notification to members of this transition.

Eligibility

Eligibility and PCP Assignment

Eligibility can change from month-to-month. Although PHC members are issued ID cards, **providers are responsible for verifying member eligibility on the day of service and prior to providing care**.

PHC providers have three options for verifying eligibility:

- ✓ PHC Online Provider Portal found on our web site and at https://provider.partnershiphp.org/UI/Login.aspx
- ✓ Interactive Voice Response (800) 557-5471
- ✓ Member Services Department at (800) 863-4155, Monday-Friday, 8:00 am-5:00 pm

Questions regarding member's PCP assignment status can also be directed to Member Services at (800) 863-4155 between the hours of 8:00 am and 5:00 pm, Monday through Friday.

PCP Selection, Assignment, and Change

At the time of enrollment, new members are encouraged to select a PCP. When this does not happen, PHC will automatically assign a member to a PCP based on home zip code to a practice open to new members. PHC members who are auto-assigned to a PCP may select another PCP at any time. All members may change PCP, to a PCP of their choosing and who is accepting new patients. In most cases, PCP changes will be effective on the first day of the following month. The PCP is responsible for the management of a patient's care and it is the PCP's office that issues a Referral Authorization Form (RAF) for specialty care. Changes to a PCP are made through PHC's Member Services department.

Some Medi-Cal members do not meet the PCP assignment criteria. These members are referred to as Direct Members and can see any Medi-Cal approved provider, willing to provide medical care without needing a RAF. Examples of Direct Members are:

- ✓ Members residing in an LTC
- ✓ California Children's Services (CCS) member
- ✓ Foster Children, if known by PHC
- ✓ Medical diagnosis such as transplant recipients or End Stage Renal Disease
- ✓ Members with a Share of Cost (SOC)

Newborn Coverage

For the Managed Medi-Cal program, newborns are covered for eligible services under their mother's membership during the month of birth and the month following. Newborns must then be enrolled via the county eligibility office to continue coverage as a Medi-Cal member.

Access to Care

Appointment Availability

The California Department of Health Care Services (DHCS) set forth access requirements for Medi-Cal Managed Care Plans and their contracted providers which include maintaining availability standards for appointments.

APPOINTMENT TYPE	PROVIDER TYPE	STANDARD
Routine Care	PCP	10 business days
	Specialty	15 business days
	Mental Health	10 business days
Urgent Care	All Provider Types	48 hours
Prenatal Care	PCP	10 business days
Wait Time in Provider Office	All Provider Types	Not to exceed 30 min
Time to Answer Phone at Provider Office	All Provider Types	Not to exceed 10 min

After-Hours Access to Care

All PCPs are required to have phone coverage 24 hours a day, 7 days a week. After-hours access must include triage for emergency care and direction to call 9-1-1 for an emergency medical condition. A physician or mid-level provider must be available for contact after-hours, either in person or via telephone. All after-hours member calls must be documented in the member's permanent medical records. If a provider who is not the member's PCP treats the member, the treating provider must forward documentation of services received to the member's PCP.

Telephone Availability	All Provider Types	• Voice message must provide instructions to call 911 or the Emergency Room. • Voice message call back not to exceed 30 min. • Voice message must provide a call back number.

Emergency Services

An authorization is not required for emergency situations as defined by the examining physician. The examiningphysician determines required treatment to stabilize the patient.

Referrals, Prior Authorizations and Appeals to UM Decisions

Referrals

PCPs are responsible for referring a PHC member to a PHC network specialist. In some instances, a specific specialty may not be available within the PHC network and an out of network referral may be issued by the PCP. Your medical group may issue a referral within that group.

Prior Authorization

All requests for Prior Authorization must be sent to PHC.

Prior Authorization Exceptions

Are identified under the PHC Provider Manual in the Health Services section on our website at www.partnershiphp.org.

