Doing Business with FCHP

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Provider Relations is responsible for distributing information to the physicians/providers on an ongoing basis to update them on Fallon Community Health Plan (FCHP) policies, procedures, benefits and other pertinent issues.

The Provider Relations staff is the main line of communication between the physician/provider and FCHP. The Provider Relations representative conducts the physician/provider orientations and general meetings, as needed.

Physicians/providers are encouraged to contact Provider Relations with questions, concerns or issues. Call the Provider Service Line at 1-866-ASK-FCHP (1-866-275-3247), Monday through Friday, 8:30 a.m. to 5:00 p.m. Select one of the prompts below.

Eligibility & Benefits, Prompt 1

Claims, Prompt 2

Care Services Department, Prompt 3

- Discharge planning
- Hospital admissions
- Referral/Prior authorizations
- Utilization review

Provider Relations Department, Prompt 4

- Complaints/compliments
- Close/reopen practice
- Orientation to FCHP policy and procedure
- Policies and procedures
- Provider appeals
- Re-education
- Removing member from physician/provider panel

Pharmacy Services, Prompt 5

Provider Relations assists in resolving problems or complaints. This includes any problems that the physician/provider feels are not satisfactorily resolved by the responsible FCHP department, as well as concerns on any other topic. Provider Relations will research and resolve the complaints and notify the physician/provider of the resolution. If you wish to speak to a Provider Relations Representative or schedule an office visit, please call 1-866-ASK-FCHP, prompt 4 (1-866-275-3247) or e-mail ASKFCHP@FCHP.org.

Any issues that the physician/provider feels are not satisfactorily resolved by Provider Relations should be directed to the Director of Provider Relations.

NOTE: Members with questions or concerns should call the FCHP Member Relations Department or the Customer Service Department at 1-800-868-5200 (TDD/TTY: 1-877-608-7677), Monday through Friday, 8 a.m. to 6 p.m. (See Section H, Member Relations, Customer Service.)

Fallon Community Health Plan (FCHP) providers can check eligibility and run claims metric reports through the Web.

Our Web-based tools give you access to member eligibility information as well as the ability to run a valuable claims metric report and perform secure file transfers to and from FCHP.

To register, please download the registration form at http://www.fchp.org/providers/provider-tools/provider-tools-registration.aspx.

Verify eligibility

- Verify that your patients are eligible for the date of service
- Verify copayments, deductibles and products
- Reduce claim denials for eligibility reasons
- Improve office efficiency by reducing time on the phone checking member eligibility

Claims metric report

- Review claim status
- Measure FCHP's performance regarding turnaround time and rejection rates.
- Review detailed reasons for rejected claims
- Review reports online or download to your computer
- Measure FCHP's performance regarding turnaround time and rejection rates

PCP panel report

- View members on your PCP panel
- See additions and deletions to your panel
- Review reports online or download to your computer

PCP referral monitoring reports

- Enables PCP to view specialists rendering services to their patients

Secure file transfers

- Register today to become a trading partner with FCHP.
- Receive confirmation that your files have been received and are ready to be retrieved.
- Personal health information is treated confidentially on our secure site.

Changing Provider Information Policy

All changes to provider enrollment ***must*** be made on a prospective basis. It is highly recommended that you use the Provider Update Form.

Provider Information Changes

30 days prior written notice is required.
If less than 30 days notice is provided, the effective date will be 30 days after receipt of notice.

- Name change
- Tax identification # change (W-9 required)
- Practice address addition or change
- Billing address change (W-9 required)
- Panel status change (except change to concierge medicine see below)

Health Care Option (HCO) Changes

Health Care Option changes are defined as changes in affiliation with one or more of the following entities: Physician Organizations, Physician Hospital Organizations, Independent Practice Associations, or group practices.
60 days prior written notice is required. If less than 60 days notice is provided, the effective date will be 60 days after receipt of the notice.

- Adding an additional HCO affiliation
- Changing an HCO affiliation (existing and new information required)
- Terminating an HCO affiliation

Individual Provider Termination from Fallon Community Health Plan

Contractual termination provisions prevail.
60 days prior written notice is required. If less than 60 days notice is provided, the effective date will be 60 days after receipt of the notice.

Conversion to/from Concierge Medicine Practice

90 days prior written notice is required.
See Concierge Medicine Policy for additional requirements.

