PROVIDER PORTAL USER GUIDE

Table Of Contents

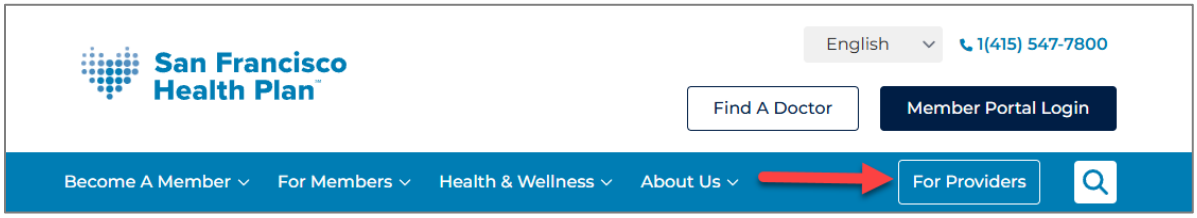
I. Introduction

SFHP Provider Portal serves to provide ease of access and seamless processing for patient information and transactions. Providers can access the following within the SFHP Provider Portal:

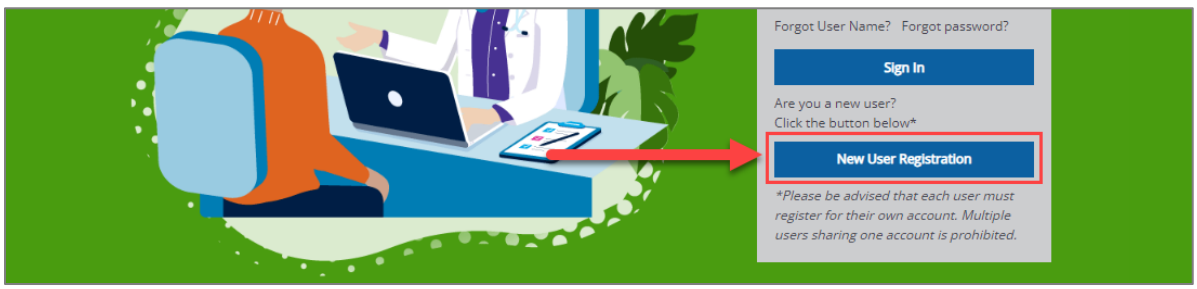
- Member eligibility
- Authorizations
- Prescription checks
- Upload claims
- And more

2. Registration

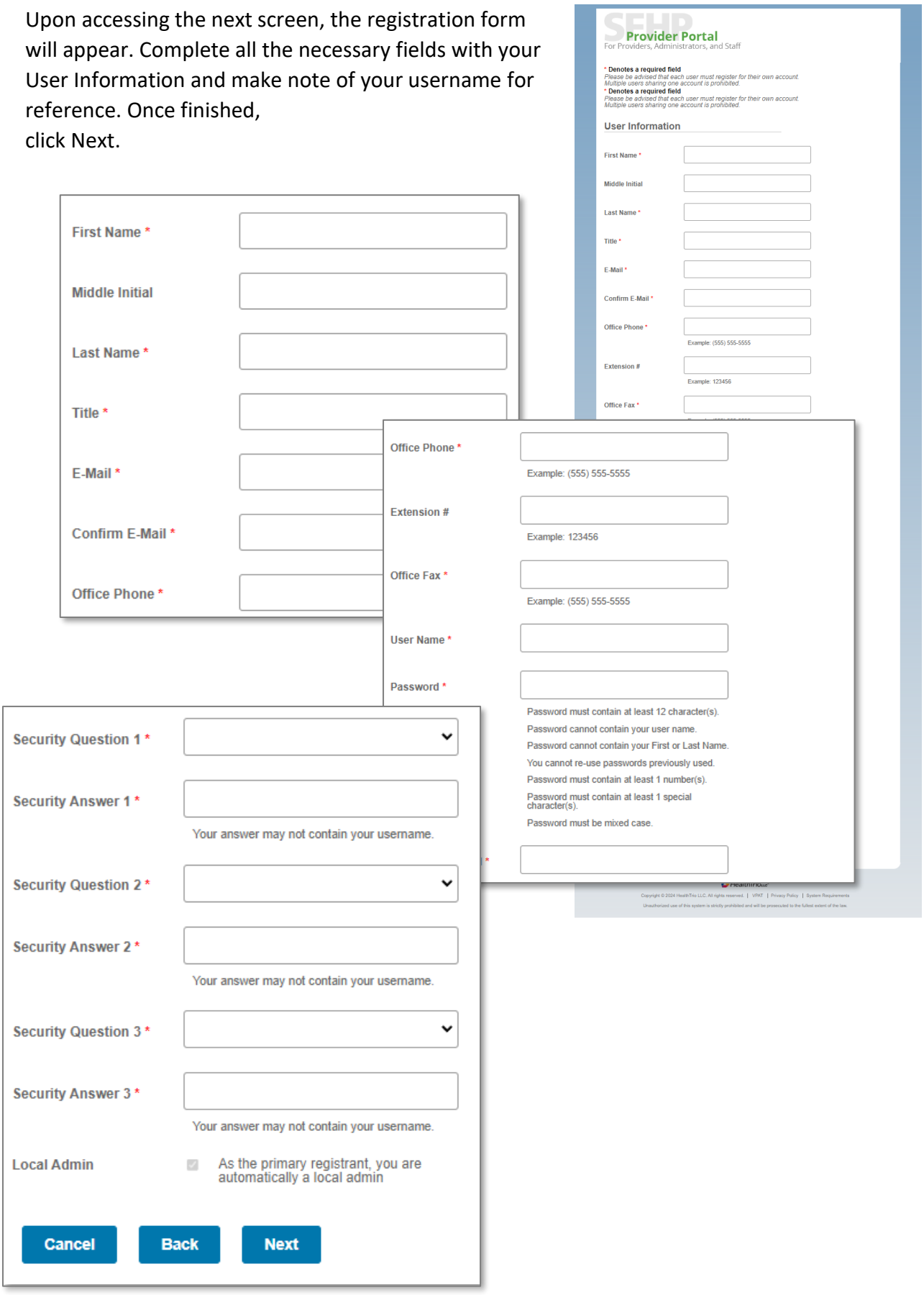
To register for an account on Provider Portal , please visit www.sfhp.org and click on the **For Providers** button then find the Provider Portal Icon.



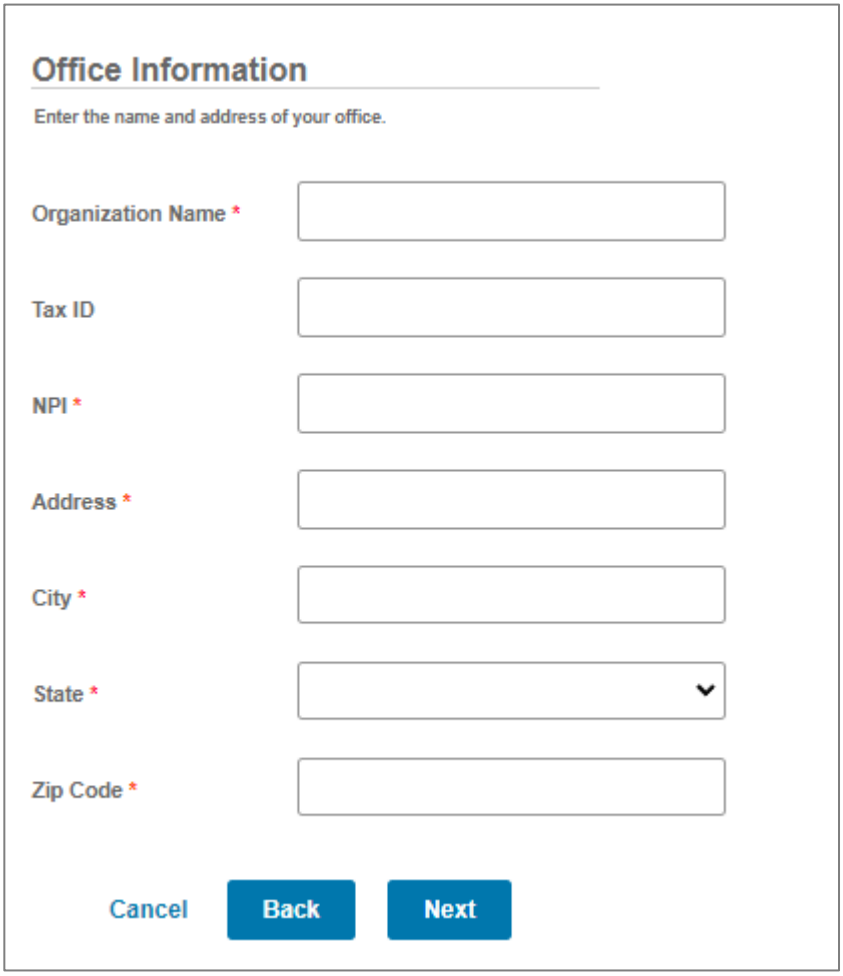
Once you have navigated to the Provider Portal page: sfhpprovider.healthtrioconnect.com click on the blue **New User Registration** button.



Upon accessing the next screen, the registration form will appear. Complete all the necessary fields with your User Information and make note of your username for reference. Once finished,
click Next.



You will now be asked for your Office Information. Please complete all fields, including the Tax ID if applicable.



You will now be taken to the Registration Summary screen to verify your information. Click Finish if the information displayed is correct. If you need to make any changes, click [edit]

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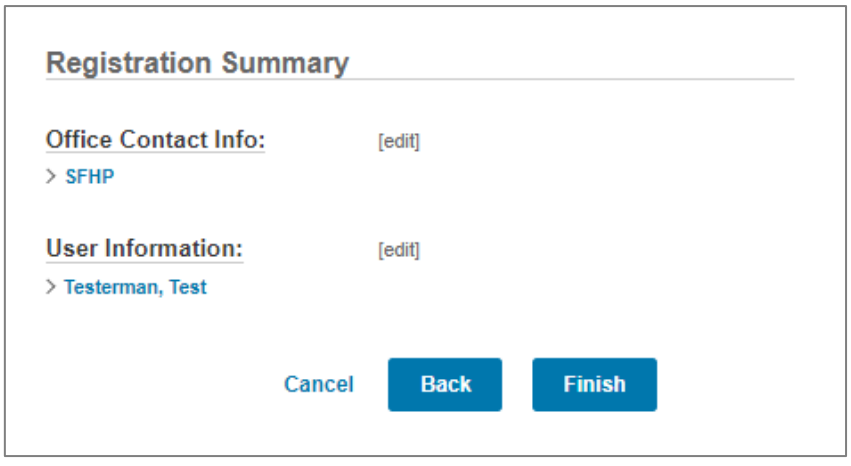
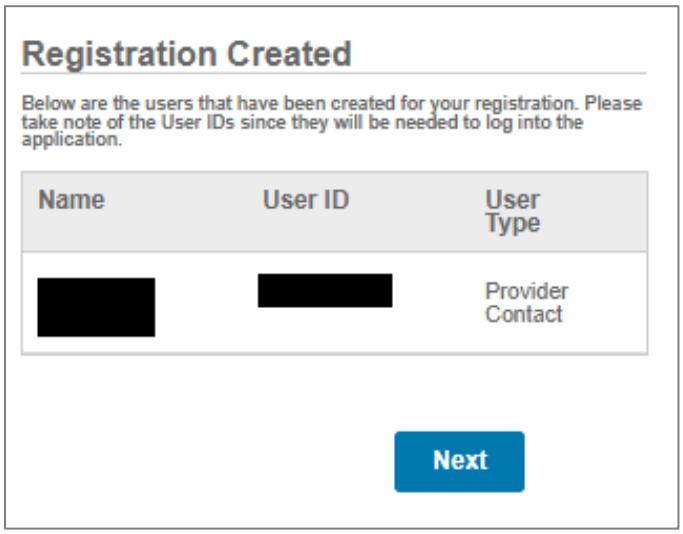
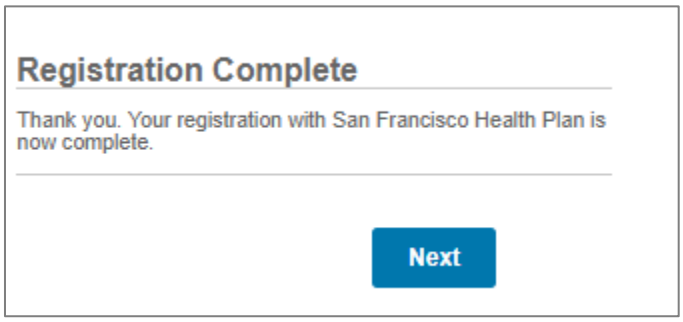


The confirmation of completed registration will appear with your First and Last name, User ID, and User Type.



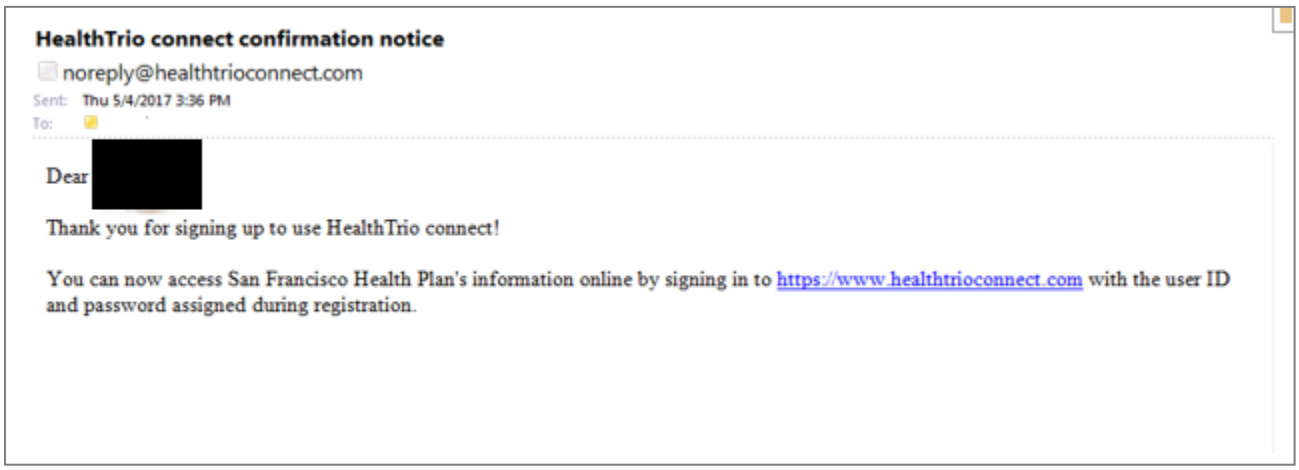
Registration is complete.
Click Next to receive your confirmation.



After you have successfully registered, you should receive a confirmation email containing your password. **This email only confirms your registration and does not guarantee portal access.**

A representative from the Provider Relations department will review your application before you are granted access to log into the portal. **Please note that it will take 2-3 business days for SFHP to activate your account.**

Once your application has been approved, the following email will be sent to the email provided on the application.



