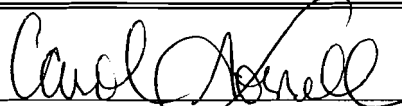
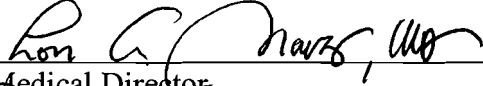
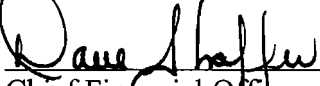
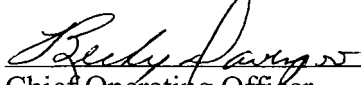
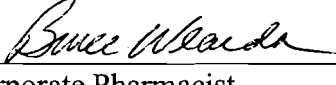


**KERN HEALTH SYSTEMS
POLICIES AND PROCEDURES**

SUBJECT: Out-of-Area Pharmacy Claims Processing		INDEX NUMBER 13.21-P		Page 1 of 3	
RESPONSIBLE DEPARTMENT HEAD: Corporate Pharmacist					
Review Date	08/1997	01/2001	02/2001	07/2005	07/2008
Effective Date			04/01/01	11/18/05	07/11/08
Revision No.	1997-08	2001-01	2001-03	2005-08	2008-07

Approved		Date	7/11/08
	Carol Sorrell, R.N. Chief Executive Officer		
Approved		Date	7-10-2008
	Medical Director		
Approved		Date	July 9/2008
	Chief Financial Officer		
Approved		Date	July 7, 2008
	Chief Operating Officer		
Approved		Date	July 1, 2008
	Corporate Pharmacist		

POLICY¹:

Kern Health Systems (KHS) will pay claims for prescriptions supplied to members at out-of-area pharmacies in emergency situations if the medication is included in the Kern Health Systems' Formulary.

PURPOSE:

To establish procedures for handling prescriptions for members out of Kern Health Systems' service area.

PROCEDURE:

1.0 PROVIDER REIMBURSEMENT

1.1 Authorization

1.1.1 Emergency or Urgent Care Prescriptions

If a member receives a prescription from an out-of-area emergency room or urgent

**KERN HEALTH SYSTEMS
POLICIES AND PROCEDURES**

SUBJECT: Out-of-Area Pharmacy Claims Processing	INDEX NUMBER 13.21-P	Page 2 of 3
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care physician, Kern Health Systems will authorize reimbursement to the out-of-area pharmacy if the medication is included in the KHS Formulary. If a contracted chain pharmacy is within a reasonable distance, that contracted chain pharmacy will be recommended first to the patient.

If the prescription is not in the KHS Formulary, the pharmacy needs authorization from the Kern Health Systems Medical Director or Corporate Pharmacist before completing the prescription. See *KHS Policy and Procedure #13.01-P: Drug Utilization and Non-Formulary Treatment Requests* for details.

1.1.2 Non-Emergency/Non-Urgent Care Prescriptions

Refills or non-emergency/urgent care prescriptions from an out-of-area pharmacy that is not in the plan network must be authorized by the Kern Health Systems Medical Director or Corporate Pharmacist prior to filling the prescription. The pharmacy should submit a Treatment Authorization Request (TAR) to Kern Health Systems. The TAR is processed according to the guidelines in *KHS Policy and Procedure #13.01-P: Drug Utilization and Non-Formulary Treatment Requests*.

1.2 Claims Submission

The pharmacy should submit a manual claim, preferably on a Medi-Cal 30-1 or similar form, to the KHS Pharmacy Department. Out-of-area pharmacy claims are not processed initially through KHS' Pharmacy Benefit Manager, Argus. Pharmacies that do not have a standard Medi-Cal billing form may submit a Pharmacy receipt. The receipt must contain the member's name, member's identification number, address, pharmacy name, pharmacy address and NPI number, medication name, national drug code number, quantity, doctor's NPI number, and amount billed. Once approved, claims are forwarded to Argus for processing so the medication will appear on the patient's profile. All possible claims for non-network pharmacies will be forwarded to Argus so the medication will be on the patient's profile. Claims should be submitted to:

Pharmacy Department
Kern Family Health Care
9700 Stockdale Highway
Bakersfield, CA 93311-3617

1.3 Reimbursement Rate

Kern Health Systems reimburses approved out-of-area pharmacy claims at KHS' pharmacy contract rates.

2.0 MEMBER REIMBURSEMENT

If a member pays for an out-of-area prescription, the member must complete a *Medical Emergency*

**KERN HEALTH SYSTEMS
POLICIES AND PROCEDURES**

SUBJECT: Out-of-Area Pharmacy Claims Processing	INDEX NUMBER 13.21-P	Page 3 of 3
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Claim Form. (See Attachment A). An original itemized receipt must be submitted with the form. This receipt must include the following information:

- A. Patient's name
- B. Date of services
- C. Name of medication, prescription number, and quantity
- D. Pharmacy's complete name, address, and phone number

The pharmacy claim is reviewed by the KHS Medical Director or Corporate Pharmacist. If the drug is included in the KHS formulary, the member is reimbursed for the amount of payment. If the drug is not included in the KHS formulary a decision is rendered according to the guidelines in *KHS Policy and Procedure #13.01-P: Drug Utilization and Non-Formulary Treatment Requests*.