Notification Details:

Please send completed Provider Update Form via:

Mail	*Fax*	*Email*
Fallon Community Health Plan Attn: Provider Relations 10 Chestnut Street Worcester, MA 01608	508-368-9902 Attn: Provider Relations	askfchp@fchp.org

Please call 1-866-ASK-FCHP, prompt 4 with any questions.

A primary care provider (PCP) or an ob/gyn provider agrees to give the plan 30 days written notice of intent to no longer accept new or additional plan members as patients. The PCP or ob/gyn provider may only decline plan members as new or additional patients if the plan provider declines all new or additional patients regardless of their insurer. The PCP or ob/gyn provider can reopen his or her panel/practice upon advance written notice to the plan. Fallon Community Health Plan (FCHP) members who have signed the enrollment application prior to or within 30 days of the panel/practice closing will be allowed to choose that provider. A PCP or ob/gyn provider cannot close his/her panel/practice to existing patients transferring to FCHP insurance.

Procedure:

1. The PCP or ob/gyn sends written notice to the FCHP Provider Relations Department, stating the date the practice is to be closed/reopened to all members and the reason for the change in status.
2. FCHP revises the marketing literature to show the change in the provider’s status. A symbol following the physician’s name in our FCHP provider directories will indicate a closed panel/practice.
3. FCHP redirects provider selection for any member choosing a provider with a closed panel/practice and gives assistance to members in provider selection.

Policy:

Fallon Community Health Plan (FCHP) requires that providers who intend to charge an access fee to FCHP members as a condition of membership in the provider's panel notify FCHP in writing at least 90 days prior to charging such fee to an FCHP member.

Procedure:

The provider must also advise their FCHP patients in writing of their intent to charge this fee and describe all relevant conditions and benefits associated with such fee. For the purpose of this requirement, the access fee can be a one-time or periodic fee, and may include additional privileges or amenities that are not covered services, in addition to membership in the physician's panel. Continuity of care coverage and payment terms will apply for any eligible FCHP member unable to pay the access fee.

Policy:

A personal physician may find it necessary at some time to end his/her relationship with a patient who is a Fallon Community Health Plan (FCHP) member and would like the member removed from his/her panel. This may be due to member noncompliance, disruptive behavior, non-payment of co-payments or other fees (when applicable) or inability to manage the member's care. In such a case, the physician should carefully terminate the relationship with the member and request that FCHP reassign the member to another primary care physician.

Procedure:

1. The physician/risk management representative calls the Provider Relations Manager to discuss the problem and come to an agreement to transfer the member if necessary.
2. If appropriate, the physician discusses the situation with the member stating that he/she will no longer provide care for the member and explaining the reasons for the decision.
3. The physician thoroughly documents the situation and the member conversation in the office records.
4. The physician sends a letter by certified mail to the member summarizing the previous discussion stating that the physician will provide care for a reasonable interval until a new personal physician is selected and advising that the physician will send copies of the medical records to the new primary care physician upon request.
5. If the member becomes a resident in a long term care facility at which the physician does not render services and the member is not physically able to come to the physician's office for office visits, or is otherwise unable to travel to the physician's office, the physician sends a letter by certified mail to the member, notifying the member that the physician-patient relationship will be ending.
6. The physician sends a copy of the above letter to the Provider Relations Department within 2 business days of the date the letter was sent to the member.
7. The Provider Relations Department initiates the procedure for the member to select a new primary care physician. This process is completed within 30 days.
8. FCHP sends a letter to the member confirming the new primary care physician selection.
9. FCHP sends a copy of the member letter to the former primary care physician.

Quality and Health Services Department

The Quality and Health Services Department supports the Fallon Community Health Plan Performance Improvement programs.

Functions:

1. Conducts medical record reviews for all member complaints related to medical treatment received by the Member Relations Department and the tracking and trending of the outcomes of these peer review proceedings.
2. Monitors routinely sentinel events resulting from outpatient care and major adverse events from inpatient care, referred by clinicians, case managers, and other appropriate staff.
3. Maintains confidential record keeping of case reviews related to complaints and adverse events ensures follow up to cases reviewed by the Peer Review Committee and documents corrective actions.
4. Submits peer reviewed quality information to the Credentialing Department for individual practitioner's review during the re-credentialing process.
5. Performs data collection for contractual reporting for the various product lines, such as Medicare and Medicaid agency requirements.
6. Responsible for HEDIS® (Healthcare Effectiveness Data and Information Set) reporting requirements, including the audit for the measurement system, interpretation of the technical specifications and the accuracy of information submitted to external agencies and public reporting.
7. Supports the Performance Improvement program by coordinating the Quality Design Teams and committees, assisting with minute taking, documentation, data collection and analyses, and trending of information.
8. Responsible for the implementation of the annual work plan and the completion of tasks assigned to the department.
9. Coordinates the requirements for employer requests related to quality management.
10. Champions the organizations' compliance to external accrediting agencies and federal and state regulations.
11. Responsible for supporting the organization's initiatives related to quality improvements and patient safety by collecting and analyzing data, implementing interventions, and ensuring follow up and re-measurement of the process.