HealthTrio connect confirmation notice

noreply@healthtrioconnect.com

Sent: Thu 5/4/2017 3:36 PM

To: [redacted]

Dear [redacted]

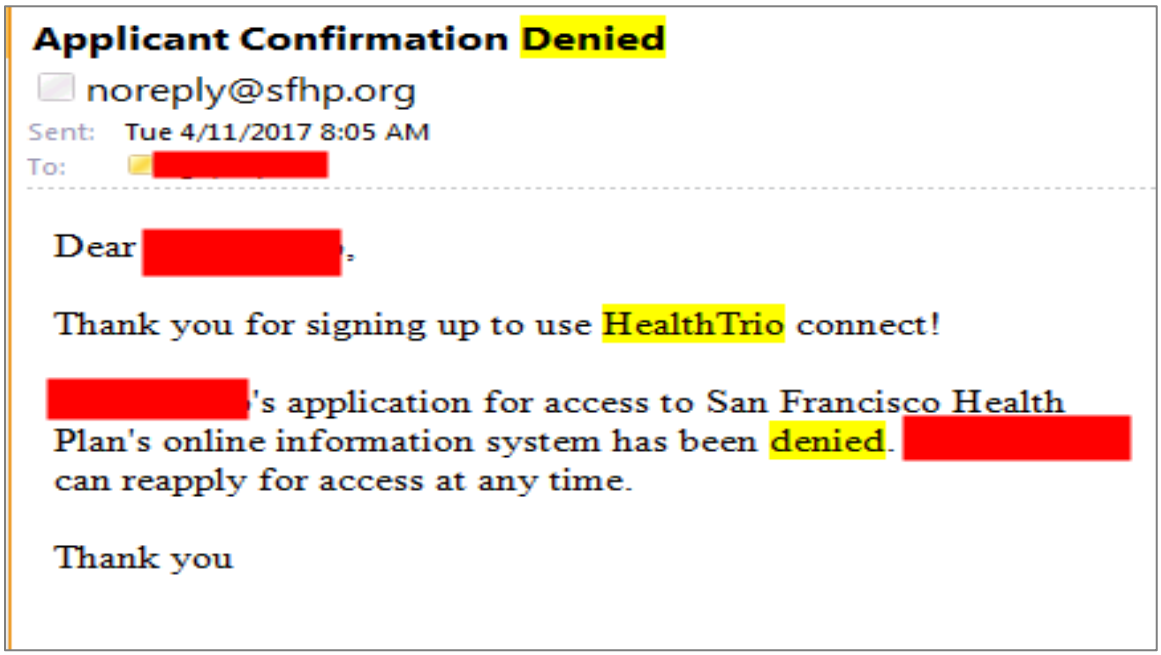
Thank you for signing up to use HealthTrio connect!

You can now access San Francisco Health Plan's information online by signing in to https://www.healthtrioconnect.com with the user ID and password assigned during registration.

In some cases, the Provider Relations department of SFHP may deny an application if it does not meet certain criteria, such as:

- Missing IRS W-9 and NPI information
- The provided email address is not associated with the provider (e.g., @yahoo.com instead of @ucsf.edu).

Below is an example of a Denial email.



Applicant Confirmation Denied

noreply@sfhp.org

Sent: Tue 4/11/2017 8:05 AM

To: [redacted]

Dear [redacted],

Thank you for signing up to use HealthTrio connect!

[redacted]'s application for access to San Francisco Health Plan's online information system has been denied. [redacted] can reapply for access at any time.

Thank you

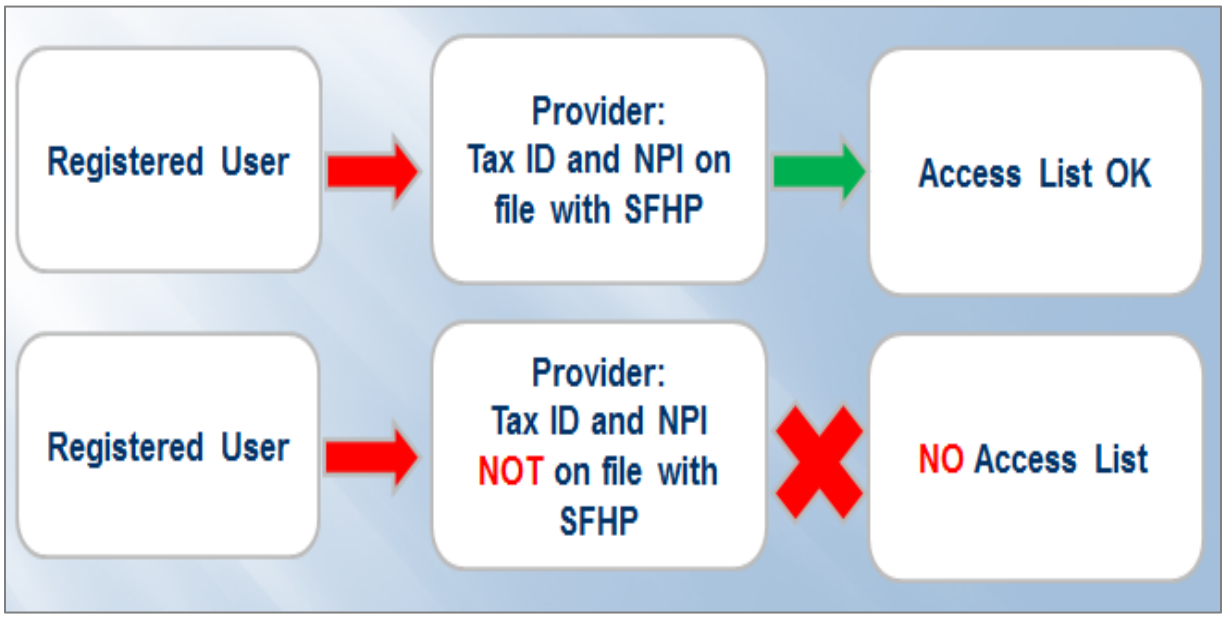
All registration questions should be directed to SFHP Provider Relations at provider.relations@sfhp.org.

Registration: Access List

Access Lists are linked to the provider's Tax ID and NPI.

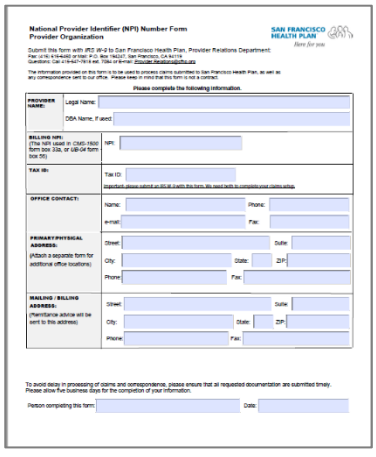
If the provider has never completed the SFHP NPI registration form and/or provided SFHP with their IRS W-9, the provider will need to submit both forms to be added to the system.

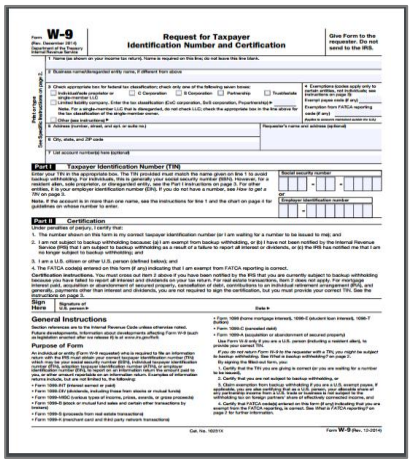
Once added, an Access List can be created, and the provider can create their Provider Portal account.



Below are the required forms for registering successfully as a provider.

- **SFHP NPI Registration Form**
- An IRS W-9 Form


National Provider Identifier (NPI) Number Form
Provider Organization


W-9
Request for Taxpayer Identification Number and Certification

Registration: Roles

There are **four** roles (types of accounts) on the SFHP Provider Portal: :

Eligibility

- This role can only access the eligibility module. It only shows benefits and eligibility.

Billing Agent

- This role is usually assigned to the provider by default. It allows for basic functions such as checking for benefits and eligibility, viewing claims, filing claims, and viewing authorization requests.

Office Manager

- This role is only granted to providers who are managers of their office or facility and can only be granted if providers request the role assignment by sending an email to provider.relations@sfhp.org. While Office Managers can perform the same functions as a Billing Agent, they can also file authorization requests, manage provider information, generate rosters, and create additional user accounts for staff in their office.

Provider

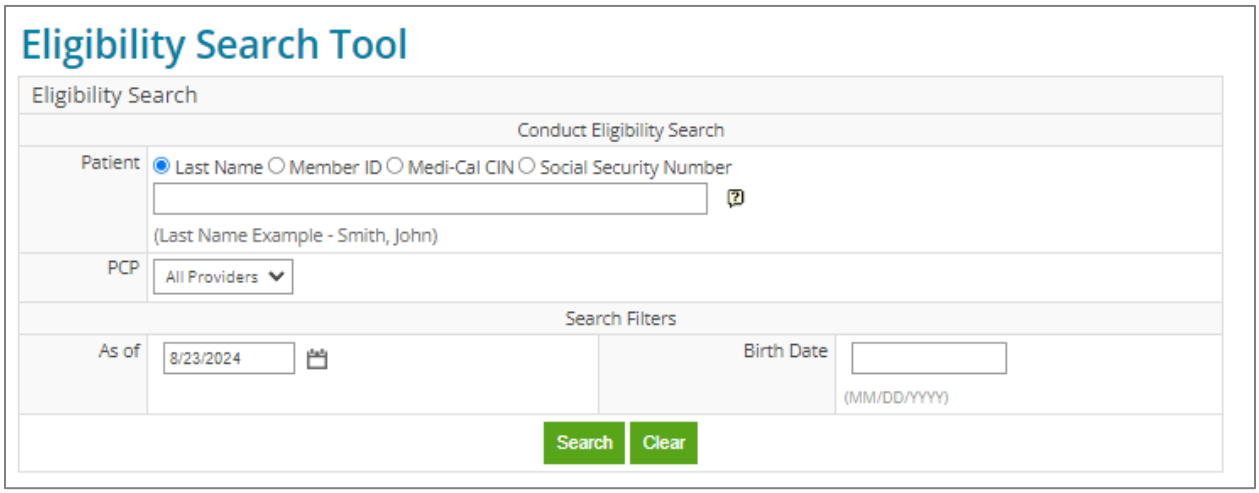
- Providers have almost the same functions as Office Managers, except they cannot manage provider information or create users. This role is usually reserved for doctors or nurse practitioners, or office staff who are required to file authorizations and generate rosters.

Role Name	Benefits and Eligibility	Review Claims/Remittance Advice	Review Authorizations	File Claims	Request Authorizations	Manage Providers	Generate Member Roster	Create Users
Eligibility	+							
Billing Agent	+	+	+	+	+			
Provider	+	+	+	+	+	+	+	
Office Manager	+	+	+	+	+	+	+	+

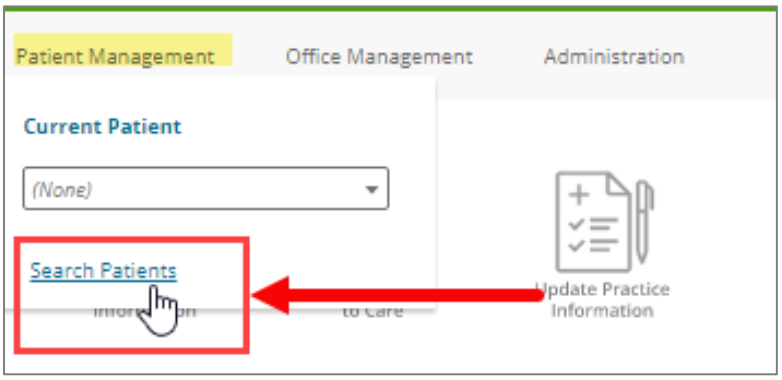
3. Eligibility and Benefits

There are two ways to look up eligibility and benefits. The first method is available on the home page after successfully logging in.

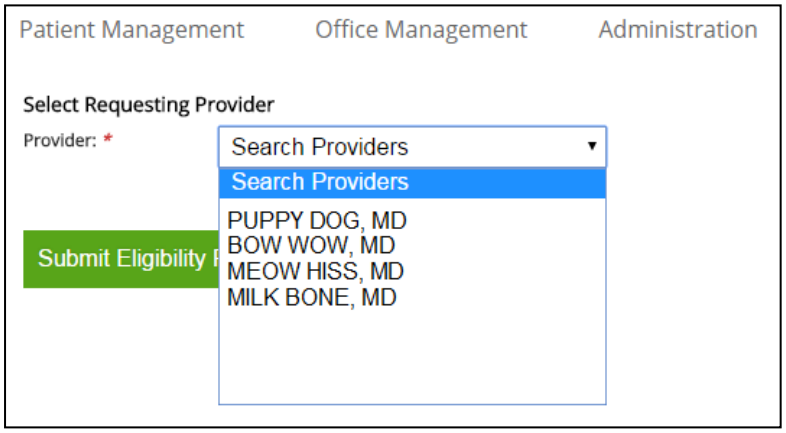
Eligibility can be looked up by entering the member's **Last Name, Member ID, Medi-Cal CIN,** and **Social Security Number.**



The second method is available by navigating to the **Patient Management** tab at the top. You will first need to search for your member by clicking **Search Patients**.

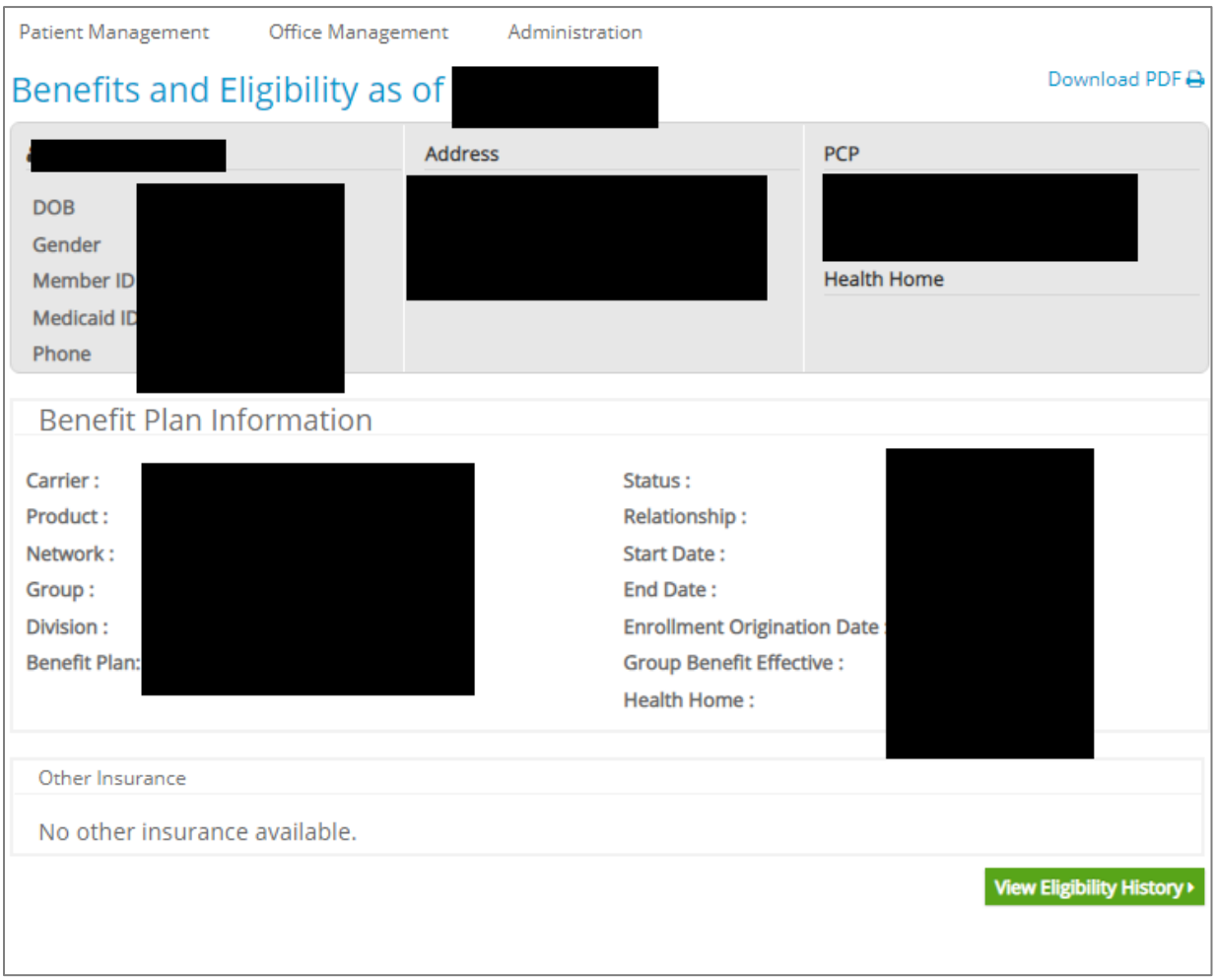


After you have located your patient, click the green **Select** button. Your patient's name should now appear under the *Current Patient* title under the **Patient Management** tab.

