

# Scripps Health Plan Services Newsletter



JUNE 2023 – SECOND QUARTER EDITION

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## PROVIDER OPERATIONS MANUAL

Our Provider Operations Manual serves as a comprehensive resource where providers can find helpful information on:

- Claims and Reimbursement
- Compliance and Privacy
- Key contacts
- Medical Management Program
- Providers' Roles and Responsibilities

### 2023 Summary of Changes

- Added the newly enacted state bills
- CCM Contact
- WPATH
- Post Stabilization

There are separate Manuals specific to SHP HMO and SHPS Managed Care:

**SHP HMO Manual:** [SHP Manual](#) **SHPS Managed Care Manual:** [SHPS Manual](#)

## SPECIAL NEEDS MODEL OF CARE TRAINING

The Centers for Medicare and Medicaid Services (CMS) requires Medicare Advantage organizations (MAOs) to provide initial and annual Model of Care Training for Special Needs plans (SNP) and those participating in Medicare Medicaid Plans (MMP or Cal MediConnect). In accordance with the regulations, Scripps Health Plan Services, in partnership with SCAN and Health Net has included their links to the Model of Care training (MOC).

The following document care be accessed through the [SCAN Health Plan website](#) and include:

- 2023 SNP MOC FAQs
- 2022 SNP MOC Training PowerPoint presentation
- 2022 SNP MOC Training – Webinar Recording

[D-SNP Provider Trainings and Webinars | Health Net](#)

Model of Care Training links are also available on our website, under our provider page [SHPS Website](#)

## MEDICAL BILLING TIPS/CPT MODIFIERS

SHPS has received a few questions about **Multiple Procedures modifiers 51 and 59**; and **Bilateral Procedures modifier 50**.

It is important to remember some key points when you are coding submissions.

CMS may not require **modifiers 51, 59, or 50** since their hard-coded logic allows the claims payment reductions on multiple and/or bilateral procedures to adjust payment automatically, per guidelines.

The processing of **modifiers 51, 59, and 50** by any other carrier besides CMS is determined by the carrier. SHPS requires these modifiers to be present on the claim for it to be processed accurately which results in faster reimbursement.

## COVID-19

For COVID-19 related information, including FAQs, testing, and vaccine information, visit Scripps Health's dedicated [COVID-19](#) webpage.

**REMINDER:** Claims for COVID services are submitted directly to the Health Plans unless the claim is for a senior member. Then those claims are submitted to SHPS.

## SENATE BILL 137

Senate Bill 137 defines strict requirements for the accuracy of both online search tools and the provider directory for payors and practitioners in California. The law requires that medical groups and/or plans validate the provider information below once or twice a year based on your contracted Status.

Update your information by completing a Provider Demographic Update Form under Directory Updates on the [SHPS Website](#).

**REMINDER:** Please email [ProviderRelations@scrippshealth.org](mailto:ProviderRelations@scrippshealth.org) when someone has joined or left your practice.

## PROVIDERS/GROUPS TERMINATING THEIR CONTRACTS

Providers seeking to terminate their contract with Scripps Health Plan Service (SHPS) and in an effort to coordinate and ensure that the members (patients) receive the sixty (60) day notice, SHPS requests a minimum of ninety (90) days written notice. Also, to ensure continuity of care for our members (patients), we request the terminating provider indicate the desired provider for whom all open referrals should be reissued to.

## AMERICAN MEDICAL RESPONSE

Although the City of San Diego has made contractual changes for ambulance transport, American Medical Response will continue to be Scripps Health Plan Service's transportation provider.

All services can be accessed through the Scripps Medical Transportation service line, 858-492-3656.