12. Develop organization-wide policies and procedures related to Quality and Health Services.
13. Monitor delegated entities for quality management, credentialing, utilization management and member rights and responsibilities.
14. Work collaboratively with the Disease Care Services Programs to improve the care delivered to members with chronic illness.

Continuity of clinical services

To ensure continuity and coordination of care, FCHP Community Health Plan assists in coordinating the care of members who must discontinue services with their current practitioner because of a change in status of the practitioner or provider contract, for reasons not related to quality of care or fraud. All services must be covered services as defined in the member's Evidence of Coverage. Members must be given timely notification of provider changes.

FCHP DIRECT CARE and FCHP SELECT CARE (HMO), FLEX CARE DIRECT (POS) & FLEX CARE SELECT (POS)

The following applies to all provider terminations, either voluntary or involuntary, with the exception of those related to quality of care or provider fraud. For HMO plans, access means that FCHP will cover the services. For POS plans, access means that FCHP will cover the services at the in-network level of benefits.

Termination of FCHP Primary Care Provider (PCP)

A member who has selected a PCP shall have access to the discontinued PCP for thirty (30) calendar days after the termination date of the PCP.

Member undergoing active treatment

A member undergoing active treatment for a chronic or acute medical condition shall have access to the discontinued practitioner through the current period of active treatment or for up to 90 calendar days, whichever is shorter. Active treatment is treatment in which discontinuity could cause a recurrence or worsening of the condition under treatment and interfere with anticipated outcomes. Treatment typically involves regular visits with the practitioner to monitor the status of an illness or disorder, provide direct treatment, prescribe medication or other treatment or modify a treatment protocol.

Pregnant Member in Second or Third Trimester

A member who is pregnant and in her second or third trimester shall be given the option to continue treatment and delivery with the discontinued practitioner through the post-partum period (six weeks post-delivery).

Terminally Ill Member

A member with a terminal illness* shall be given the option to continue treatment with the discontinued practitioner who is treating the member for an ongoing illness until the member's death.

**defined as an illness which is likely, within a reasonable degree of medical certainty, to cause one's death within six months, or as otherwise defined in section 1861 (dd) (3) (A) of the Social Security Act (42 USC 1395X(dd)(3)(A)]*

New Member

A new member shall be given the option to continue with a non-FCHP provider if:

1. The member's employer only offers the member a choice of carriers in which said provider is not a participating provider; and
2. Said provider is providing the member with an ongoing course of treatment or is the member's PCP.

The new member may continue coverage with the provider for:

1. Up to thirty (30) calendar days for a PCP; or
2. Up to thirty (30) calendar days for a physician providing a course of ongoing treatment; or
3. Through the first post-partum visit for a pregnant member in her second or third trimester; or
4. Until the member's death for a member with a terminal illness.

Member Notification

All affected members shall be notified in writing by the FCHP Enrollment Department within 30 calendar days prior to a provider's contract termination date. In the case of discontinued PCPs, affected members are defined as members who have designated the discontinued PCP as their primary care provider. In the case of discontinued specialty physicians, utilization data will be used to identify those members who had seen the discontinued specialist for specialty services during the preceding 24 months.

In the case of a terminated hospital, the member shall be sent notice at least 60 calendar days before the contract termination. This 60 day requirement does not apply in the following circumstances: a hospital that has left FCHP's provider network without giving the full 60-day notice; a hospital whose contract FCHP has terminated because of emergent reasons such as a suspension or revocation of the hospital's license; certificate or legal credential; the indictment or conviction of the hospital or an agent thereof for a felony or for any criminal charge related to the rendering of health care or medical services; cancellation or termination of the professional liability insurance required by the agreement with the provider without replacement coverage being obtained.

Notification to affected members shall include information regarding assistance in choosing another contracted practitioner and referral to the FCHP website for a list of contracted practitioners in the member's geographic area. The member may also call FCHP's Customer Service Department for assistance in selecting a new PCP.