Appeal of UM Decisions

Providers appealing utilization management decisions on behalf of members must follow MCUP3037 in the Provider Manual. PHC will send a Notice of Appeal Resolution to the provider within 30 calendar days. If the appeal involves an imminent and serious threat to the health of the member, including, but not limited to, severe pain, potential loss of life, limb or major bodily function, a resolution will be provided within 72 hours.

Medi-Cal State Fair Hearing Process

Medi-Cal members or their authorized representatives have the option of filing a State Hearing with the Department of Social Services if they disagree with a Medi-Cal Managed Care Plan's decision regarding denial of a requested service. A State Hearing is an appeal with an Administrative Law Judge from the Department of Social Services. An expedited State Hearing may also be requested. Requests for State Hearings can be submitted by telephone at (800) 952-5253 or in writing to:

California Department of Social Services State Hearing Division
PO Box 944243, Mail Station 9-17-37
Sacramento, CA 94244-2430
Fax: (916) 651-5210 or (833) 281-0905 **Online:** https://www.cdss.ca.gov/hearing-requests

Members Rights

Members have the following rights per DHCS:

- To be treated with respect, giving due consideration to the Member's right to privacy and the need to maintain confidentiality of the Member's medical information.
- To be provided with information about the plan and its services, including Covered Services.
- To be able to choose a Primary Care Provider within the plan's network.
- To participate in decision making regarding their own health care including the right to refuse treatment.
- To voice grievances, either verbally or in writing, about the organization or the care received.

Members have the following rights per DHCS:

- To receive oral interpretation services for their language. This includes communication access to SPD beneficiaries in alternative formats or through other methods that ensure communication, including assistive listening systems, sign language interpreters captioning, written communication, plain language or written translations and oral interpreters, including for those who are limited English proficient, or non-English speaking.
- To formulate advance directives.
- To have access to family planning services, Federally Qualified Health Centers, Indian Health Service Facilities, sexually transmitted disease services and Emergency Services outside the plan's network pursuant to the Federal law.
- To request a State Medi-Cal state hearing, including information on the circumstances under which an expedited state hearing is possible.

Members have the following rights per DHCS:

- To have access, and where legally appropriate, receive copies of, amend or correct their Medical Record.
- To access Minor Consent Services.
- To receive written Member informing materials in an alternative format (including Braille, large size print, or audio format) upon request and in a timely fashion appropriate for the format being requested.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- To receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand.
- Freedom to exercise these rights without adversely affecting how they are treated by the plan, providers, or the State.
- To receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR§164.524 and 164.526.

Member Complaints and Grievances

Time frames for filing & resolving complaints	
Time frame for filing (from date of denial, service, incident or bill)	
Type of complaint	Timeframe
Grievance	No time limit
Time frame for processing	
Type	Grievance and appeals process
Standard	30 calendar days
Expedited	72 hours

A Medi-Cal member must first exhaust a Medi-Cal Managed Care plan's appeals process prior to proceeding with a State Hearing. Requests for State Hearings must be submitted within 120 calendar days of an action with which the member is dissatisfied. For standard State Hearings, the State will make a decision within 90 days of the request.

Benefits

Behavioral Health Services

PHC covers outpatient mental health services for Medi-Cal members with mild to moderate conditions.
Beacon Health Options (Beacon) manages behavioral health services for all PHC Medi-Cal members, including non-specialty (mild to moderate) mental health services. To refer a member for mental health services, call Beacon's toll-free Access Line at (855) 765-9703. Kaiser members access Kaiser for Mental Health Services.