# SPOTLIGHT ON SHPS UTILIZATION MANAGEMENT – REFERRAL REQUESTS

## Important reminders:

- **Referral requests should be made electronically through Epic or Scripps Care Link.** Do not fax referral requests unless absolutely necessary (e.g., system issues, waiting for Scripps Care Link access).
- **The Authorization Change Request form is no longer in use.**
- **There are regulated timeframes for making referral decisions are below:**

| CATEGORY         | COMMERCIAL TIMEFRAMES                                     | MEDICARE TIMEFRAMES                                       |
|------------------|---|---|
| Routine          | Within five (5) business days of receipt                  | Within fourteen (14) calendar days of receipt             |
| Urgent           | Within seventy-two (72) hours of receipt                  | Within seventy-two (72) hours of receipt                  |
| Routine Pharmacy | Within seventy-two (72) hours from the receipt of request | Within seventy-two (72) hours from the receipt of request |
| Urgent Pharmacy  | Within twenty-four (24) hours from the receipt of request | Within twenty-four (24) hours from the receipt of request |

- **Approved referrals cannot be modified** due to regulatory requirements. If you need to add a CPT code, please submit a new referral request.
- **Request a peer-to-peer meeting with a physician reviewer.** The physician reviewer name and direct telephone number is printed on all referral denial letters.
- **Physician reviewers are not financially incentivized,** motivated, or otherwise rewarded for issuing denials of requested health services and are not offered any financial incentives that would encourage underutilization of services.
- **Need help to coordinate language interpreter services?** Call our SHPS Customer Service department to assist at 888-680-2273 (MSO members) or 844-337-3700 (Scripps Health Plan members).
- **If you are unable to obtain a timely referral** to an appropriate provider for a member, you may contact the member’s health plan for assistance (see the “Managed Care Grievance Process” section of this newsletter for plan contact information) or file a complaint with the Department of Managed Health Care. The department has a toll-free telephone number (888-466-2219) and a TDD line (877-688-9891) for the hearing and speech impaired, as well as an internet website [www.dmhca.gov](http://www.dmhca.gov).

## RETRO-AUTHORIZATION UPDATE

To align with Medicare regulations, all Medicare Advantage post-service request are to be submitted to the SHPS claims department. The utilization management department will no longer provide retro-authorization for Medicare Advantage members. SHPS UM department continues to review Commercial member post-service request for authorization.

## POST-STABILIZATION CARE

### Notification is required within 24 hours of admission for all Scripps Health Plan Services Managed Care Members

For Emergent Medical Admissions or Transfers

Call Scripps Centralized Transfer Center at (858) 678-6205

*If you do not obtain authorization to provide post-stabilization care to a member, neither Scripps Health Plan Services nor the member will be held financially responsible for any unauthorized care provided by the hospital.*

***Your facility cannot balance bill our members.***

*Managed Care/HMO Plans and Medical Groups Contracted with Scripps Health Plan Services:*

|                           | Commercial | Medicare | Scripps Medical Foundation                                     |
|---------------------------|------------|----------|--|
| Alignment Health Plan     |            | X        | Scripps Clinic Medical Group<br>Scripps Coastal Medical Center |
| Anthem Blue Cross         | X          | X        |  |
| Blue Shield of California | X          | X        |  |
| Cigna                     | X          |          |  |
| Health Net                | X          | X        |  |
| SCAN Health Plan          |            | X        |  |
| Scripps Health Plan       | X          |          |  |
| United Healthcare         | X          | X        |  |

## WORLD PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH (WPATH) TRAINING REQUIREMENTS

Each Commercial delegate responsible for decision-making on requests related to a gender dysphoria diagnosis MUST complete all WPATH requirements.

- All decisions related to a gender dysphoria diagnosis must be made by an individual that has completed all WPATH training requirements.
- WPATH requirements include completion of all didactic modules **and** participation in the live panel discussions.

Note: You must complete the SOC8 training modules **and** live panel discussions.

**PLEASE ENSURE THAT YOU ARE COMPLIANT WITH THIS REQUIREMENT NO LATER THAN 6/30/2023.**

**DIRECT LINK WPATH TRAINING:** [Health Plan Information - WPATH World Professional Association for Transgender Health.](#)

## **NONPHARMACOLOGICAL PAIN MANAGEMENT TREATMENT**

Information regarding the benefits and uses of nonpharmacological pain management treatment is available at <https://www.scripps.org/services/integrative-medicine/integrative-pain-management>.