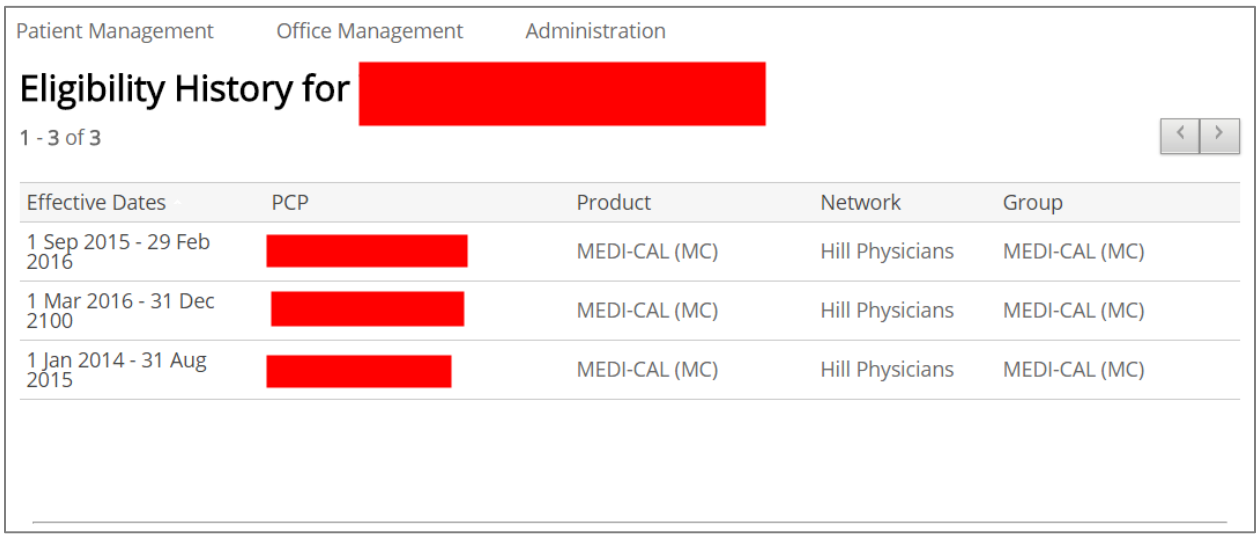


You will be taken to a new page indicating the patient's information and demographics. The following information will be provided on this page:

- Patient's name
- Date of birth
- Gender
- Member ID
- Medicaid ID (tentative)
- Phone number
- Address
- PCP
- Carrier
- Product (Medi-Cal, Healthy Workers, Healthy Kids)
- Network (or Medical Group)
- Division
- Benefit Plan
- Status
- Relationship
- Start Date
- End Date
- Enrollment Origination Date
- Group Benefit Effective
- COB/Other Health Coverage

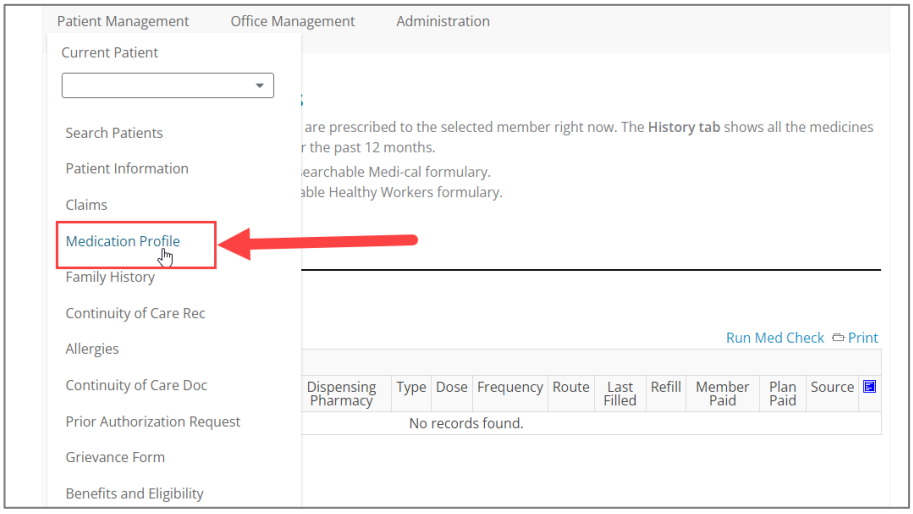


To view past eligibility records, click on the **View Eligibility History** below. Past records such as previous providers and medical groups will be listed in this section.

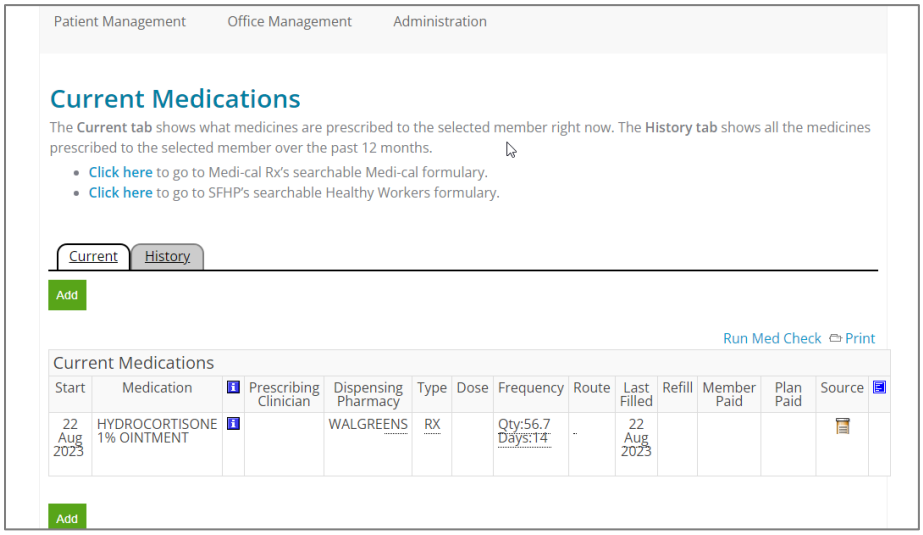


4. Patient Medications

Patient medication information is available for providers to view previous prescriptions and consumption. To access your patients' medication history, ensure that their name is provided under the *Current Patient* dropdown menu of the Patient Management tab. Then, click on **Medication Profile.**



Available medications will be provided in the next screen.

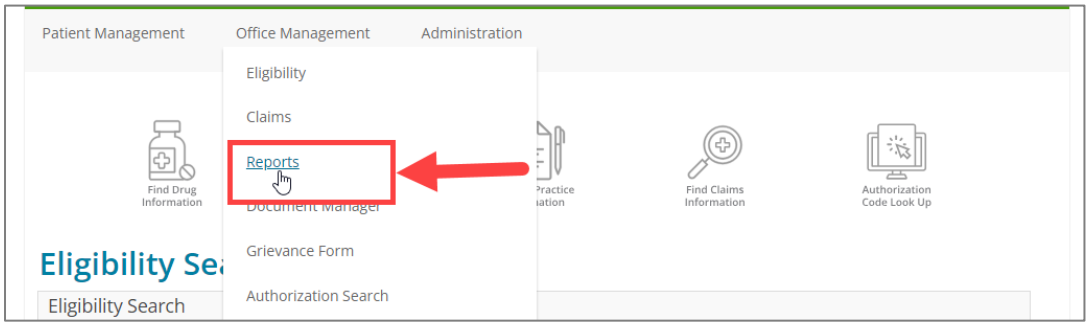


5. Patient Rosters

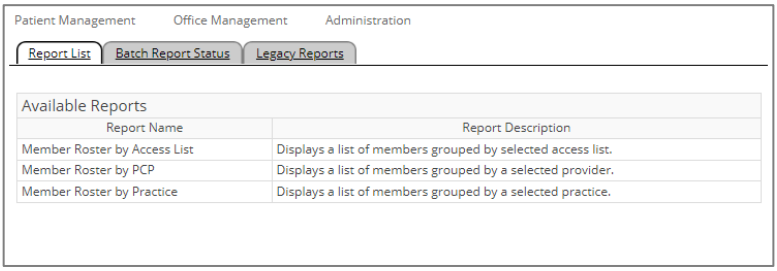
This function is only available for the **Office Manager and Provider roles**. Your roster will only generate if:

- The provider is a PCP
- Your Access List is associated with PCPs
- Have PCP locations

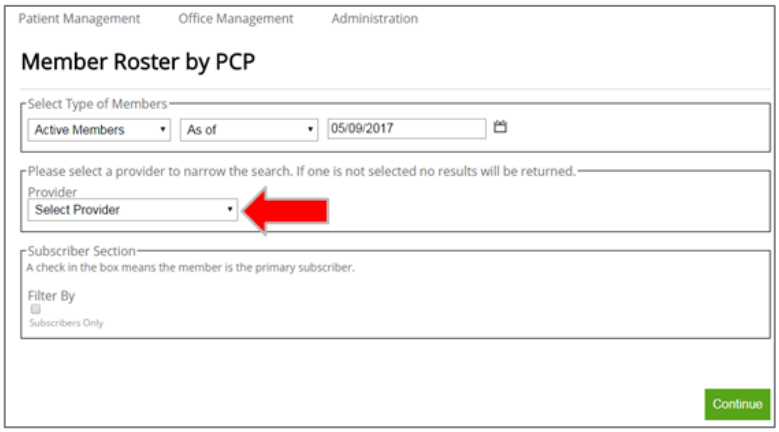
To generate a roster, click on **Office Management Reports**.



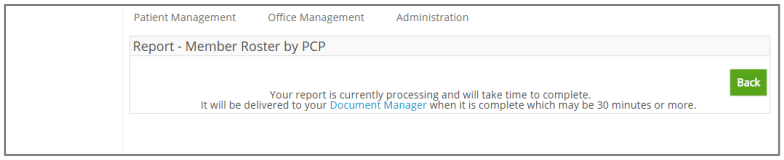
A new page will appear indicating which reports are available. You may choose to generate your rosters by having them grouped by PCPs, Access List, or by Practice.



Below is an example of a roster being generated by PCP. You will need to select a provider from the drop-down list.



Rosters will take approximately 20-30 minutes to generate. If you are unable to view or retrieve a roster, please contact Provider Relations at 1(415) 547-7818 extension 7084.

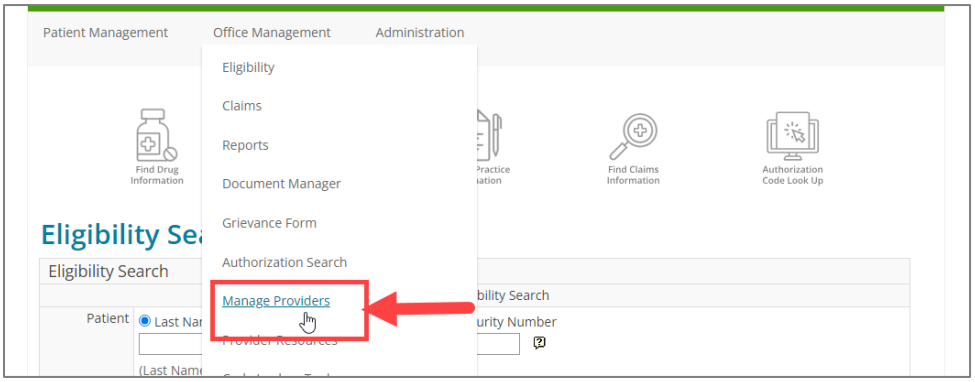


6. Managing Provider Information

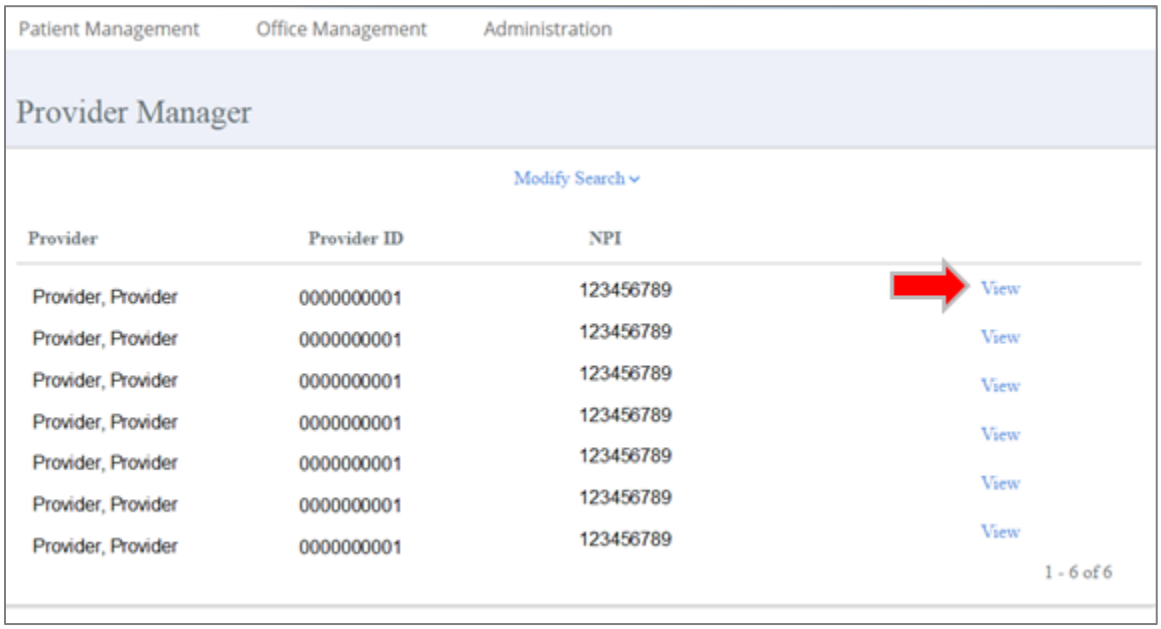
The Office Manager role allows users to modify provider information, as listed below:

- Provider ID
- Gender
- Type of practitioner
- Networks
- Ethnicity
- Website
- NCQA certifications
- NPI
- Birth Date
- Specialty
- Network tiers
- Residency
- Religion
- Email
- State license
- Birth Year
- Board certification
- Affiliated hospitals
- Accreditations
- Languages
- Quality rating

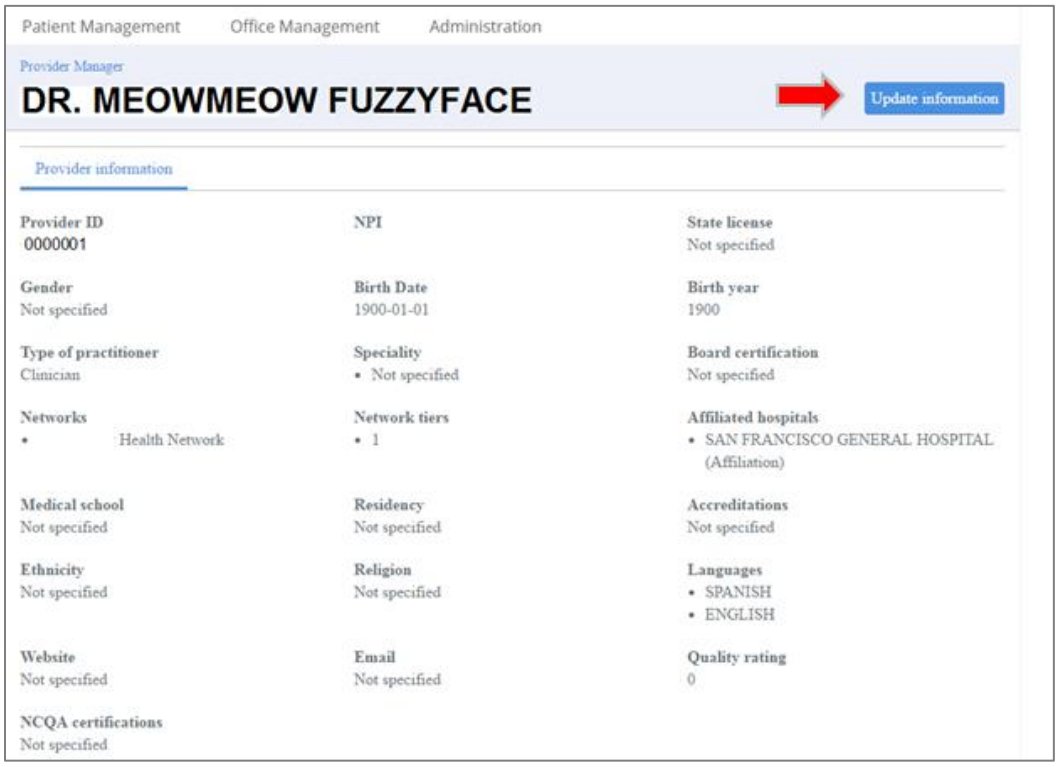
These changes can be made by navigating to **Office Management Manage Providers**.



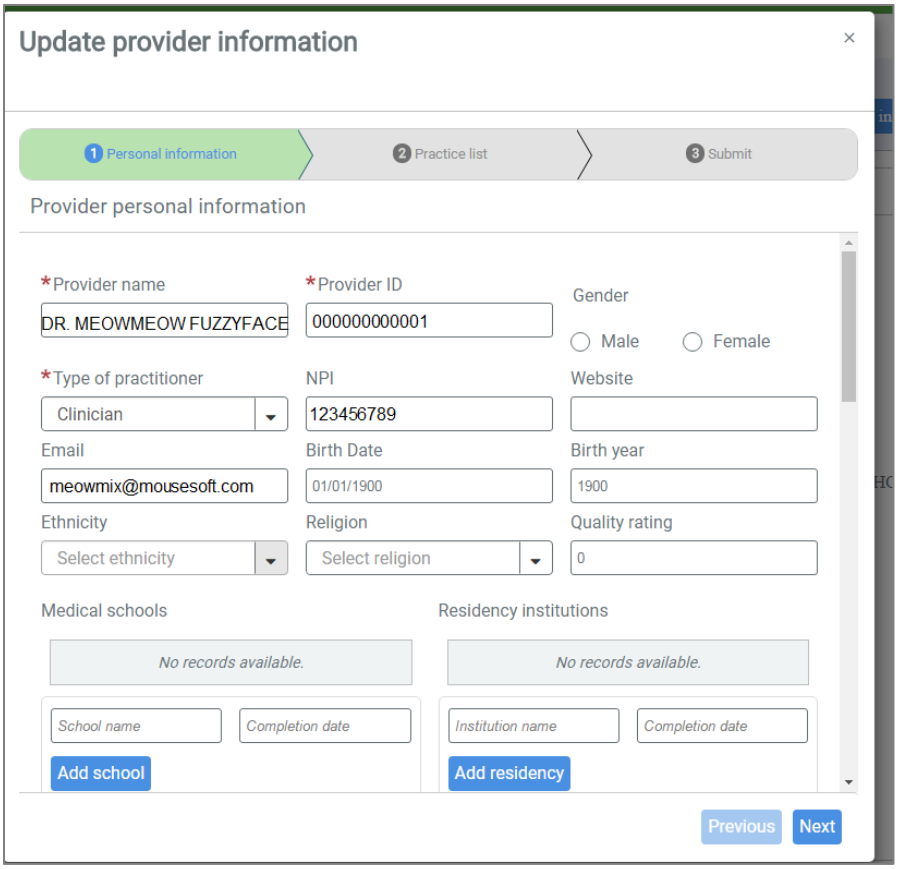
The next screen will take you to the Provider Manage page. A list of providers will be populated (please allow several seconds for this screen to load). To modify a provider from your list, click **View.**



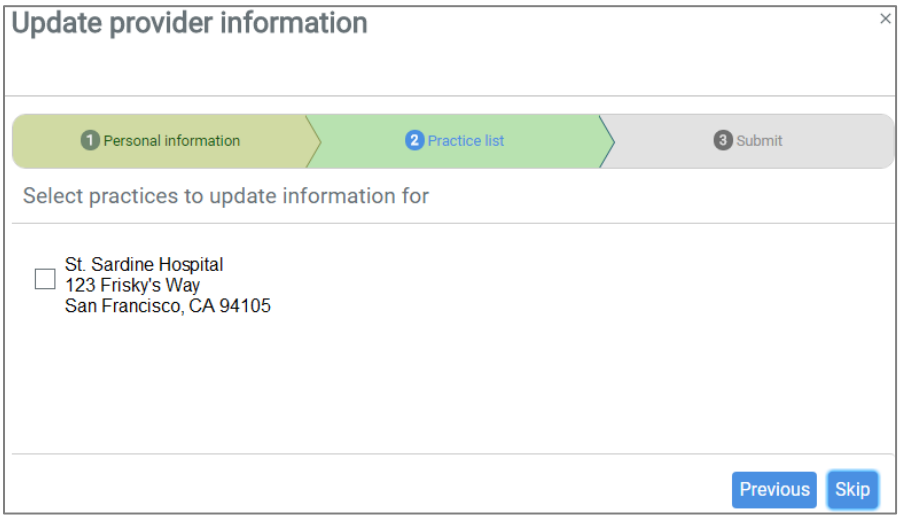
The next screen will populate with the provider's demographics and information. This is a snapshot of how the provider currently appears in the SFHP directory. If there is inaccurate or missing information, click on the **Update information** button.



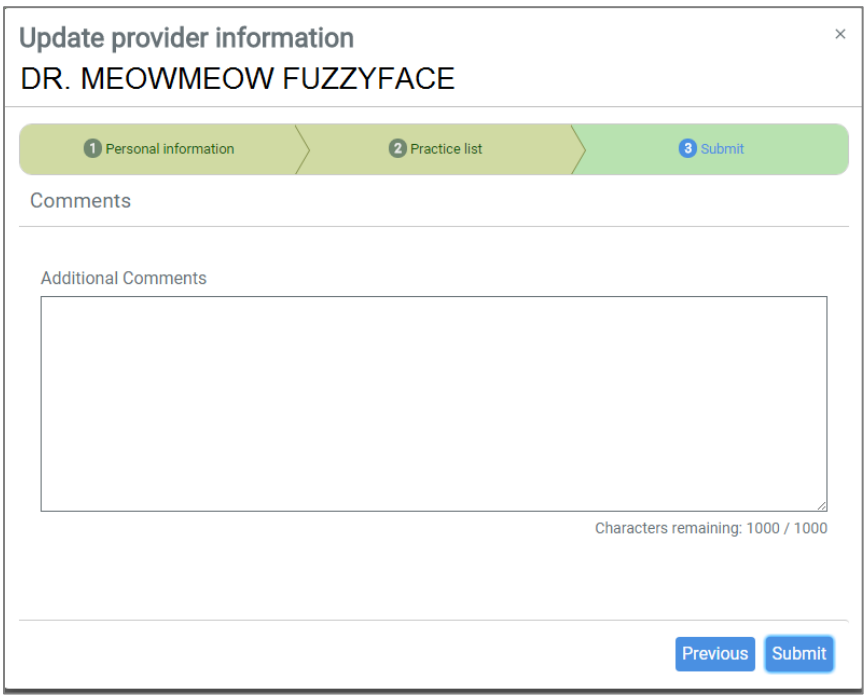
The next screen will appear within the page prompting you to update the provider's information. Please be sure to scroll through the window to ensure that all necessary information is captured and correct, then click Next.



The second page is for updating the provider's practice location. Click the checkbox to indicate that you would like to make changes. You may click Next or press the X button at the top right if no further changes to the provider need to be made.



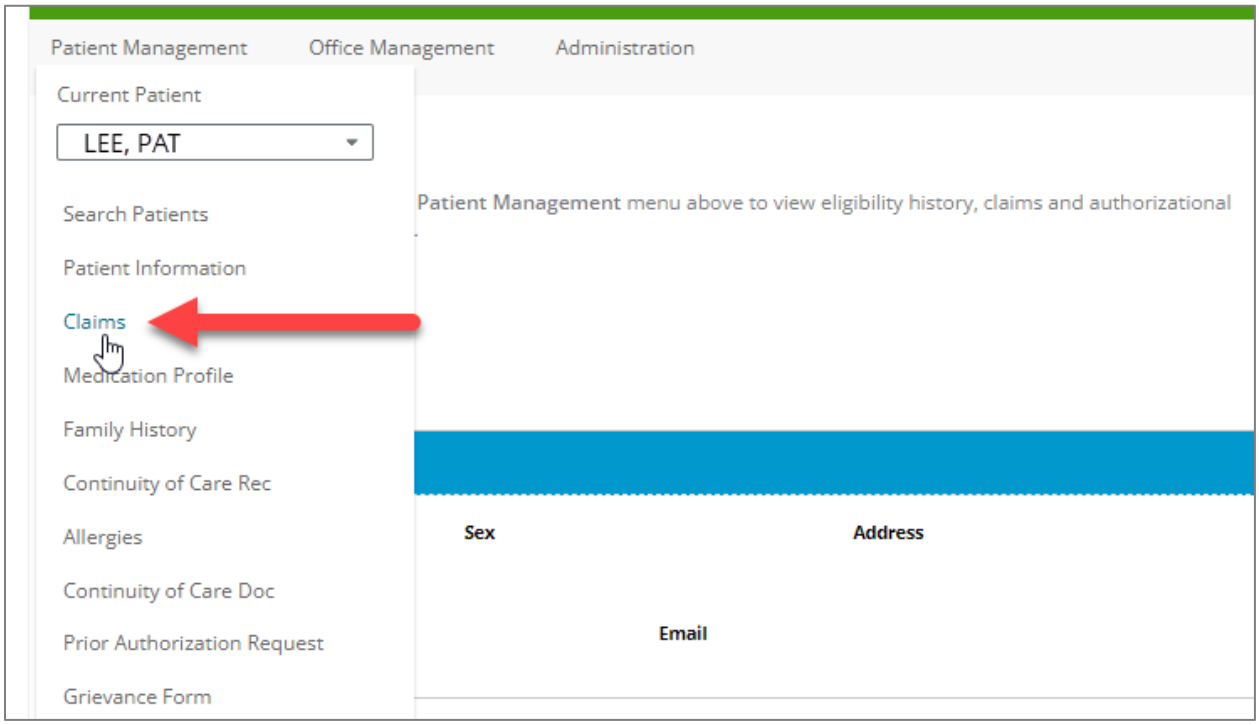
In the box that appears in the next screen, enter the information you would like to update along with its corresponding fields. For example, if an address needs to be updated because the provider has moved locations, please be sure to indicate that you would like the previous location (check marked on the previous page) removed and replace with the new address that will be type in the box.



After pressing **Submit**, your request will be sent to a Provider Relations representative for review and update.

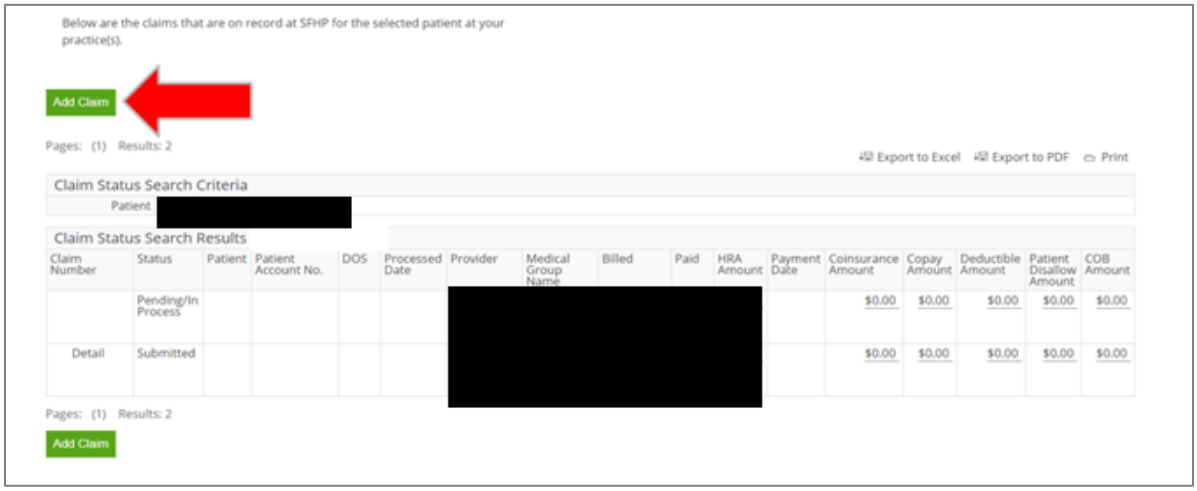
7.Claims

All roles allow users to file and view claims. To view claims, select **Patient Management** from the menu and search for your patient. Ensure that the patient's name now appears under **Current Patient,** then click **Claims** from the menu.