Coverage Conditions

In all of the above listed circumstances, continuity of clinical services will only be authorized if the provider agrees to all of the following:

1. to accept reimbursement at the rate applicable prior to the contract termination as payment in full;
2. to not impose cost sharing with respect to the member in an amount that would exceed the cost sharing according to the terms of the contract;
3. to adhere to FCHP's quality improvement standards and to provide FCHP with necessary medical information related to the care provided; and
4. to adhere to FCHP's policies and procedures, including procedures regarding referral, obtaining prior authorization and providing treatment pursuant to a treatment plan, if any.

If a discontinued PCP, who is in the notification period prior to contract termination, determines that a member needs a specialty visit, the specialty referral will be processed in accordance with usual preauthorization procedures. FCHP's Health Care Services Department will work with the discontinued practitioner and member to ensure that the member is directed to an appropriate, contracted specialist to receive care and to insure that communication is established between the specialist and the member's new PCP.

FCHP reserves the right to approve treatment by a non-contracted provider when it is determined that the patient's clinical condition may by compromised if such treatment is not offered.

FCHP SENIOR PLAN (MEDICARE ADVANTAGE)

The following applies to all provider terminations, either voluntary or involuntary, with the exception of those related to quality of care or provider fraud.

Member Undergoing Active Treatment

A member undergoing active treatment for a chronic or acute medical condition shall have access to the discontinued practitioner through the current period of active treatment or for up to 90 calendar days, whichever is shorter.

Active treatment is treatment in which discontinuity could cause a recurrence or worsening of the condition under treatment and interfere with anticipated outcomes. Treatment typically involves regular visits with the practitioner to monitor the status of an illness or disorder, provide direct treatment, prescribe medication or other treatment or modify a treatment protocol.

Pregnant Member in Second or Third Trimester

A member who is pregnant and in her second or third trimester shall be given the option to continue treatment and delivery with the discontinued practitioner through the post-partum period (six weeks post delivery).

Member Notification

All affected members shall be notified in writing by the FCHP Enrollment Department within 30 calendar days prior to the provider's contract termination date. In the case of an involuntarily terminated hospital, the member shall be sent such notice at least 60 calendar days before the contract termination date. In the case of discontinued PCPs, affected members are defined as the members who have designated the discontinued PCP as their primary care provider. In the case of discontinued specialty physicians, utilization data will be used to identify those members who had seen the discontinued specialist for specialty services during the preceding 24 months.

Notification to affected members shall include information regarding their option to stay with FCHP Senior Plan and choose a new practitioner, or return to original (non-HMO) Medicare, in order to continue to see the discontinued practitioner. Included in any written notification to members, FCHP will provide a listing of contracted specialists known to be accepting Medicare beneficiaries and all documentation, phone numbers and contacts necessary for the beneficiary to remain or return to the system without unreasonable delay (including, but not limited to):

A. Instructions to the member on how to return to original Medicare, the non-Medicare Advantage option, and a list of contracted practitioners accepting Medicare beneficiaries,
B. Telephone numbers to contact practitioners listed;

C. Telephone numbers for FCHP's Customer Service and Access Nurse.

If the beneficiary chooses to remain enrolled with FCHP Senior Plan, the Plan is obligated to offer care from a comparable contracted physician.

Coverage Conditions

In all of the above listed circumstances, continuity of clinical services will only be authorized if the provider agrees to all of the following:

1. to accept reimbursement at the rates applicable prior to the contract termination;
2. to not impose cost sharing with respect to the member in an amount that would exceed the cost sharing according to the terms of the contract;
3. to adhere to FCHP's quality assurance standards and to provide FCHP with necessary medical information related to the care provided; and
4. to adhere to FCHP's policies and procedures, including procedures regarding referral, obtaining prior authorization and providing treatment pursuant to a treatment plan, if any.

If a discontinued PCP, who is in the notification period prior to contract termination, determines that a member needs a specialty visit, the specialty referral will be processed in accordance with usual preauthorization procedures

FCHP's Health Care Services Department will work with the discontinued practitioner and member to ensure that the member is directed to an appropriate, contracted specialist to receive care and to insure that communication is established between the specialist and the member's new PCP.

FCHP reserves the right to approve treatment by a non-contracted provider when it is determined that the patient's clinical condition may be compromised if such treatment is not offered.

FCHP PREFERRED CARE (PPO)

The following applies to all provider terminations, either voluntary or involuntary, with the exception of those related to quality of care or provider fraud. Access means that FCHP Preferred Care will cover the services at the in-network level of benefits.