## **POTENTIAL QUALITY ISSUES (PQI)**

A PQI is any suspected provider quality of care or service issue that has the potential to impact the level of care being provided to the enrollee/patient. Providers may include independent physicians, medical groups, hospitals, nurses, ancillary providers, and their staff as well as health plan staff.

Please see PQI guide and reporting form on our [SHPS Website](#).

## **SENATE BILL 1207 & HEALTH AND SAFETY CODE SECTION 1367.625 MATERNAL MENTAL HEALTH**

**Maternal Mental Health** law, as described in California SB 1207 and the Health and Safety Code (Section 1367.625) requires that a licensed health care practitioner (provider) who provides prenatal or postpartum care for a member shall ensure that all mothers are offered screening or is appropriately screened for maternal mental health conditions. Maternal mental health means a mental health condition that occurs during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression. As a contracted provider, you are required to comply with this regulation. Scripps Health Plan, in accordance with California Senate Bill (SB) 1207 and Health and Safety Code Section 1367.625, encourages you to perform the screening, diagnosis, treatment, and referral to appropriate mental health services, including maternal mental health. Efforts and outcomes of our maternal mental health program are monitored and designed to promote quality and cost-effective outcomes.

Scripps Health Plan members with a positive screening can be referred to our Evernorth Behavioral Health Network of providers and/or be referred to our Care Management Program, which includes maternal mental health and is designed to assist with healthcare needs, care coordination, and connecting members with appropriate resources. No prior authorization is required to access care with our behavioral health care network of providers.

## ACCESS TO CARE STANDARDS

Access Standards: As a contracted provider, you are required to comply with the regulatory standards regarding access to care and services for our members. The following standards are monitored on an ongoing basis:

### NON-EMERGENCY APPOINTMENT ACCESS STANDARDS-MEDICAL

| Appointment Type  | Time-Elapsed Standard  |
|---|--|
| <b>Non-urgent</b> appointments for Primary Care Physician (PCP)   | Must offer the appointment within ten (10) business days of the request              |
| <b>Non-urgent</b> appointments with Specialist physicians (SPC)   | Must offer the appointment within fifteen (15) business days of the request          |
| <b>Urgent Care</b> appointments that do not require prior authorization (PCP)   | Must offer the appointment within forty-eight (48) hours of request                  |
| <b>Urgent Care</b> appointments that require prior authorization  | Must offer the appointment within ninety-six (96) hours of request                   |
| <b>Follow-up appointment</b> with a non-physician mental health or substance use disorder (MHSUD) provider for those undergoing a course of treatment | Must offer the appointment within ten (10) business days following prior appointment |
| <b>Non-urgent appointments</b> for ancillary services (for diagnosis or treatment of injury, illness, or other health condition)                      | Must offer the appointment within fifteen (15) business days of the request          |

The timeframes for obtaining out-of-network specialty services if needed are consistent with the timeframes for obtaining in-network specialty services as outlined in the table above.

**If you are unable to obtain a timely referral** to an appropriate provider for a member, you may contact the member's health plan for assistance (see the "Managed Care Grievance Process" section of this newsletter for the plan contact information) or file a complaint with the Department of Managed Health Care. The department has a toll-free telephone number (888-466-2219) and TDD line (877-688-9891) for the hearing and speech impaired, as well as an internal website [www.dmhca.ca.gov](http://www.dmhca.ca.gov).