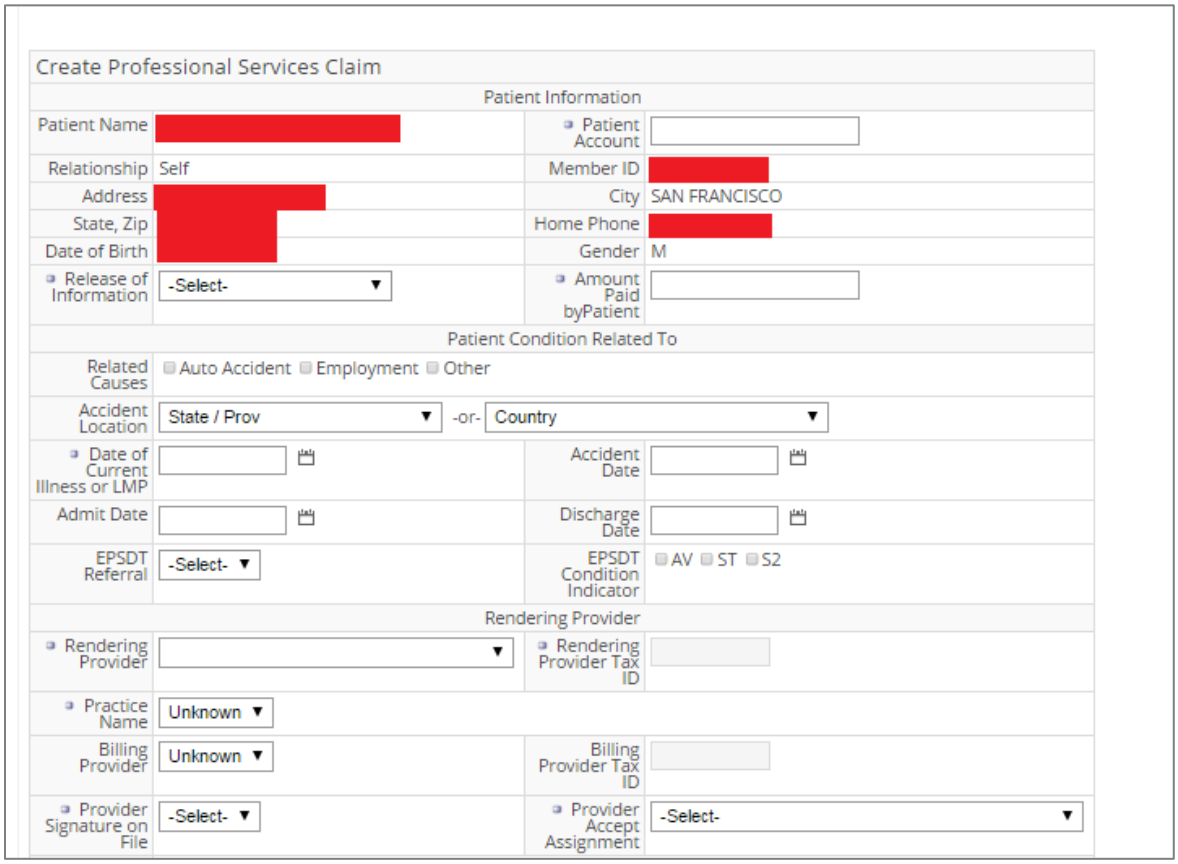


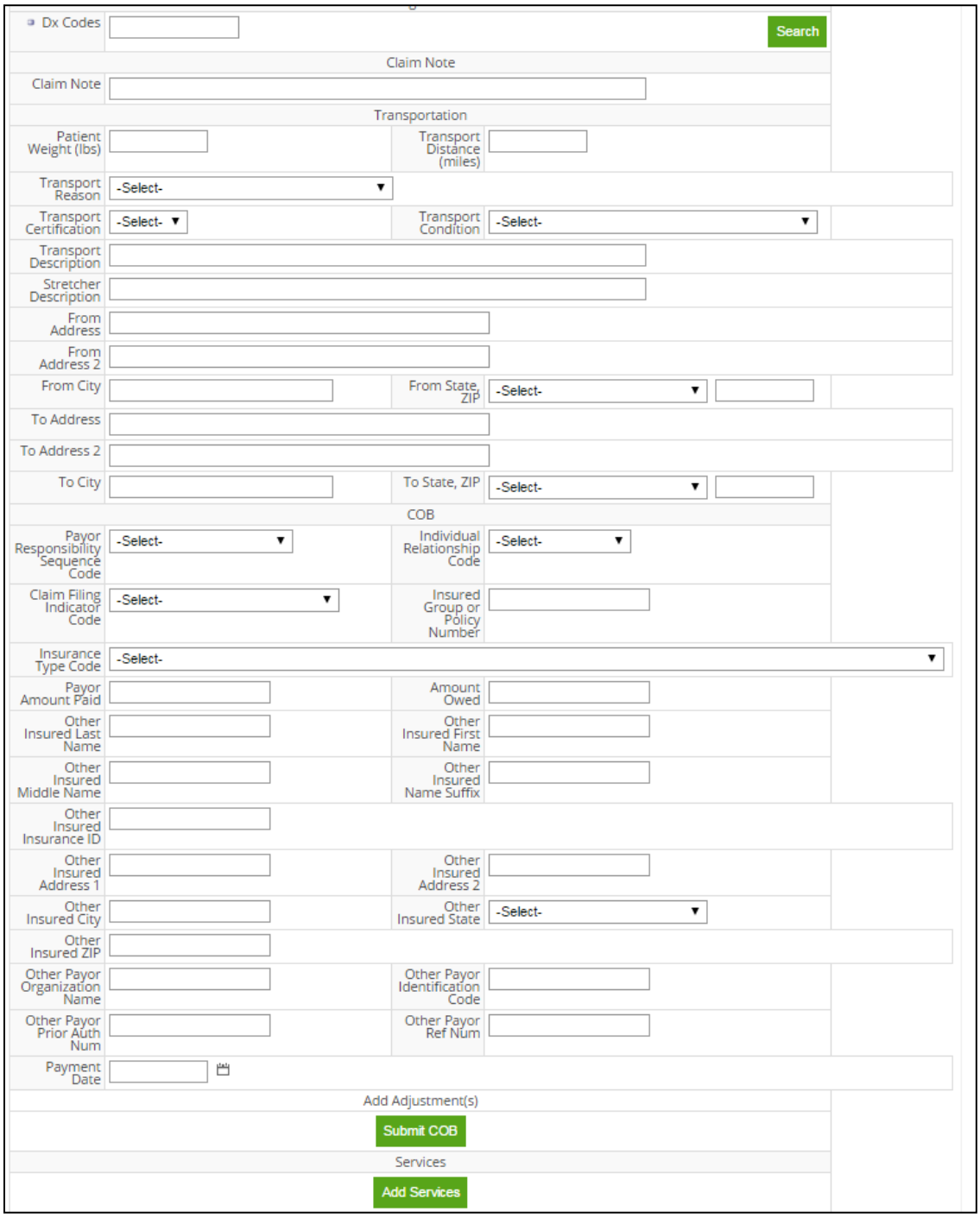
Claims that have already been filed for the member will appear on the next page. If no claims appear on this page, then no claims were filed. Alternatively, if the patient's coverage is with a Delegated Medical Group (DMG) that processes their own claims, you will need to contact their medical group for claims information.

To view claims, click on the Claim Number. You will be taken to the Claim on the next page. To create a new claim, click on the **Add Claim** button.

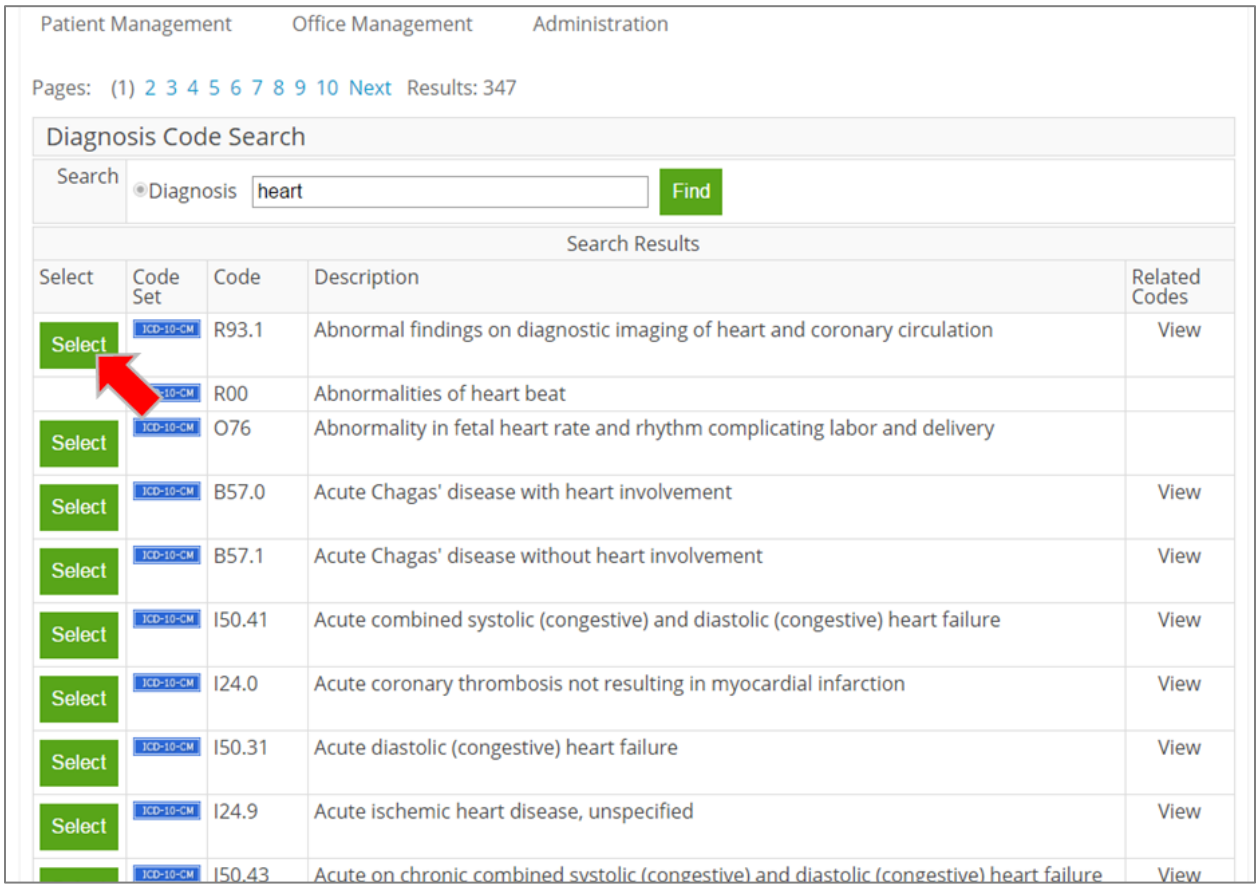


Enter all the necessary claim information on the Add Claim page. Fields marked with a blue circle are required fields.

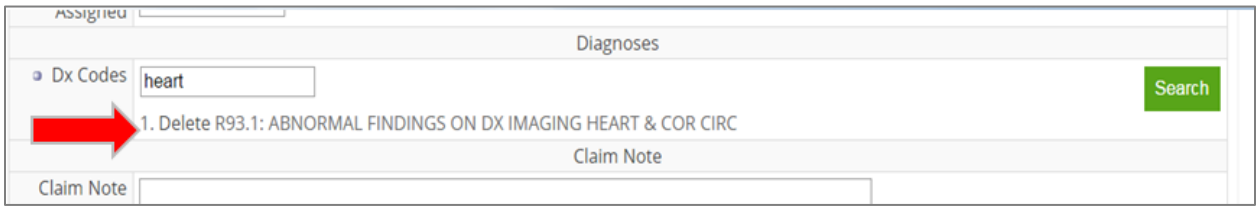




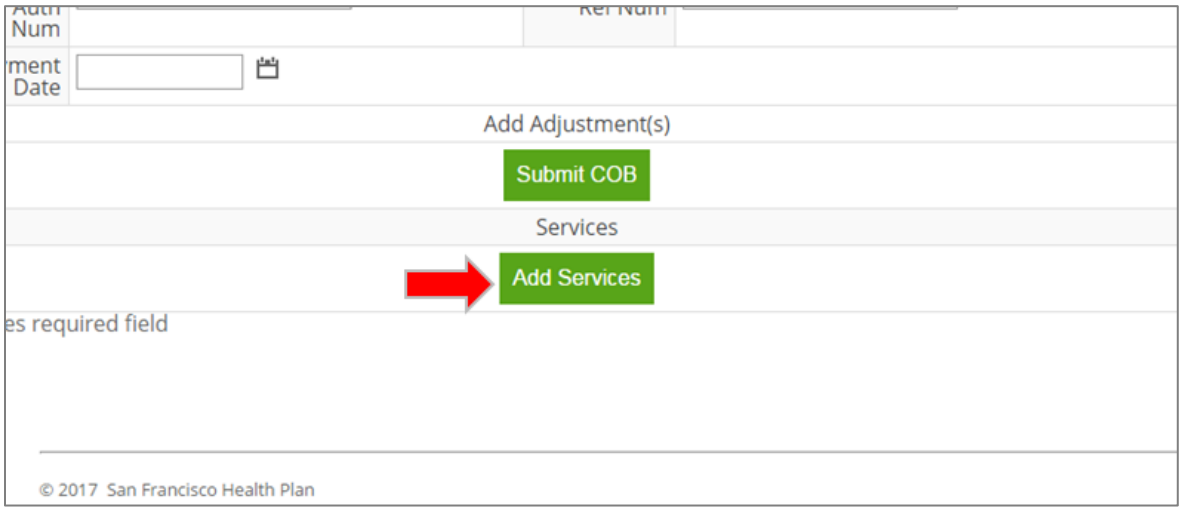
Select your diagnosis code from the results listed.



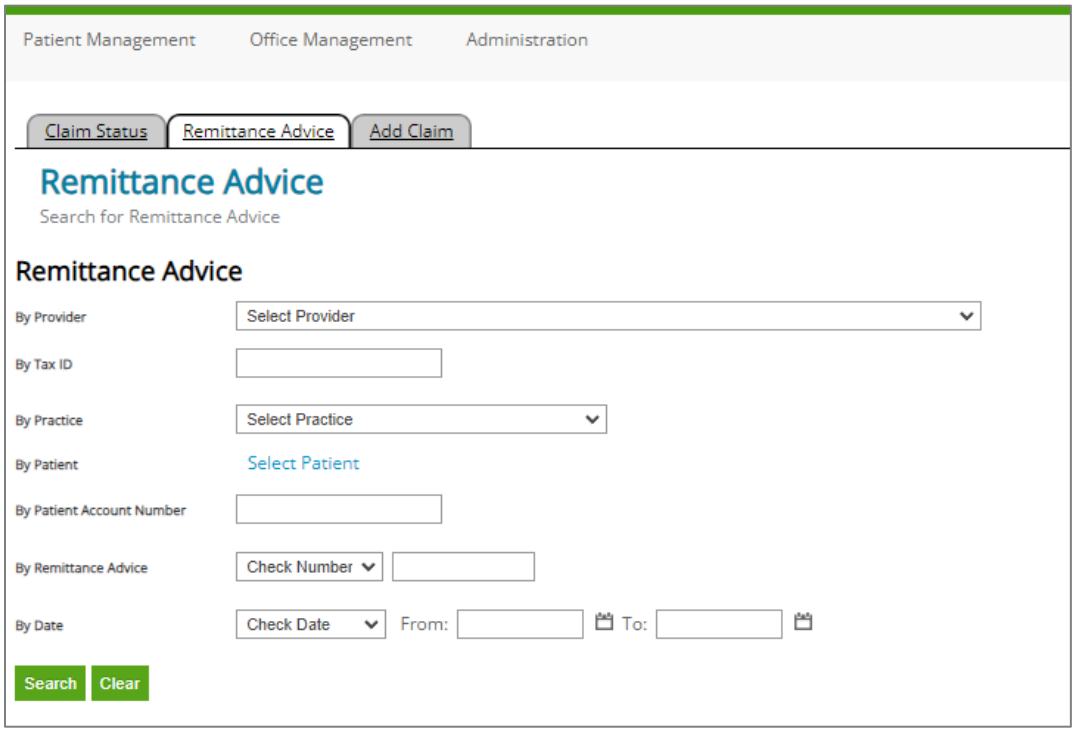
You may delete diagnoses by clicking the word ‘Delete’ by the line item.