Mild to moderate mental health benefits include:

- ✓ Individual and group mental health evaluation and treatment (psychotherapy)
- ✓ Psychological testing, when clinically indicated to evaluate a mental health condition (prior authorization required)
- ✓ Outpatient services for the purpose of monitoring drug therapy
- ✓ Psychiatric consultation
- ✓ Outpatient laboratory, drugs, supplies, and supplements (continuation of current benefit)

Wellness and Recovery

PHC also has a Wellness and Recovery benefit for substance use disorders for Medi-Cal beneficiaries in Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou and Solano counties. Members can be screened and connected to a treatment provider by calling Beacon Health Options at (855) 765-9703. In the seven Wellness and Recovery counties, services are available to all Medi-Cal recipients who meet the medical necessity criteria as determined by the American Society of Addiction Management (ASAM) scale. The range of services includes:

- ✓ Outpatient treatment
- ✓ Intensive outpatient treatment for individuals with greater treatment needs
- ✓ Detoxification services (withdrawal management)
- ✓ Residential treatment
- ✓ Medically assisted treatment (methadone, buprenorphine, disulfiram, naloxone)
- ✓ Case management
- ✓ Recovery services (aftercare)

*Expanded SUD services are available in Napa, Marin, and Yolo counties, and are administered by the counties. A more limited benefit is administered by the remaining four counties — Del Norte, Lake, Sonoma, and Trinity.

For more information on the Wellness and Recovery benefit, please visit the PHC website at http://www.partnershiphp.org/Providers/HealthServices/Pages/Drug%20Medi-Cal/Drug-Medi-Cal-Benefit.aspx.

Behavioral Health Treatment (BHT) for Autism Spectrum Disorder (ASD)

Treatment includes applied behavior analysis and other evidence-based services. PHC members must be under 21 years or age and have behaviors that interfere with home or community life. The services should develop or restore, as much as possible, the daily functioning of a Member with ASD. BHT services must be:

- ✓ Medically necessary
- ✓ Prescribed by a licensed doctor or a licensed psychologist
- ✓ Approved by the Plan

Vision Benefits

Vision Service Plan (VSP) administers vision benefits for PHC Medi-Cal members. Optometry services are a vision benefit and are available every 24 months. Ophthalmology services are a medical benefit through PHC and there is no age restriction for these services.

Providers can refer a member to a participating VSP provider. For questions regarding vision benefits or to find a VSP provider, please contact VSP at 1-800-877-7195 or visit www.vsp.com.

Pharmacy Benefits

For information about program-specific pharmacy benefits, exclusions or the pharmacy network visit www.partnershiphp.org or contact the PHC Pharmacy Services Department at 1(800) 863-4155.

Health Assessments

Initial Health Assessment (IHA)

An IHA is an initial comprehensive preventive clinical visit with a primary care practitioner. DHCS requires that PCPs complete an IHA with new PHC members within 120 calendar days of enrollment for all ages. The IHA, at aminimum, includes a history of the member's physical and mental health, an identification of risks, an assessmentof need for preventive screens or services and health education, and the diagnosis and plan for treatment of any diseases. It enables the member's PCP to assess and manage the acute, chronic, and preventative health needs ofthe member.

Staying Healthy Assessment (SHA)

The Staying Healthy Assessment (SHA) is an Individual Health Education Behavioral Assessment (IHEBA) approved by the Department of Health Care Services (DHCS) and is designed to help determine and meet any specific behavioral health education needs the patients might require. The SHA consists of seven age-specific pediatric questionnaires and two adult questionnaires. Our threshold languages are available on PHC website as well as information on other languages.

The SHA, through its set of questionnaire can help providers identify high-risk behavior, set priorities for behavior change, and refer patients for appropriate services. PHC wants our providers to meet state regulations. The purpose of the SHA is to ensure Medi-Cal member's healthcare needs are met. The state may audit your office so make sure the SHA is being utilized.

Timeline Requirements:

- ✓ Age 0 -17 - within 120 days of enrollment.
- ✓ Age 7-12 - 1st Scheduled Exam, after entering new age group.
- ✓ Adults/Seniors - within 120 days of enrollment, then every 3-5 years. PCP reviews and initials

For more information, please visit the PHC website at http://www.partnershiphp.org/Providers/HealthServices/Pages/SHA-Training-for-Providers.aspx.