## SHPS COMPLEX CARE MANAGEMENT

**Complex Care Management (CCM)** is a team of highly trained registered nurses and social workers who are available to assist you and your patients to reach their health care goals. At no cost to your patient, we are here to provide that extra level of support to overcome health and social challenges. CCM partners with you and your patients to develop a customized care management plan of care, connection to available community resources, education on complex health conditions and help navigating through the health care system. CCM offers the extra level of support needed by developing a one-to-one relationship with your patient through telephonic and video outreach. In addition to complex cases with co-morbid conditions and high utilization, the CCM team offers specialty focus areas including:

- Three (3) or more admissions within a 12-month period
- Two (2) or more emergency room visits in a 6-month period
- Re-admission within 30 days with the same or similar diagnosis or condition
- Poly-pharmacy utilization consisting of more than 30 prescriptions
- Cancer diagnosis requiring multiple treatment modalities with complex care coordination across multiple disciplines
- Major organ transplant/ Major trauma
- High Risk OB/ High Risk Pediatric
- Minimum of one (1) complex condition with high risk for hospitalization or two (2) or more conditions expected to last at least 12-months.

Did you know that anyone can make a referral to our Care Management Program? Referrals can be made via: **Epic: Ambulatory Order #210 (Ambulatory referral to SHPS Complex Care Management)**

### Orders

Problem List Visit Diagnoses BestPractice Meds & Orders **SmartSets** Disp & CC Chart

Medications & Orders

+ Create Medication List Comments

case man| + New Order + Patient-Reported

After visit

Ambulatory referral to SHPS Complex Case Management

**Click this Ambulatory order**

Email: [shcmreferrals@scrippshealth.org](mailto:shcmreferrals@scrippshealth.org)

Voicemail: [888-399-5678](tel:888-399-5678)

Fax: 858-260-5834

[CM Referral Form](#)

## SERVICE FEE

A \$15 service fee will apply for copies of Canceled Checks or Remittance Advice effective 7/1/2023.

Once payment is received a copy will be issued. Please consider signing up for Scripps Care Link and EFT to access copies and avoid the service fee.

**REMINDER:** For password resets and unlocking your Scripps Care Link account please call the IS Service Desk, 858-678-7500.

## SCRIPPS CARE LINK

Scripps Care Link is our online web portal where you can check Scripps Health Plan member eligibility, enter referral requests, check the status of your referral requests, and view claims. You can send in-basket messages to SHPS departments and retrieve remittance advices.

Go to our Website for a Scripps Care Link Application [SHPS Website](#)

If your office uses a billing company, please have them email provider relations @ [ProviderRelations@scrippshealth.org](mailto:ProviderRelations@scrippshealth.org) to inquire about access.

## ELECTRONIC FUNDS TRANSFER (EFT)

The EFT Enrollment Form can be found on our website: [SHPS Website](#)

A prerequisite is being able to retrieve your ERAs (835 files) via one of our Clearinghouses, Office Ally, or Change.

Download and complete an EFT Enrollment form and return your signed form to SHPS by fax (858)260-5851 or email to [ProviderRelations@scrippshealth.org](mailto:ProviderRelations@scrippshealth.org).

Once your Vendor EFT is activated, paper Remittance Advices (RAs) will no longer be provided by SHPS.

RAs should be available electronically via your clearinghouse or through Scripps Care Link. If you have not applied for access to Scripps Care Link\_ yet, you can find this application on the website as well.

Confirm your EFT is active and contact Providers Relations to report any issues.

## ELIGIBILITY AND CLAIMS STATUS AUTOMATED PHONE SYSTEM FOR PROVIDERS

Our **automated phone system** allows for a quick check of claims status and Scripps Health Plan HMO eligibility status for one or more patients 24 hours a day, 7 days a week. Using this system saves you valuable time on the phone and offers a convenient self-serve option at any time of day. If you are in need to speak to a live agent, we are available Monday-Friday 8 a.m. – 5 p.m. SHP (844) 337-3700, SHPS (888) 680-2273.