Pregnant Member in Second or Third Trimester

A member who is pregnant and in her second or third trimester shall be given the option to continue treatment and delivery with the discontinued practitioner through the first post-partum visit.

Terminally Ill Member

A member with a terminal illness* shall be given the option to continue treatment with the discontinued practitioner who is treating the member for an ongoing illness until the member's death.

**defined as an illness which is likely, within a reasonable degree of medical certainty, to cause one's death within six months, or as otherwise defined in section 1861 (dd) (3) (A) of the Social Security Act (42 USC 1395X(dd)(3)(A)]*

Member Notification

No notification will be made to members regarding the termination of a FCHP Preferred Care specialist.

New Member

A new member shall be given the option to continue with a non-participating physician if:

1. The member's employer only offers the member a choice of carriers in which said physician is not a participating provider; and
2. Said physician is providing the member with an ongoing course of treatment or is the member's PCP.

The new member may continue coverage with the provider for:

1. Through the first post-partum visit for a pregnant member in her second or third trimester; or
2. Until the member's death for a member with a terminal illness.

Coverage Conditions

In all of the above listed circumstances, continuity of clinical services will only be authorized if the provider agrees to all of the following:

1. to accept reimbursement at the rate applicable prior to the contract termination as payment in full;

2. to not impose cost sharing with respect to the member in an amount that would exceed the cost sharing according to the terms of the contract;
3. to adhere to FCHP Preferred Care's quality improvement standards and to provide FCHP Preferred Care with necessary medical information related to the care provided; and
4. to adhere to FCHP Preferred Care's policies and procedures, including procedures regarding pre-certification, if any.

Clinical Practice Guidelines

Clinical Practice Guidelines are systematically developed statements designed to assist in decision making about appropriate healthcare for specific clinical conditions. The Fallon Community Health Plan (FCHP) uses guidelines to ensure high quality, cost effective care for selected medical problems. Therefore, the Clinical Practice Guidelines developed and used at FCHP have the following attributes.

1. The guidelines are derived from published research rather than simple expert opinion.
2. The guidelines used by FCHP are created by a panel from within the system that includes representatives of the key groups likely to be affected by the guidelines.
3. The guidelines give specific, unambiguous recommendations for care.
4. The guidelines are developed for clinical conditions where significant variations in practice can be demonstrated.
5. The guidelines are developed for high volume clinical conditions which therefore warrant the time and expense of the guideline project.
6. The guidelines are living documents which are updated periodically to reflect changes in medical knowledge.
7. The guidelines are developed in areas where monitoring use of the guideline is feasible.
8. The guidelines serve as the clinical basis for the disease management programs.

The number of guidelines developed, reviewed and monitored is limited. Topics are selected by the guidelines committee after screening for suitability based on factors mentioned above.

Guidelines are developed to improve the quality of care delivered and the process of care delivered. They are meant to educate and inform physicians in the same way as a textbook or journal article. The recommendations suggest how to treat the "average" patient with a particular problem. However, for most illnesses, 80-90% of patients are treated approximately the same and it is to those situations that guidelines are directed.

FCHP endorsed guidelines are available at www.fchp.org, or contact the Quality and Health Services Department at 508-368-9101 for a copy.

Patient safety

Fallon Community Health Plan monitors and enhances patient safety as an organizational priority, with particular focus on the following mechanisms:

1. *Clinical Peer Review,* with multiple identified sources for case reviews, and with comprehensive policies and procedures for the evaluation of possible errors of commission and omission. Corrective action plans address practitioner-specific components as well as system issues identified through peer review meetings.
2. *Outpatient Adverse Drug Events,* with proactive case finding, utilizing voluntary reporting as well as sentinel events, and with direct linkage to the peer review process for serious preventable events.
3. *Pharmaceutical Patient Safety* in collaboration with the Pharmaceutical Benefits Manager with procedures in place for point of dispensing communications to identify and classify by severity drug-drug interactions.
4. *Inpatient Care,* monitored through sentinel event reporting from case managers, as well as by regular reports submitted by contracted facilities to Fallon Community Health Plan, including Leapfrog standards compliance.
5. *Screening of new drugs and technologies,* through the Fallon Community Health Plan's Pharmacy & Therapeutics Committee and Technology Assessment Committee, with input from national guidelines and research consortia.