Coordination of Care for Medi-Cal Members

California Children's Services (CCS)

CCS provides diagnostic and treatment services, medical case management, and physical and occupational therapy services for children age 21 years and younger who have CCS-eligible physical disabilities and complex medical conditions. PHC's Whole Child Model (WCM) program provides diagnostic, treatment and case management services for children under age 21 who have been diagnosed with a condition eligible for CCS. While PHC is responsible for coordinating services for children in our service area, the county CCS staff where the member lives is responsible for determining the child's eligibility and entrance to the CCS WCM program.

If the child is eligible for the CCS WCM program, PHC will provide case/care management, provider referrals and treatment authorizations. A list of CCS-eligible conditions can be found on the DHCS website at https://www.dhcs.ca.gov/services/ccs/Pages/medicaleligibility.aspx.

All providers and hospitals should refer possible CCS-eligible members directly to their county CCS office for determination of program eligibility. The following information must be included in the referral:
Child's Name, Date of Birth, CIN#, CCS Diagnosis, Date of Onset and Medical Records

For more information on CCS and PHC, please visit the PHC website at http://www.partnershiphp.org/Providers/Medi-Cal/Pages/Whole-Child-Model.aspx.

Health Education

PHC members must be provided with health education services at no cost. Health education services include but arenot limited to primary and obstetrical care, clinical preventive services, education and counseling, and patient education and clinical counseling.

Visit PHC's website at www.partnershiphp.org to access PHC's Health Education Library. Health Education resources are available in PHC's threshold languages. If you would like more information about Health Education, please contact PHC at CLHE@partnershiphp.org.

Cultural and Linguistics Training

If you do not currently offer Cultural Competency training to your staff, you can access PHC's webinar and training attestation on our website at http://www.partnershiphp.org/Providers/HealthServices/Pages/Providers-Language-Assistance.aspx.

Providers are expected to ensure employees receive training to increase their cultural competency and improve communications with patients. If your provider office does not offer Cultural Competency training, you can access PHC's webinar and training. Providers must attest to this training.

The goal is to increase awareness and understanding of issues affecting patients from different walks of life. This includes the LGBT community; immigrants to the US; and seniors and persons with disabilities. Cultural competence in health care describes the ability of systems and health care professionals to provide high quality care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet each individual's social, cultural, and linguistic needs.

Provider Groups

In order to maintain an accurate provider directory, and stay compliant with SB137, **all contracted medical groups and providers that provide Cultural Competency training to their medical staff must complete and return the attestation.** Once the attestation is on file with PHC, all practitioners associated with the provider group will appear in the PHC provider directory with the Cultural Competency icon to denote those practitioners who have completed training.

Information and Tools

More information and tools on the Cultural and Linguistics training, please visit the PHC website at:
http://www.partnershiphp.org/Providers/healthservices/pages/health%20education/cultural-andlinguistic-toolkit.aspx

For questions regarding the Cultural and Linguistic Provider Toolkit, please contact your Provider Relations Representative or the PHC Health Education team at (707) 863-4256.

Interpreter Services

PHC has coordinated a toolkit to educate providers about documenting patient language needs in medical charts, accessing interpreter services and referring patients to culturally and linguistically appropriate community service programs. Providers can access PHC's webinar and training attestation at http://www.partnershiphp.org/Providers/HealthServices/Pages/Providers-Language-Assistance.aspx.

PHC providers are required to provide Interpreter Services to PHC Medi-Cal members and must:

- ✓ **Document a member's preferred language (if other than English) in the medical record.**
- ✓ **Document the request and refusal of language/interpretation services in the member's medical record.**

Providers should discourage members from using friends, family and minors as interpreters.