To check **Scripps Health Plan HMO member eligibility**, please have the following information ready:

- 
- Your Tax ID number
- Member ID number (example: SH012345601 – you will input numbers only 012345601)
- Member date of birth

The system will provide the following **eligibility information**:

- Medical Group and PCP
- Coverage Information
- Effective and Term dates
- List of copays
- Maximum out of pocket limit (met/not met)

To check **claims status** for any of our managed care members, please have the following information ready:

- NPI associated with the claim (vendor or rendering provider NPI)
- Member Date of Birth
- Date of Service associated with the claim
- Billed Amount associated with the claim
- 

The system will provide the following **claims information**:

- Claim Status
- If claim paid: claim number, paid amount, patient responsibility, check number, and check date
- If claim denied: claim number, received date, and denied date
- If claim is pending: claim number and received date

## SHPS COMPLIANCE PLAN

Providers can view the SHPS Compliance Plan on the [SHP](#) and [SHPS](#) websites under provider resources.

## HOW TO REPORT COMPLIANCE CONCERNS

There are multiple ways to report compliance concerns, including potential fraud, waste, and abuse:

- Notify your supervisor or manager
- Notify SHPS Compliance Department: [SHPSCompliance@scrippshealth.org](mailto:SHPSCompliance@scrippshealth.org)
- Notify SHPS Chief Compliance Officer: [Pantovic.Linda@scrippshealth.org](mailto:Pantovic.Linda@scrippshealth.org) or (858) 927-5360
- Anonymously through the Scripps Health Compliance and Patient Safety Alertline ([online](#) or by phone 1-888-424-2387)

## MEDICAL RECORD DOCUMENTATION STANDARDS

Consistent, current, and complete documentation in the medical record is an essential component of quality patient care. There are specific elements that reflect a set of commonly accepted standards for medical record documentation. Providers will be required to meet minimum documentation standards to continue participation in the SHPS network. This includes electronic medical record (EMR) documentation. SHPS conducts periodic audits and ongoing oversight of documentation to ensure compliance with such standards. Medical record documentation audit activities are often directed to the PCP; however, audits of other practitioners and ancillary providers will be conducted as directed by the SHPS Compliance Department as a result of claims trends, suspected fraud, waste, or abuse, documentation issues, and/or as directed by any of our Scripps Health Plan Services Committees. Please refer to the “Medical Record Documentation Standards - Tip Sheet” available via the SHP and SHPS websites under [SHP Forms, Credentialing & Dispute Resolution](#) or [SHPS Provider Resources](#).

## STANDARDS OF CONDUCT – DOING THE RIGHT THING

[Scripps Health Standards of Conduct](#) serves as a primary education and communication tool that demonstrate how Scripps’ mission and values influence patient care, conduct daily business, interact with each other, and make everyday decisions. It is everyone’s responsibility for upholding these guiding principles and for providing care and conducting business in a manner consistent with these standards. Scripps Health has relevant and specific compliance guidance for physicians, advanced practice clinicians, vendors, and third parties.

## LANGUAGE ASSISTANCE PROGRAM (LAP)

State and federal law requires that health plans establish a **Language Assistance Program for limited English proficient members**. Providers are required to assist members in accessing language services made available by each health plan. Providers can access a qualified medical language interpreter for office appointments or other member encounters by contacting the member's health plan.

To request interpreter or translation services for SHP members, contact SHP's Customer Service line by calling **(844) 337-3700**, or TTY **(888) 515-4065**. Face-to-face interpreter service requests must be submitted at least five (5) days prior to an appointment. Should an interpreter not be available for face-to-face services, health plans can also arrange for telephone interpreting services. Scripps Clinic and Coastal providers also have access to interpreters through in-office **Blue Phones** or may contact their Operations Supervisor for assistance.

For SHPS Managed Care members, you can contact SHPS Managed Care Customer Service at **(888) 680-2273** for assistance.

## NON-DISCRIMINATION IN HEALTH CARE

SHPS requires providers to deliver services to members without regard to race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability. Provider offices, facilities, equipment, personnel, and administrative services must be at a level and quality necessary to perform duties and responsibilities to meet all applicable legal requirements, including the accessibility requirements of the Americans with Disabilities Act (ADA). The Health Industry Collaborative Effort (HICE) has prepared [Better Communication, Better Care: Provider Tools to Care for Diverse Populations](#). Provider guidance on civil rights is also available on the U.S. Department of Health and Human Services (HHS) [website](#).