Service and Quality Oversight Committee

The Service and Quality Oversight Committee and practitioners develop, implement and oversee FCHP's quality program. This Board of Directors committee provides oversight for the program, including clinical care, customer service, professional credentialing, member relations, utilization management, and disease care services. The Committee recommends policy decisions, analyzes and evaluates results of quality improvement activities, ensures practitioner participation in the quality program through planning, design, implementation or review, institutes needed actions and ensures follow-up as appropriate. The Service and Quality Oversight Committee fulfill the requirement of the Patient Care Assessment Committee as outlined in Article 5 of the amended and restated Corporate Bylaws of Fallon Community Health Plan. The meeting minutes reflect all committee decisions and actions, and are signed and dated.

Responsibilities:

The committee:

1. Annually reviews and approves a comprehensive evaluation of the Quality Service Program's effectiveness for review and recommends approval to the Board of Directors.
2. Annually reviews and approves the Quality Services Program Description to ensure that the infrastructure supports the scope of the program.
3. Annually reviews and approves The Quality Services Work Plan which includes the business initiatives for the organization's Quality Services Program. Assures that the plan is aligned with the strategic plan of the organization, identifying major clinical and service initiatives, time lines, measurable outcomes and responsible staff.
4. Monitors reports submitted by the Clinical Quality Improvement Committee and Service Quality Improvement Committee, which include, but are not limited to:
    - Updates or status reports on the Quality Services Business Initiatives.
    - Customer Service performance reports as measured by the CAHPS® survey and other routine and ad hoc reports.
    - Clinical quality performance as measured by HEDIS® results and other routine and ad hoc reports.
    - Disease and Care Services performance reports.
    - Pharmacy and Technology Assessment reports.

- Utilization Care Services reports.

5. Recommends new or revised policies or quality initiatives based on the analysis of data received and opportunities identified

Fallon Community Health Plan (FCHP) is required to document HIPAA regulations to ensure physicians and providers are aware of and follow FCHP's policies and procedures for electronic transactions.

Physician and providers will be subject to provisions of the rules promulgated under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). These rules include the Standards for Privacy of Individually Identifiable Health Information, the Standards for Electronic Transactions, the proposed Security and Electronic Signature Transactions, the pro-posed National Standard Health Care Provider Identifier and National Standard Employer Identifier and any other rules promulgated under HIPAA.

Physicians and providers will conform each electronic transaction submitted to FCHP to the X12 Implementation Guide Specifications Addendum applicable to the transaction, and to the applicable FCHP Companion Guide. FCHP may modify the Companion Guide at any time without amendment to this Provider Manual. Only the last-issued X12 Implementation Guide Specifications Addendum of each type will be effective as of the date specified in the X12 Implementation Guide Specifications Addendum. FCHP will reject any transaction that does not conform to the applicable Specifications Addendum, as adopted under HIPAA, and the FCHP Companion Guide.

Physicians and providers will cooperate with FCHP in such testing of the transmission and processing systems used by both parties in connection with FCHP as FCHP deems appropriate to ensure the accuracy, timeliness, completeness and security of each data transmission.

Physicians and providers warrant their authority to disclose to FCHP the data contained in each submission and will provide evidence of that authority to FCHP upon request. Physicians and providers are solely responsible for the preservation, privacy and security of data in its possession, including data in transmissions received from FCHP and other persons.

Physicians and Providers agree:

- Not to copy, disclose, publish, distribute, or alter any data, data transmissions, or the control structure applied to transmissions, or use them for any purpose other than the purposes for which was specifically given access and authorization by FCHP, or in any manner except as necessary to comply with the terms of the above

information.

- Not to obtain access to any data, transmission, or FCHP's systems by any means or for any purpose other than as FCHP has expressly authorized.
- If a physician or provider receives data not intended for their viewing, the physician or provider will immediately notify FCHP to arrange for its return or retransmission as FCHP directs. After such return or re-transmission, the physician or provider will immediately delete all copies of such data remaining in its possession

Fallon Community Health Plan (FCHP) assists in coordinating the care of members who must discontinue services with their current physician/provider when a notice of nonrenewal or termination is issued.

FCHP will notify all affected members in writing within 30 days of receipt of provider's notice of nonrenewal or termination and within 30 days of the plan's issuing such a notice.

To ensure timely notification to members, FCHP requires all primary care providers, specialists, specialty and primary care groups to provide **60 days** written notice to FCHP prior to their notice of nonrenewal or termination. This requirement also will include **all** physicians/providers contracted through a group or provider organization.

All physician/provider notifications of notice of nonrenewals and/or terminations may be sent to the following address:

Fallon Community Health Plan
10 Chestnut St.
Worcester, MA 01608
Attn: Provider Relations Department