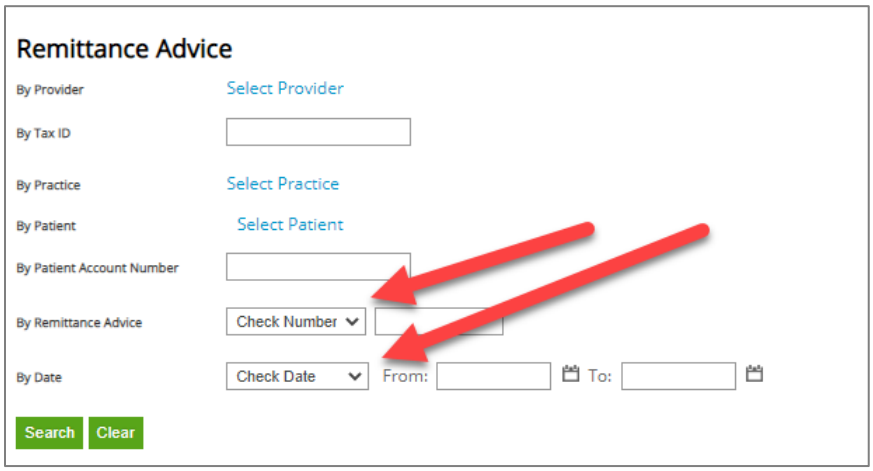
After selecting your diagnosis code, click on Add Services. Once Services have been added, click **Submit COB** to complete filing a claim.



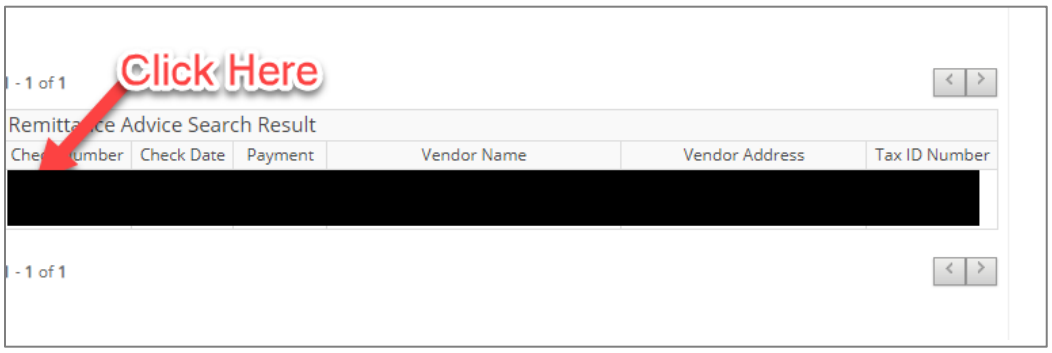
To review Remittance Advice, select the Remittance Advice tab from the claim home screen. Office Management>Claims.



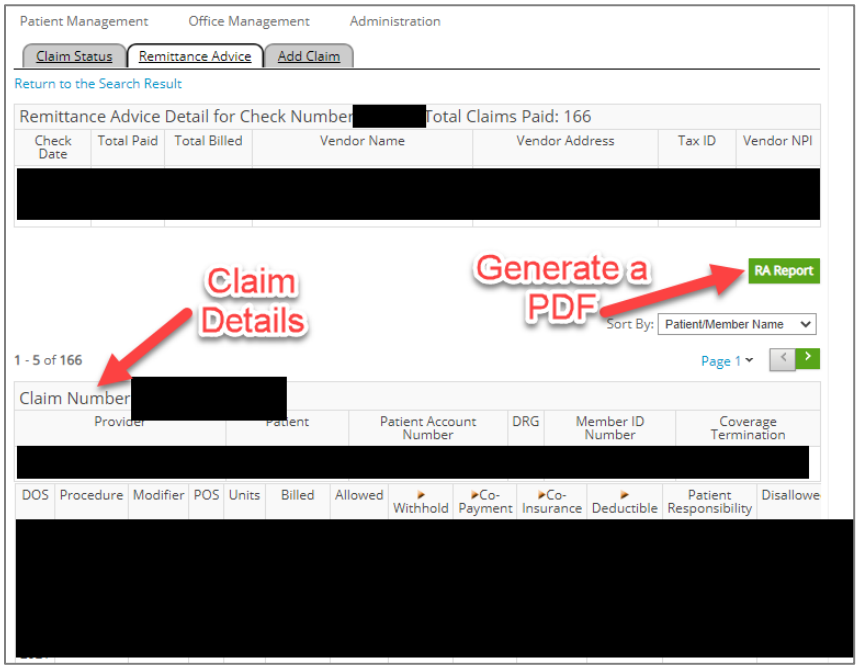
On the following screen, it is best to search by check number or check date. Select search once you have entered your search criteria.



You will be taken to a page which shows your search results. Select the check number to view additional details.



On the following page you may view claim details and generate a pdf.



8. Jiva Portal

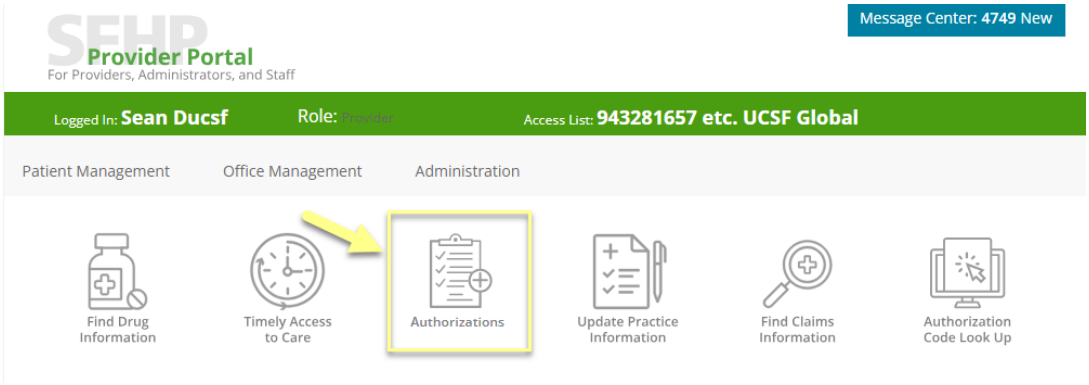
User Guide for Authorization Requests

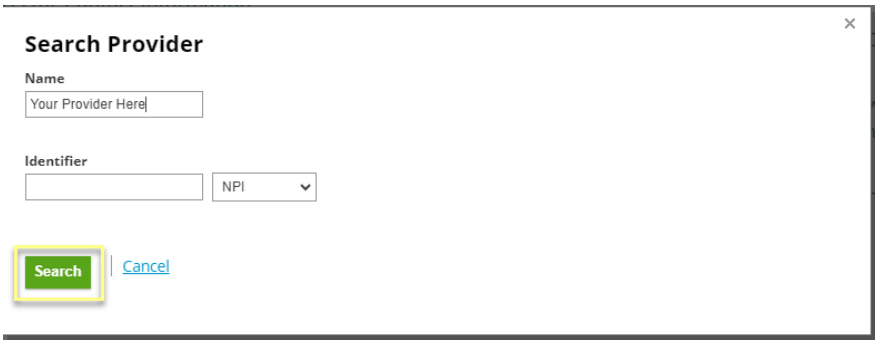
Member data displayed in this document is anonymized.

Access via the Provider Portal

Jiva is accessible through the Authorizations page in the **SFHP Provider Portal**. Selecting a provider in the Authorizations page, authenticates the Jiva session for that specific provider.

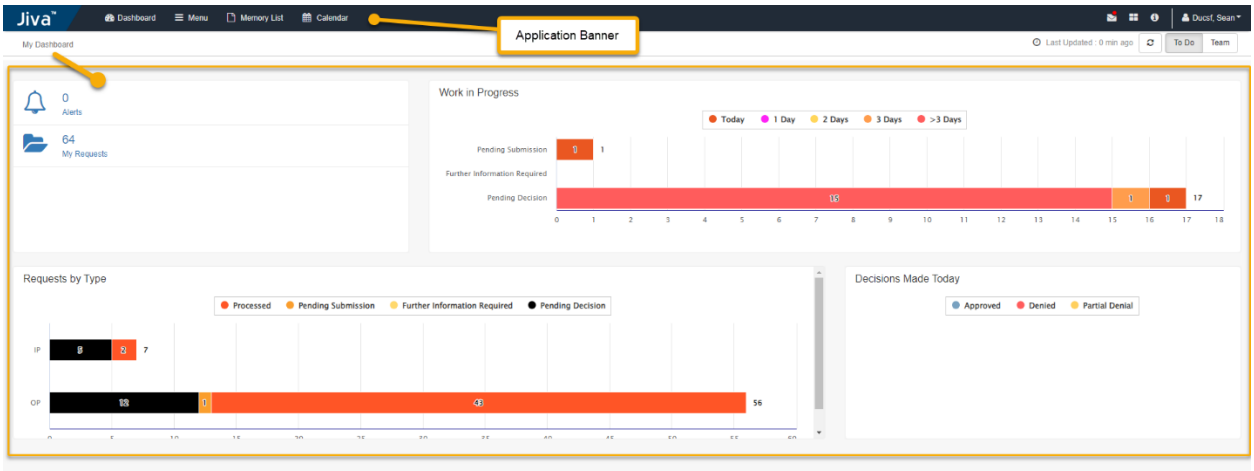
1. From the SFHP Provider Portal home page, select **Authorizations**.
2. Review the information on the Authorizations page to determine if an authorization is required or to access helpful information, such as links to forms.
3. Select the **Search Providers** link.
4. In the **Search Provider** screen, enter your provider details (name or NPI) then **Search**.
5. **Ensure your web browser allows Pop-ups** and select **Submit** on the main Authorizations page.
    a. Jiva Provider Portal will open in a new browser tab or window.





Jiva Home Page Navigation

The home page in Jiva consists of the Application Banner across the top and the Dashboard.



Application Banner

The Application Banner is displayed across the top and provides access to links and functions.

LINK	DESCRIPTION
DASHBOARD	Opens the *My Dashboard* home page.
MENU	Access to the *New Request* and *Search Request* functions.
MEMORY LIST	Quick access to the last 10 screens opened.
CALENDAR	Lists the activities assigned to you by day, week, and month.
	Message inbox, with a red dot indicator for unread messages.
	Legend of icons.
	Help function that provides context-centric guidance for each screen.
USERNAME	On the top right corner, the username of the logged-on user provides access to additional information and functions.
MY DASHBOARD	Displays the episodes that are associated with you.
MY TEAM*	Displays the episodes that are associated with your team. *not applicable for all users.

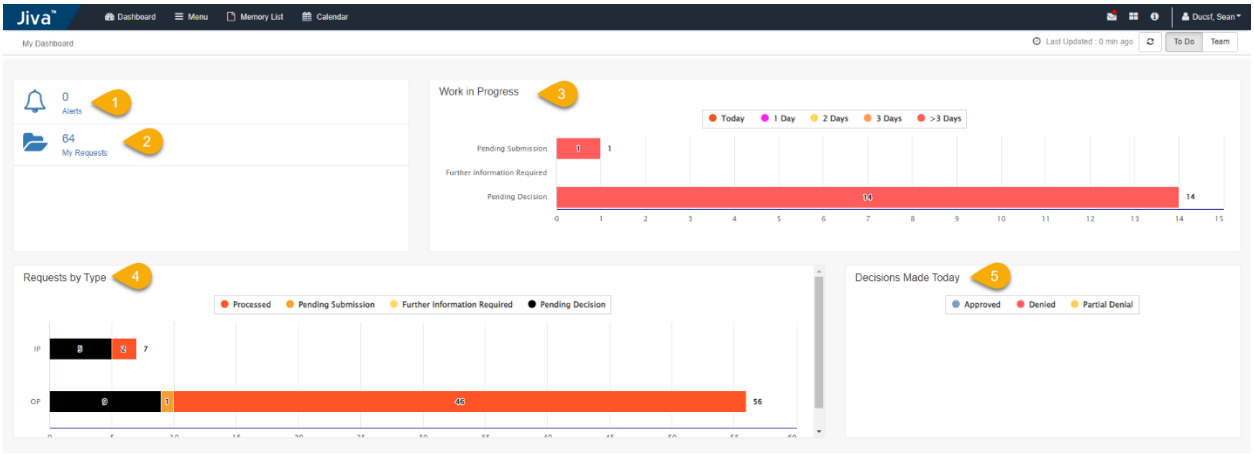
My Dashboard

The Jiva Dashboard is a visual display of information that provides access to authorization requests using interactive widgets. The widgets display a history of the last 60 days and show only authorization requests created by the logged-on user.

WIDGET	FUNCTION
ALERTS	Link to the alerts list.
MY REQUESTS	Main access point for viewing authorization requests created by the logged-on user.

WORK IN PROGRESS	• Pending submission
	  ○ Authorization requests that were saved as a draft and not yet submitted to SFHP.
	• Further information required
	• Pending decision
	  ○ Authorization requests that were submitted to SFHP but have not yet been processed.

REQUESTS BY TYPE	• IP
	  ○ Inpatient authorization requests
	• OP
	  ○ Outpatient authorization requests
	• Color-coded statuses:
	  ○ Processed
	  ○ Pending submission
	  ○ Further information required
	  ○ Pending decision



Viewing Your Requests from My Dashboard

There are several lists which provide more detailed information by clicking on the various dashboard widgets.

My Requests

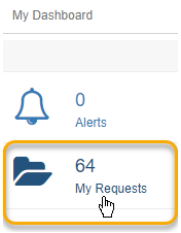
The My Requests screen displays the requests that were submitted by the logged-on user. By default, it displays requests for the last 60 days, but the date range can be adjusted and filters can be applied for episode type and status.