3.0 CONTRACTED OUT-OF-AREA PHARMACIES

KHS is contracted with several chain pharmacies within California. Members should be directed to the nearest Rite-Aid, Long's, Walgreens, or Sav-On pharmacy for prescriptions needed outside of the Kern County Service Area. These pharmacies are recommended to patients requiring out-of-area prescriptions.

Attachments:

- Attachment A – *Medical Emergency Claim Form*

¹ **Revision 2008-07:** Revised PBM, updated Section 1.2. Medical Emergency Claim Form revised. **Revision 2005-08:** Routine revision. Policy reviewed against DHS Contract 03-76165 (Effective 5/1/2004). **Revision 2001-03:** changes made as result of DHS/DMHC Medical Review Audit (YE 08/31/00). Also addition of HFAM PO Box. **Formerly:** #6.12. Policy changed to a Pharmacy policy per request of the Corporate Pharmacist on Revision 2005-08.



**Kern Family
Health Care**

A DIVISION OF KERN HEALTH SYSTEMS

The Friendly Face

Medical Emergency Claim Form Information for Members

Kern Health Systems will pay claims for prescriptions supplied to members at out of area pharmacies in emergency situations if the medication is included in the **Kern Health Systems' Formulary**.

In order to receive a refund, the attached form must be filled out completely and have the required items attached. Upon receiving the claim, Kern Health Systems will evaluate the claim. If the claim has all of the required information and meets the guidelines for out of area emergency care, the claim will be approved. You should expect to receive a notice on your claim within eight weeks.

The following are instructions to follow to complete and submit a Medical Emergency Claim Form:

Member Information Complete name, CIN number and address information. It is important to have the correct address and phone number listed.

Emergency & Accident Information List all information related to the emergency or accident. Include the date(s), location, and details.

Other Coverage Information List any other insurance coverage you have related to the emergency or accident such as auto insurance, Medicare or any other type.

Release Please sign the release in section 5 so we can obtain additional information from healthcare providers, if needed, to complete the processing of your claim.

Receipts In order to process your claim for a refund you must attach the pharmacy receipts. **Each receipt must include the following information:** Patient's name, Date of Services, Name of medication, Prescription number, quantity, and the Pharmacy's complete name address and telephone number.

The completed claim can be dropped off at our office or mailed to:

Kern Family Health Care
Member Services Department
9700 Stockdale Highway
Bakersfield, CA. 93311



**Kern Family
Health Care**

The Friendly Face
Of Kern Health Systems

Medical Emergency Claim Form

- ▶▶ Complete the information below
- ▶▶ Attach Medical Bills
- ▶▶ Mail To: Address Listed Below
ATTN.: Member Services

Member Information	Name (as shown on ID card)		Member No.
	Address		Medi-Cal <input type="checkbox"/> Healthy Families <input type="checkbox"/>
	City	Zip Code	Daytime Phone Number
Emergency Information	Complete this section explaining the medical reason you received emergency treatment. Please use the reverse side of this form if you need additional space.		
Accident Information	Was this emergency treatment due to an accident? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please complete the following information:		
	Date of the accident:		Location of the accident:
	Details of the accident:		
Other Coverage Information	Are any of your expenses covered by another group health plan, auto insurance, Medicare, workers compensation or any other type of plan? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, please list the name and address of the insurance company: Name: _____ Address: _____ Policy Number: _____		
Release	TO ALL PROVIDERS OF HEALTH CARE: You are authorized to provide Kern Family Health Care information concerning health care advice, treatment or supplies provided to this member. This information will be used to evaluate claims for benefits. This authorization is valid for the term of my coverage with Kern Family Health Care. I know that I have a right to received a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original. Member or Authorized Person's signature _____ Date _____		





**Kern Family
Health Care**

La Cara Amable

De Kern Health Systems

Formularia de reclamo de servicios de Emergencia

- ▶▶ Complete toda la información que se le pide
- ▶▶ Envíe las cuentas de los servicios médicos
- ▶▶ Envíe a: la dirección indicada abajo

Atención: Departamento de Servicio al Miembro

Información Del Miembro	Nombre (Como esta en la tarjeta de indentificación)		Número de miembro	
	Dirección		Medi-Cal <input type="checkbox"/>	Healthy Families <input type="checkbox"/>
	Ciudad	Código postal	Número de Teléfono	
Información sobre la Emergencia	En ésta sección, explique cual es la razón porque fué a recibir atención médica de Emergencia. Si necesita Espacio adicional, continúe al otro lado de la hoja.			
Información sobre el accidente	La atención médica de emergencia fue causada por un accidente? <input type="checkbox"/> No <input type="checkbox"/> Si Si es así complete la información:			
	Fecha del accidente:		Lugar del accidente:	
	Detalles del accidente:			
Información sobre otra aseguranza	Algunos de los gastos fueron cubiertos por otra aseguranza médica, aseguranza de auto, Medicare, compensación de trabajadores o algún otro plan? <input type="checkbox"/> No <input type="checkbox"/> Si Si es así, escriba el nombres y dirección de la compañía de seguros:			
	Nombre: _____ Dirección: _____ Número de póliza: _____			
Consentimiento	Para los Proveedores de Atención médica: Usted está autorizado a proveer información a Kern Family Health Care concerniente a la atención médica, tratamiento, suplementos provistos a éste miembro. Esta información es valida mientras tenga cobertura con Kern Family Health Care. Entiendo que tengo el derecho a recibir una copia de ésta authozación si así lo pidio y que una copia es tan válida como el original. Firma del Miembro o persona autorizada: _____ Fecha _____			