Providers are expected to disclose complaints of discrimination to SHPS. If you or a member believe that SHPS has failed to provide language services or has discriminated against an individual in another way, a grievance may be submitted to the SHPS Appeals & Grievances Department in person or by mail, phone, fax, email, or online:

**Scripps Health Plan Services**  
**Attn: Appeals & Grievances Department**  
10790 Rancho Bernardo Rd., 4S-300  
San Diego, CA 92127  
Phone: (844) 337-3700 TTY: (888) 515-4065  
Fax: (858) 260-5879  
Email: [SHPSAppealsAndGrievancesDG@scrippshealth.org](mailto:SHPSAppealsAndGrievancesDG@scrippshealth.org)  
Online: [www.scrippshealthplan.com](http://www.scrippshealthplan.com)

The U.S. Department of HHS, Office for Civil Rights (OCR) also accepts complaints of discrimination electronically through the OCR Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by phone at (800) 368-1019 TDD: (800) 537-7697, or by mail at:

**U.S. Department of Health and Human Services**  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201

## LEGISLATIVE UPDATES

There are several state bills, effective this year, that may impact you. The information below is a summary of these legislative bills.

| # | State Bill   | Effective Date | Summary  |
|---|--|----------------|--|
| 1 | <b>AB 2585 - Nonpharmacological Pain Management Treatment</b>                          | 1/1/2023       | <ul style="list-style-type: none"> <li>Plans are encouraged to use evidence-based nonpharmacological therapies for pain management.</li> </ul>   |
| 2 | <b>SB 107 - Gender-affirming Health Care</b>   | 1/1/2023       | <ul style="list-style-type: none"> <li>Plans must not release medical information allowing a child to receive gender-affirming health care or mental health care in response to any civil action based on another state's law that authorizes a person to bring a civil action against a person or entity that allows a child to receive gender-affirming health care or mental health care.</li> <li>Plans must not release medical information who have requested that information and who are authorized by law to receive that information pursuant to Civil Code § 56.10(c), if the information is related to a person or entity allowing a child to receive gender-affirming health care or mental health care, and the information is being requested pursuant to another state's law that authorizes a person to bring a civil action against a person or entity who allows a child to receive gender-affirming health care or mental health care.</li> </ul>  |
| 3 | <b>SB 225 - Health Care Coverage: Timely Access to Care</b>                            | 1/1/2023       | <ul style="list-style-type: none"> <li>Plans must arrange for covered services for providers outside the Plan's network if medically necessary for the enrollee's condition.</li> <li>Prohibits plans from preventing, discouraging, or disciplining network providers/employees for informing an enrollee about timely access requirements.</li> </ul>  |
| 4 | <b>SB 245 - Health Care Coverage: Abortion Services &amp; Cost Sharing</b>             | 1/1/2023       | <ul style="list-style-type: none"> <li>Plans must not impose a deductible, coinsurance, copayment, or any other cost sharing requirement on abortion and abortion-related services, including preabortion and follow-up services, as well as imposing any UM review (i.e., prior authorization).</li> </ul>  |
| 5 | <b>SB 523 - Contraceptive Equity Act of 2022 and Health and Safety Code § 1367.25.</b> | 1/1/2023       | <ul style="list-style-type: none"> <li>Plans must provide coverage for services and contraceptive methods for enrollees:               <ol style="list-style-type: none"> <li>All FDA-approved contraceptive drugs, devices, and other products, including all FDA-approved contraceptive drugs, devices, and products available over the counter, as prescribed by enrollee's provider.</li> <li>Voluntary tubal ligation and other similar sterilization procedures.</li> <li>Clinical services related to the provision or use of contraception, including consultations, examinations, procedures, device insertion, ultrasound, anesthesia, patient education, referrals, and counseling.</li> </ol> </li> <li>Plans must provide coverage without cost sharing for the original, brand name contraceptive if there is not a therapeutic equivalent generic substitute available in the market.</li> <li>Plans must defer to the determination and judgment of the provider and provide coverage for the alternative prescribed contraceptive drug, device, product, or service without imposing any cost sharing requirements if the covered therapeutic equivalent of a drug, device, or product is deemed medically inadvisable by enrollee's provider.</li> <li>Plans must not infringe upon an enrollee's choice of contraceptive drug, device, or product and shall not impose any restrictions or delays on the coverage required, including prior authorization, step therapy, or utilization control techniques.</li> <li>Prohibits plans from requiring an enrollee to make any formal request (i.e. prior authorization requests, any utilization controls or any other forms of medical management restrictions), other than a pharmacy claim, for coverage of receiving a 12-month supply of self-administered hormonal contraceptives at one time.</li> </ul> |
| 6 | <b>AB 2352 - Prescription Drug Coverage</b>  | 7/1/2023       | <ul style="list-style-type: none"> <li>Plans must furnish specific prescription drug information upon request:               <ul style="list-style-type: none"> <li>-Enrollee's eligibility for the prescription drug.</li> <li>-Most current formulary/formularies.</li> <li>-Cost sharing information for the prescription drug and other formulary alternatives, accurate at the time it is provided, including any variance in cost sharing based on the patient's preferred dispensing pharmacy, whether retail or mail order, or the provider.</li> <li>-Applicable UM requirements for the prescription drug and other formulary alternatives.</li> </ul> </li> </ul>   |