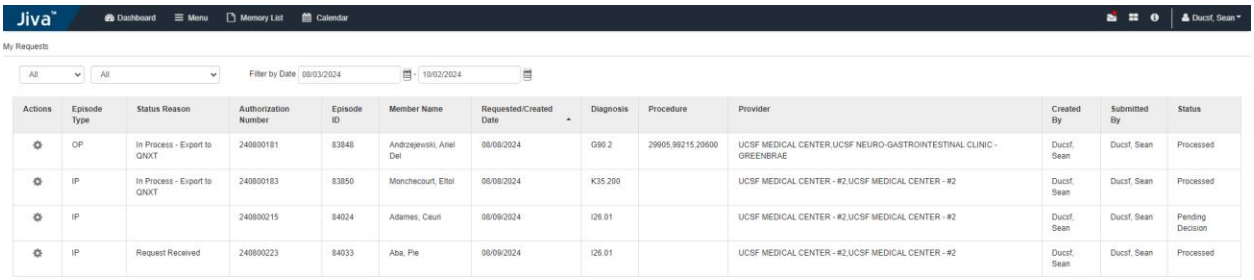
In the Episode Type drop-down, selecting the value All will show both Inpatient and Outpatient episodes. In the Status drop-down, these options can be used to filter results as follows:

Pending Decision	Decisions have not been rendered on the Stay and/or Service Request lines.
Processed*	Decisions have been rendered on one or more Stay and/or Service Request lines. *The authorization may not yet be in a final status.

In the search results list, the third column titled Status Reason shows the current state of the auth request (i.e. Approved, Denied, In Process).

In the Actions column, click on the gear icon to either open the episode or view the Episode Abstract.

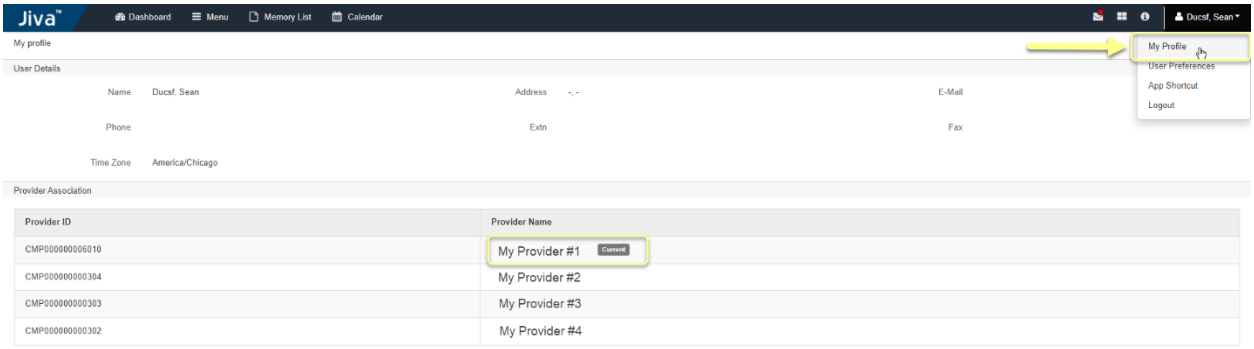




Search Requests

Provider users can search for authorization requests when they are affiliated with the providers listed in the request. Some users may have multiple provider affiliations; however, authorizations will only show in the search results when they are logged on using the exact provider that is listed on the authorization.

For example, the below user is associated with 4 providers but is currently logged in as *My Provider #1*, as shown in the **My Profile** screen. This means that this user can only see authorizations which have *My Provider #1* as the episode provider.



Using the Search Request Parameters

One or more of the below search parameters can be used to find authorizations. Upon selecting Search, the list of results is displayed below, unless there are no authorizations matching the search criteria.

In the search results list, the columns displayed are:

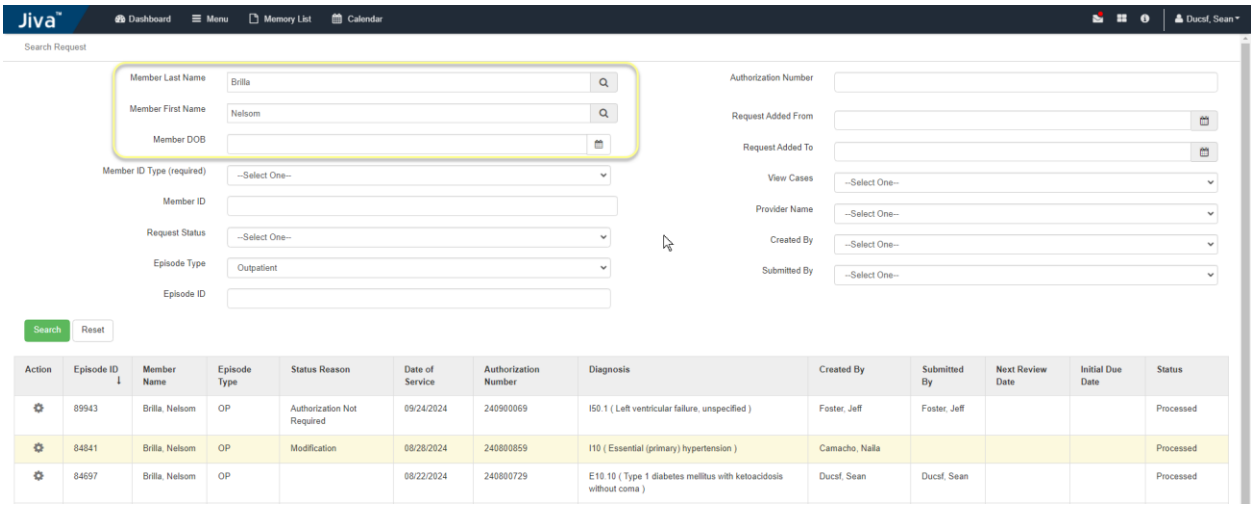
- **Action**
  - Selecting the gear icon allows access to **View Episode Abstract** or **Open** the episode
- **Episode ID**
  - This reference is internal to Jiva and does not need to be used by provider
- **Member Name**
  - *Last, First* format
- **Episode Type**
  - OP for Outpatient
  - IP for Inpatient
- **Status Reason**
  - This is the status for the overall episode. If it is blank, the authorization has not yet been finalized
- **Date of Service**
  - Auth Start Date
- **Authorization Number**
  - This is the number which should be used when referring to SFHP authorizations
- **Diagnosis**

    - Only the primary diagnosis is listed
- **Created By**
    - Provider or SFHP user that created the authorization request
    - Provider or SFHP user that submitted the authorization request.
- **Submitted By**
    - This is the user that submitted the authorization request
- **Next Review Date**
- Initial Due Date
    - The date when a response is due from SFHP.
- Status
    - Processed

Additional details about the authorization can be found without navigating away from Search Results by selecting the **Gear** > **View Episode Abstract**.

To perform a new search, selecting **Reset** will clear the search parameters entered.

Search by Member Name or DOB:

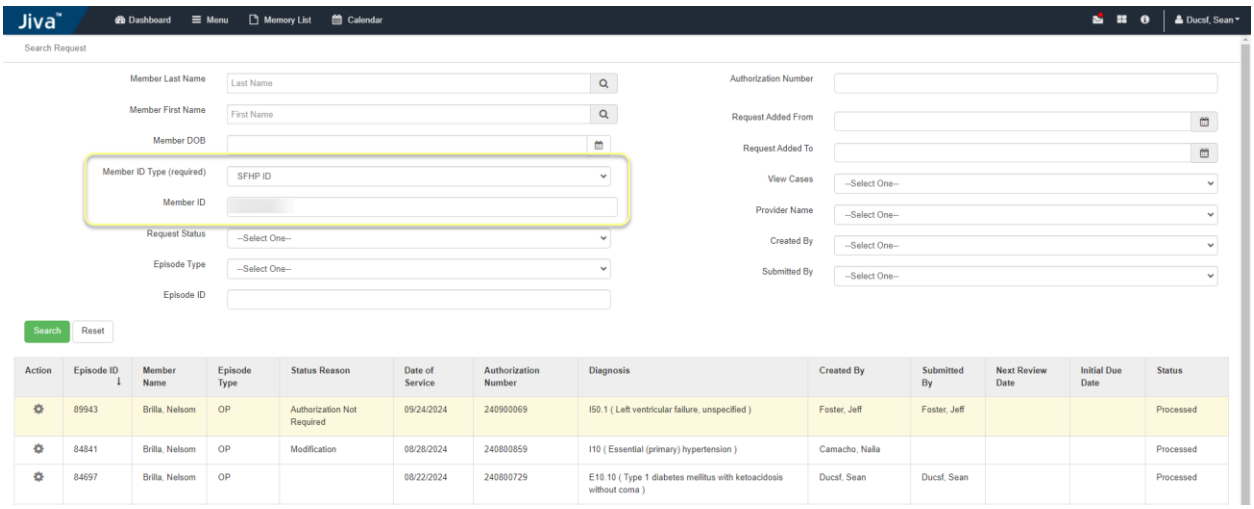


The name fields are look-ups where the name must be selected from the list.

Member DOB should be entered in MM/DD/YYYY format.

Search by SFHP ID or CIN:

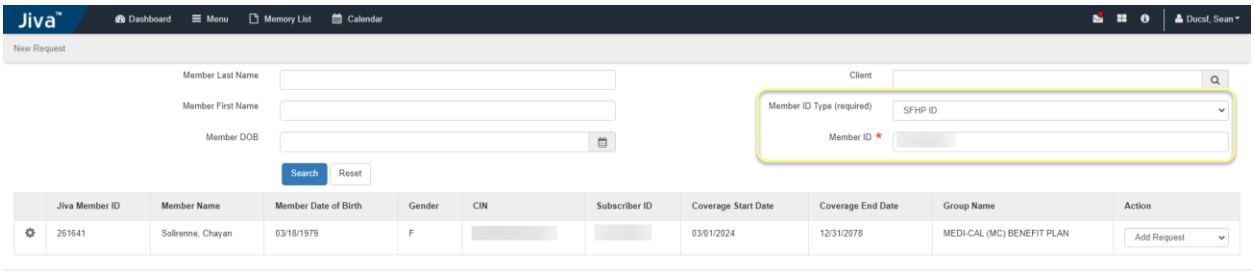
When searching by **Member ID**, it is mandatory to select the **Member ID Type**. This is not required when searching by any other parameters except Member ID. Either the SFHP ID or the CIN can be used.



New Requests

Creating an authorization request is done through the **Menu** > **New Requests** screen by searching for a member, then selecting the **Add Request** action from the search results row.

It is mandatory to search for a member using either the SFHP ID or their Medi-Cal CIN, and this **Member ID Type** must be selected from the drop-down above the **Member ID** field.



Additional search parameters can be entered into the fields; however, this is not necessary since the member is uniquely identifiable by their SFHP ID or CIN.

Upon selecting **Search**, the list of results is displayed below, unless there are no members matching the search criteria.

The columns displayed are:

COLUMN TITLE	DESCRIPTION
JIVA MEMBER ID	Unique identifier for the member, used only in Jiva. *Providers do not need to use this ID, since the SFHP ID or CIN should be used.*
MEMBER NAME	The member's legal name in Last, First format.
MEMBER DATE OF BIRTH	The DOB in MM/DD/YYYY format.

GENDER	Birth sex of the member as indicated on their SFHP enrollment. Gender identity is not listed here.
CIN	The Member's CIN is displayed if their Medi-Cal eligibility is shown.
SUBSCRIBER ID	The member's SFHP ID.
COVERAGE START DATE	The date the eligibility segment began.
COVERAGE END DATE	The date the eligibility segment ended or, if dated 12/31/2078, is currently active.
GROUP NAME	The member's Line of Business for the Member ID searched. *Note: If the member has both Medi-Cal and Heathy Workers, this column will show only the one that matches the SFHP ID entered.*
ACTION	Add Request drop-down to create an Outpatient or Inpatient auth request.

Member Eligibility

It is the responsibility of providers to check the member's eligibility before creating a new authorization request. This is done by reviewing the Member Abstract.

1. In the New Request screen, search for the member using their SFHP ID or CIN.
2. In the Search Results list, select the gear ⚙ icon in the first column then select **View Member Abstract**. The Member Information page is opened.
3. In the **Member Information** page, confirm the member's demographic details are correct in the Member Details and Contact sections.
    a. **Member Details**: Name, Date of Birth, Birth Sex, PCP, Ethnicity, Subscriber ID
    b. **Contacts**: Mailing Address, Physical Address, Phone Number(s)
4. Review the Member IDs, which will display the CIN for Medi-Cal members.
5. Check the member's eligibility segments listed in the **Policy Details** section, looking first to the Term Date* column to determine which segment is currently active (future date of 12/31/2078).

COLUMN TITLE	DESCRIPTION
GROUP	Line of Business
POLICY NAME	Medical Group
SUBSCRIBER ID	SFHP ID
EFFECTIVE DATE	The date which the eligibility segment* began.
TERM DATE	The date which the eligibility segment ended or, if dated 12/31/2078, is the current **Active** segment. *Members may have more than one current eligibility at a time, such as Medi-Medi*

	(Medicare AB + Medi-Cal) or Healthy Workers + Medi-Cal.
ELIGIBILITY STATUS	The status of the segment during the date span listed. *Active: Member has or had active coverage during the dates listed.* *Hold: Member is or was on a Medi-Cal Hold during the dates listed and it was not lifted.*

** Eligibility segments are divided by certain coverage changes, such as new coverage, change in Medical Group or PCP, or reinstatement after a Medi-Cal Hold.*

Medical Group

Some members belong to delegated medical groups (DMGs) that provide UM services and make authorization decisions based on their own policies and procedures. SFHP does not review requests for DMGs. Please forward those requests directly to the delegated medical group.

Submit requests directly to the following authorizing entities:

- All American Medical Group (AAMG)
- American Specialty Health Plans of California (ASH)
- Brown & Toland (BTP)
- Carelon Behavioral Health
- Hill Physicians (HILL)
- Jade Health Care (JAD)
- North East Medical Services (NEMS)
- North East Medical Services with San Francisco Health Network (SFHN)
- Pharmacy Prescriptions
- Vision Service Plan (VSP)

For more information, visit **https://www.sfhp.org/programs/medi-cal/your-care-network/#YourMedicalGroup**.

Outpatient Prior-Authorizations

Use the provider portal to request prior authorization of outpatient services like office visits, radiology, durable medical equipment, and ambulatory procedures. Some CPT and HCPCS service codes will not require prior authorization, and some will generate automatic approvals. All other codes will require medical necessity review by the SFHP Prior-Authorizations Nurse team.

Request routine services up to 3 months before the service date. Expedited services should occur in less than 5 business days from submission and meet Medi-Cal guidelines for expedited requests. If a service has already occurred, SFHP considers it retrospective. This type must meet certain guidelines for SFHP to review the request.

Routine Outpatient Pre-Service Requests

- ♣ After reviewing **Member Eligibility**, select the **Add Request** drop-down in the **Action** column.
    - Search results may display multiple eligibility rows. The rows can have both current and past **Coverage End Dates**.
    - Select any row and **Add Request**. The system will automatically apply the most recent coverage regardless of the selection.
- ♣ Select **Outpatient** in the drop-down to open the **Outpatient Request** screen.
- ♣ Make the following selections in the **Episode Details** section:
    - **Request Type**: Prior-Authorization
        - – Use **Prior Authorization** for requests that will take place in the future.
        - – Use **Retrospective** for services that have already occurred.
            - ♦ ⚠ Request **Prior Authorization** and **Retrospective** services separately.
            - ♦ Use the following link for **retrospective requests**.
    - **Request Priority**: Routine
        - – Use the following link to enter an **expedited request** if applicable.
        - – Retro requests cannot be expedited
    - **Time Request:** 5 Business Days
        - – This field will automatically populate based on the selected priority.
    - **Reason for Request** defaults to **Office Visits;** change if applicable.
        - – **Reason for Request** may automatically change if the first service code entered is associated with a different reason than the one selected.
        - – SFHP may also update the **Reason for Request** if needed.
- ♣ Verify the selected **eligibility** segment shown in the **Policy Details** section is the correct coverage for the service.
    - Select **Change Coverage** for the following reasons:
        - – *Medicare* or *COB* appears as the set coverage.
            - ♦ SFHP processes authorization requests using the Medi-Cal, Medi-Medi, or Healthy Workers HMO eligibility segments only and *not* Medicare or COB.
        - – The date(s) of service fall outside the dates of the eligibility segment

- ♦ **Example**: a retrospective date of service occurred before the current eligibility and requires selection of a termed eligibility segment.
- – Selected eligibility doesn't cover the requested service
  - ♦ **Example**: Healthy Workers HMO doesn't cover a service, but Medi-Cal does.