PHC provides telephone interpretive services for PHC members with limited English proficiency. Providers may access Language Line Services 24 hours a day. For PHC members:

- ✓ Log on to PHC Provider Portal at https://provider.partnershiphp.org/UI/Login.aspx
- ✓ If you have any questions or need a Provider Portal login, contact: EsystemsSupport@partnershiphp.org

Member/Provider Face-To-Face Interpretive Services

PHC will only pay for face-to-face interpreters for special situations:

- ✓ Services for hearing impaired members
- ✓ Complex courses of therapy or procedures

Prior authorization via phone is required. To request a face-to-face interpreter, contact the PHC Member Services Department at **(707) 863-4120** or **(800) 863-4155**. Requests must be made at least three (3) days, preferably five (5) days prior to scheduled appointment.

Services for the Hearing Impaired

- ✓ **Members** who are hearing impaired may contact the free **California Relay Service** at (800) 735-2922.
- ✓ **Providers** may use the free **California Relay Service** at **(800) 735-2922** to communicate with a hearing impaired member via phone. For office visits, follow the instructions above to request a sign language interpreter.

Please Avoid Using Family Members or Friends as Interpreters

PHC strongly discourages the use of family members or friends, especially minors, as interpreters for PHC members. If a member declines interpreter services, the State requires providers to document such in the medical record.

Medi-Cal SPD Training

California Department of Health Care Services (DHCS) enacted mandatory enrollment of Seniors and Persons with Disabilities (SPD) into managed care. PHC has developed a training tool that meets the DHCS requirements for SPD Training. The tool and additional resources are in the Provider section of our website. The link to the training tool is on the Health Services web page and listed **Seniors and Persons with Disabilities (SPD) Health Risk Assessment (HRA).**

There is a quiz at the end of the training. Providers must complete it in order for PHC to verify compliance with the State requirements. Providers who have completed SPD Sensitivity Training can send the signed attestation of completion to compliancereports@partnershiphp.org or fax it to (**707) 863-4395**.

The attestation should include:

- ✓ the name of the provider representative
- ✓ contact information
- ✓ the provider or organization name
- ✓ the organization NPI number(s)

Questions about the training should be directed to the PHC Health Education Department at CLHE@partnershiphp.org.

HIPAA

PHC and its' contracted providers share a responsibility to protect member/patient information, in oral, written and electronic formats. Any time a PHC member's information is lost in a breach, a provider must notify PHC so that a report can be filed with the proper regulatory agency regarding the details of the lost information. The following are some questions and answers to help you understand HIPAA and your responsibilities as a PHC provider.

The Health Insurance Portability and Accountability Act (HIPPA) is a Federal law that protects Protected Health Information (PHI). PHI includes any information that can be used to identify a member or patient. A HIPAA Breach occurs whenever member or patient information is lost. This can happen by accident or theft. PHI includes any personal information that can identify a member/patient.

If you already notified another agency, do you still have to notify PHC? Yes and report it immediately; as soon as the breach is identified. Providers must contact the PHC Privacy Officer as soon as they are aware that a breach occurred. Contact the PHC Privacy Officer by phone at **707-420-7625**, or by mail at 4665 Business Center Dr., Fairfield CA 94534.

Fraud, Waste and Abuse (FWA)

- **Fraud:** An intentional act of deception, misrepresentation, or concealment in order to gain something of value.
- **Waste:** Over-utilization of services (not caused by criminally negligent actions) and the misuse of resources.
- **Abuse**: Excessive or improper use of services or actions that is inconsistent with acceptable business or medical practices. This refers to incidents that, although not fraudulent, they may directly or indirectly cause financial loss.

The PHC Anonymous Fraud Hotline - Call (800) 601-2146
Members, providers and employees can call the fraud hotline 24 hours a day, 7 days a week to report suspicious and fraudulent activity anonymously. Reports are forwarded to PHC for review.

Medi-Cal Fraud Issues - Call (800) 822-6222
Providers and members should call the Bureau of Medi-Cal Fraud and Elder Abuse. Providers and members can also call PHC to report suspicious and fraudulent activity, however, members and providers will also be referred to the State for complete reporting.