## MANAGED CARE GRIEVANCE PROCESS

Scripps Health Plan Services is not delegated for grievances by any of the major health plans except for Scripps Health Plan (HMO) when we are the Plan. **Refer the patient to contact their health plan directly.**

Patient may file a complaint by call customer service, submit via mail, or use online grievance form. They can find the Health Plan contact information on the insurance identification card. (See below).

| Health Plan Name                 | Phone Number   | Link to Appeals and Grievances Form   |
|----------------------------------|----------------|---|
| Alignment Health Plan            | 1-866-634-2247 | <a href="#">Grievances and Appeals   Alignment Health Plan</a>  |
| Anthem Blue Cross                | 1-800-331-1476 | <a href="https://www.anthem.com/ca/forms/">https://www.anthem.com/ca/forms/</a>   |
| Blue Shield                      | 1-800-393-6130 | <a href="https://www.blueshieldca.com/bsca/bsc/public/member/mp/login">https://www.blueshieldca.com/bsca/bsc/public/member/mp/login</a>                                     |
| Cigna                            | 1-800-997-1654 | <a href="https://www.cigna.com/individuals-families/member-resources/appeals-grievances">https://www.cigna.com/individuals-families/member-resources/appeals-grievances</a> |
| Health Net                       | 1-800-675-6110 | <a href="https://www.healthnet.com/content/healthnet/en_us/members.html">https://www.healthnet.com/content/healthnet/en_us/members.html</a>                                 |
| United Healthcare                | 1-866-414-1959 | <a href="https://www.uhc.com/member-resources/forms">https://www.uhc.com/member-resources/forms</a>   |
| SCAN                             | 1-800-559-3500 | <a href="#">How to Complete a Grievance (scanhealthplan.com)</a>  |
| <b>Scripps Health Plan (HMO)</b> | 1-844-337-3700 | <a href="http://www.scrippshealthplan.com">www.scrippshealthplan.com</a><br><a href="#">Grievance and Appeal Process - Scripps Health Plan</a>                              |

## STAY CONNECTED

- Email: [ProviderRelations@scrippshealth.org](mailto:ProviderRelations@scrippshealth.org)
- Epic In-Basket: Within your Scripps Care Link account
- Phone: Managed Care (all plans) (888) 680-2273
- Phone: Scripps Health Plan HMO (844) 337-3700
- Scripps Health Plan Services website [SHPS](#)
- Scripps Health Plan website [SHP](#)