Additional Options for Reporting FWA: For Providers: (707) 863-4100; For Members: (800) 863-4155

Online Services Provider Portal

Providers should use the web-based platform, the Online Services Provider Portal, to access the following:

- ✓ Check Eligibility Verification
- ✓ Capitation Reports
- ✓ Submit RAFs and TARs
- ✓ View status of authorizations
- ✓ View status of claims
- ✓ Submit eCIF (Claims Inquiry Form)
- ✓ Monthly eligibility downloads
- ✓ Eligibility Reports – must be downloaded monthly as information is not stored

To access the Provider Portal visit https://provider.partnershiphp.org/UI/Login.aspx. The PHC website has training modules on how to create a user account or reach out to esystemssupport@partnershiphp.org for help.

Authorizations: eRAF and eTAR

PHC is a Managed Care Health Plan. Most members are assigned to a unique Primary Care Provider (PCP). To refer a patient for specialty care, the PCP submits an electronic Referral Authorization Form (eRAF) to PHC for the member. PHC processes the eRAF and forwards it to the Specialist.

Other services may require an electronic Treatment Authorization Request (eTAR). Services requiring an eTAR include, but are not limited to:

- ✓ All inpatient admissions
- ✓ Outpatient CT scans, MRIs, and PET scans
- ✓ Certain chemotherapies and medications
- ✓ Specific outpatient procedures

PHC TAR Guidelines are different from those required by Medi-Cal. Details, including timeline requirements and documentation are located on the PHC website:
http://www.partnershiphp.org/Providers/HealthServices/Documents/MCTARRequiremnts.pdf

Billing Guidelines

PHC strongly encourages electronic claims submission. Claims must be billed with the five (5) digit CPTcodes, HCPCS codes and modifiers following Medi-Cal requirements. PHC is the "payor of last resort" and will coordinate benefits following adjudication by the primary payor.

The PHC claims reimbursement information is located on the PHC website at:
http://www.partnershiphp.org/Providers/Claims/Pages/default.aspx

Balance Billing is Prohibited

Providers who offer services or supplies to Medi-Cal members are prohibited from balance billing the member for any cost-sharing not related to the member's share of cost for Medi-Cal services. This includes deductibles, co-insurance and co-payments.

Provider Directory and Provider Manual

Provider Directory

PHC providers can find a searchable Online Provider Directory on the PHC website at
http://www.partnershiphp.org/Members/Medi-Cal/Pages/Find-a-Primary-Care-Provider.aspx.

The Online Directory is updated daily to reflect changes made the previous business day. To report an error, please email PHCDirectory@partnershiphp.org.

As a reminder, PHC must be notified 90 days prior to closing or moving a site location.

Provider Manual and PHC Policies

The PHC Provider Manual is designed as a reference guide and communications tool for PHC providers and their staff related to providing comprehensive, effective, and quality medical services to PHC members. Please visit the PHC website at http://www.partnershiphp.org/Providers/Medi-Cal/Pages/Provider-Manuals.aspx for updated policies and procedures as they relate to PHC providers and members.

Provider Emergency Notification (PEN)

The Provider Emergency Notification (PEN) is designed for the PCP network to notify PHC the status of the site during a State of Emergency, Public Safety Power Shutoff (PSPS), office closure due to COVID-19 or devastation such as fire, earthquake or flood.

It is important to send your notification e-mail the night before possible closure or before 9 a.m. the following morning.

In an emergency we encourage you to notify PHC of your clinic's status with the following information:

- Daily clinic status (open or closed)
- Alternative phone numbers (if applicable)

PEN-NR@partnershiphp.org - **Northern Region** counties (Del Norte, Siskiyou, Modoc, Humboldt, Trinity, Shasta, Lassen)
PEN-SR@partnershiphp.org - **Southern Region** counties (Mendocino, Lake, Sonoma, Napa, Yolo, Solano, Marin)