- In the **Change Coverage** screen, select the correct eligibility segment; then **Save**.

♣ Search for a **Diagnosis** by entering the ICD-10 code or its description.

- Must add at least 1 diagnosis.

♣ Select **Attach Providers**.

- Attach one **Requesting Provider** and one **Rendering Provider**
- ⚠ Only attach *1 of each provider type*. Deactivate any additional providers by using the gear icon ⚙.
- ⚠ Enter providers before entering service codes.
  - – Entering providers before the service code allows the system to determine network eligibility and whether a code requires prior authorization.

Steps ↓	**Attaching the *same* Requesting and Rendering providers**	Steps ↓	**Attaching *different* Requesting and Rendering providers**
1	Search for the Provider.	1	Search for the **Requesting** Provider.
2	Select **Multiple Attach** *2 times* from the gear ⚙ icon.	2	Select **Multiple Attach** from the gear ⚙ icon.
3	The 2 matching provider rows will appear above the **Add** button	3	Search again for the **Rendering** Provider.
4	Leave 1 of the provider roles as **Requesting;** change the other provider role to **Rendering**.	4	Select **Multiple Attach** from the gear ⚙ icon a second time to attach the **Rendering** provider.
5	Select **Attach** at the bottom.	5	Change Provider Role from **Requesting** to **Rendering** for the second provider. *The provider role defaults to **Requesting** and needs to be changed to **Rendering** manually when applicable.*

♣ Add **Contacts.** SFHP requires a **Phone Contact** and a **Fax Contact** for processing.

- ⚠ Use **Requesting Provider** as the **Fax Contact** type; other contact types will not fax letters.
- Use any contact type for the **Phone Contact.**
- Follow the steps in the table below to add contacts:

Fax Steps ↓	**Add Fax Contact**	**Phone Steps ↓**	**Add Phone Contact**
1	Enter **Name** & **Clinic/Department**	1	Leave already entered **Name**
2	Select the **Contact Type** dropdown. Type "req" into search and select **Requesting Provider** from the list.	2	Select **Uncheck All** from the **Contact Type** dropdown to remove the previous selection.
3	Select **Fax** in the **Phone Type** field	3	Type "pro" into the search and select **Provider** from the list *Can select other **Contact Types** for **Phone Contacts** if applicable*
4	Enter **Fax** number in the **Phone Number** field	4	Select **Phone** in the **Phone Type** field ⚠ *Do not select **FAX** for phone numbers.*
5	Select **Add.** *Contact record displays above the **Add** button.*	5	Enter the phone number
6	Clear the **Contact Type, Phone Type**, and **Phone Number** fields before entering the next **Contact**	6	Select **Add.** Once all contact records are added, select **Save**.

- Edit newly added **Contacts** from the gear icon ⚙ if applicable.

♣ Enter at least 1 **Service Code**.

- Attach providers before adding service codes.
- Select ***Authorization Request via Provider Portal*** from the **Service Type** dropdown.

- **Place of Service** optional to enter

♣ **Code Type** defaults to **CPT**. Select **HCPCS** from the dropdown if applicable.
- **Search** by service code or its **description**.
- Select code in blue popup to add
- Add a modifier if applicable
- Add at least 1 unit to the **Requested #** field; Do not enter "0".
- The **Start Date** defaults to today's date (the day of entry).
  - Date(s) of service can occur on any day or days between the **start date** and **end date**
  - No need to make the **Start Date** the date of service
- Enter any **end date** as a placeholder; the system will auto-calculate the correct date once saved
- Once service details are entered, select **Add**.
  - Added services will display in the **Service Request** table.
  - Cannot modify service codes once added.
  - Delete and reenter incorrect codes by selecting the circle-backslash ⊘ icon to the left of the code

♣ Add supporting **documentation**.
- Select the Browse button to upload a file.
- Enter the **Document Title, Type,** and **Description**.

♣ Leave a **note** with information pertinent to the request.
- Select ***Provider Portal*** as the note type.
  - Select ***Provider Portal – Urgent Justification*** for expedited requests.

♣ Select **Submit** to send to SFHP
- **Saving as Draft** does not send the request to SFHP.
- To see your Draft Requests, go to the Dashboard and click on the **Pending Submission** bar in the **Work in Progress** widget.
- Select **Cancel** to remove the request if applicable

Request Details

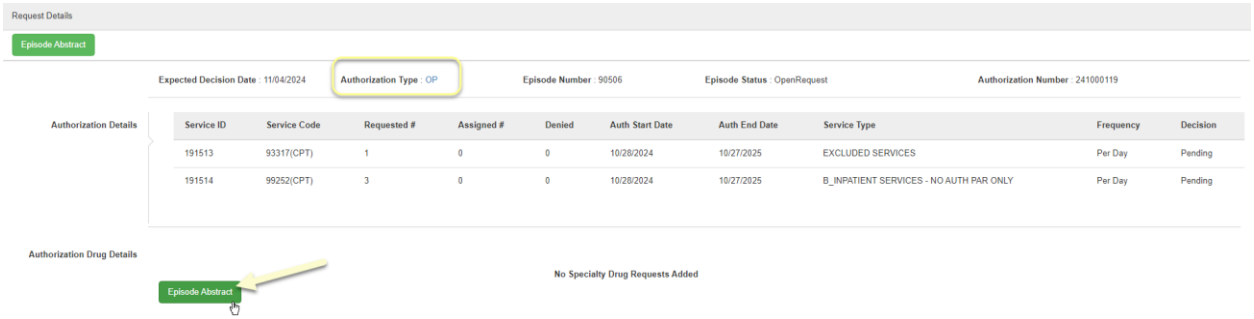
Once submitted, the Request Details page displays information about the authorization. The system may have changed some of the information after submission to meet SFHP processing guidelines.

LABEL	DESCRIPTION
EXPECTED DECISION DATE	Date by which SFHP will process the request and send a Notice of Action (NOA) letter explaining the decision.

	Some exceptions apply, and SFHP may **delay the decision.*
AUTHORIZATION TYPE	Also known as **Episode Type** and displays as **OP** for **Outpatient** requests and **IP** for **Inpatient** requests. **OP and IP are links that enter the episode when selected*
EPISODE NUMBER	An internal reference number. Providers do not need to use this information. **Use the **Authorization Number** to refer to specific requests*
EPISODE STATUS	Delineates whether a request needs review and displays as OpenRequest unless none of the service codes require prior-authorization.
AUTHORIZATION NUMBER	The unique identifier assigned to a request.
SERVICE ID	A reference number SFHP uses internally for stay and service lines. Providers do not need to use this information.
SERVICE CODE	The CPT or HCPCS code.
REQUESTED #	The number of units requested for each code.
ASSIGNED #	The number of units SFHP approved for each code. **The system may automatically approve certain codes*
DENIED #	The number of units SFHP denied for each code, if any.
AUTH START DATE	The first date services can occur. **This date does not need to match the date of service.*
AUTH END DATE	The last date services can occur. **This date does not need to match the date of service*
SERVICE TYPE	Reference categories SFHP uses internally for code groupings. Providers do not need to use this information.
FREQUENCY	A default field. Providers do not need to use this information.

DECISION	An immediate determination whether to cover or review the service. The system will display one of the following decisions: • **Approved** if the service qualifies for auto-approval. • **Pending** if the service requires SFHP review. • **Authorization Not Required** if the service can go directly to claims without review.

In the **Request Details** screen, select **Episode Abstract** to review a summary page of the request. To see the full authorization request and access additional functions, such as adding notes or documents, select the **Authorization Type** link: **OP** or **IP**.



Expedited Outpatient Requests

Providers should create **Expedited** requests for medically urgent pre-services. Retrospective services do not qualify for urgent processing. Expedited requests require a rationale. Leave a note with the **Note Type** "***Provider Portal – Urgent Justification Note***" and explain the reason why the request requires urgent processing.

Elective or non-medically urgent surgeries and procedures submitted as expedited due to imminent service dates do not meet expedited guidelines per the Department of Healthcare Services (DHCS). SFHP will downgrade these requests to a **Routine** priority.

1. To create an expedited request, select **Menu** then **New Request**.
2. **Search** for the member
3. Select the **gear** icon ⚙ next to the member's name to **View Member Abstract.**

4. Verify **Member Eligibility** in the **Policy Details** section above.
5. Select the **Add Request** drop-down in the **Action** column:
    - Search results may display multiple eligibility rows for a single member. The rows can have both current and past **Coverage End Dates**.
    - Select any row and **Add Request**. The system will automatically apply the most recent coverage regardless of the selection.
6. Select **Outpatient** in the drop-down to open the **Outpatient Request** screen.
7. Make the following selections in the **Episode Details** section:
    - **Request Type**: Prior-Authorization
        - Expedited requests cannot be retrospective
        - If the service has already occurred, go to **Retrospective Outpatient Requests**.
    - **Request Priority**: Expedited
        - Use the following link to enter **Routine Outpatient Requests** if applicable.

⚠ SFHP cannot process submissions that have both retrospective and prospective dates listed together. Request **Prior Authorization** and **Retrospective** services separately.

    - **Time Request** is a read-only field that displays the timeframe during which SFHP will review a request. SFHP views all expedited requests within 24 hours for triaging; however, SFHP has up to 72 hours to render a decision.
    - **Reason for Request** defaults to **Office Visits;** change if applicable.
        - **Reason for Request** may automatically change if the first service code entered is associated with a different reason than the one selected.
        - SFHP may also update the **Reason for Request** if needed.
8. Verify the selected **eligibility** segment shown in the **Policy Details** section is the correct coverage for the service.
    - Select **Change Coverage** for the following reasons
        - *Medicare* or *COB* appears as the set coverage.
            - SFHP processes authorization requests using the Medi-Cal, Medi-Medi, or Healthy Workers HMO eligibility segments only and *not* Medicare or COB.
        - The date(s) of service fall outside the dates of the eligibility segment
            - **Example**: a retrospective date of service occurred before the current eligibility and requires selection of a termed eligibility segment.
        - The selected eligibility doesn't cover the requested service.
            - Example: Healthy Workers HMO doesn't cover a service but Medi-Cal does
    - In the **Change Coverage** screen, select the correct eligibility segment then **Save**.

9. Search for a **Diagnosis** by entering the ICD-10 code or its description.
    - Add at least 1 diagnosis code.
10. Select **Attach Providers**.
    - Attach 1 **Requesting Provider** and 1 **Rendering Provider.**
    - ⚠ Only attach *1 of each provider type.* Deactivate any additional providers by using the gear icon ⚙.
    - ⚠ Enter providers before entering service codes.
        - Entering providers before the service code allows the system to determine network eligibility and whether a code requires prior authorization.

ENTER PROVIDERS

Steps ↓	**Attaching the *same* Requesting and Rendering providers**	Steps ↓	**Attaching *different* Requesting and Rendering providers**
1	Search for the Provider.	1	Search for the **Requesting** Provider.
2	Select **Multiple Attach** *2 times* from the gear ⚙ icon.	2	Select **Multiple Attach** from the gear ⚙ icon.
3	The 2 matching provider rows will appear above the **Add** button	3	Search again for the **Rendering** Provider.
4	Leave 1 of the provider roles as **Requesting;** change the other provider role to **Rendering**.	4	Select **Multiple Attach** from the gear ⚙ icon a second time to attach the **Rendering** provider.
5	Select **Attach** at the bottom.	5	Change Provider Role from **Requesting** to **Rendering** for the second provider. *The provider role defaults to **Requesting** and needs to be changed to **Rendering** manually when applicable.*

11. Add **Contacts.**

- SFHP requires a **Phone Contact** and a **Fax Contact** for processing.
- ⚠ Use **Requesting Provider** as the **Fax Contact** type; other contact types will not fax letters.
- Use any contact type for the **Phone Contact**.

ENTER CONTACTS

Fax Steps ↓	**Add Fax Contact**	Phone Steps ↓	**Add Phone Contact**
1	Enter **Name** & **Clinic/Department**	1	Leave already entered **Name**
2	Select the **Contact Type** dropdown. Type "req" into search and select **Requesting Provider** from the list.	2	Select **Uncheck All** from the **Contact Type** dropdown to remove the previous selection.
3	Select **Fax** in the **Phone Type** field	3	Type "pro" into the search and select **Provider** from the list *Can select other **Contact Types** for **Phone Contacts** if applicable*
4	Enter **Fax** number in the **Phone Number** field	4	Select **Phone** in the **Phone Type** field ⚠ *Do not select **FAX** for phone numbers.*
5	Select **Add.** *Contact record displays above the **Add** button.*	5	Enter the phone number
6	Clear the **Contact Type, Phone Type**, and **Phone Number** fields before entering the next **Contact**		Select **Add.** Once all contact records are added, select **Save**.

- Edit newly added **Contacts** from the gear icon ⚙ if applicable

12. Enter one or more **Service Codes**.
    - Attach providers before adding service codes.
    - Select ***Authorization Request via Provider Portal*** from the **Service Type** dropdown.
    - **Place of Service** optional to enter
    - **Code Type** defaults to **CPT**. Select **HCPCS** from the dropdown if applicable.
    - Search for services by the code or the description.
    - Select the blue popup after entering a code in order to add it.
    - Add a **Modifier** if applicable
    - Add at least 1 unit to the **Requested #** field; do not enter "0".
    - The **Start Date** defaults to today's date (the day of entry).

  - Date(s) of service can occur on any day or days between the **start date** and **end date.**
  - No need to make the **Start Date** the date of service.
- Enter any **end date** as a placeholder; the system will auto-calculate the correct date once saved.
- Once all service details are entered, select **Add**.
  - Added services display in the **Service Request** table.
  - Cannot modify service codes once added.
  - Delete and reenter incorrect codes by selecting the circle-backslash ⊘ icon to the left of the code.

13. Add supporting **documentation**.
    - Select the Browse button to upload a file.
    - Enter the **Document Title, Type,** and **Description**.
14. Leave a **note** with information pertinent to the request.
    - Select ***Provider Portal*** as the note type.
    - Select ***Provider Portal – Urgent Justification*** for expedited requests.
15. Select **Submit** to send to SFHP.
    - **Save as Draft** does not send the request to SFHPs.
    - To see Draft Requests, go to the Dashboard and click on the **Pending Submission** bar in the **Work in Progress** widget.
    - Select **Cancel** to remove the request if applicable.

Request Details

Once submitted, the Request Details page displays information about the authorization. The system may have changed some of the information after submission to meet SFHP processing guidelines.

Label	Description
Expected decision date	Date by which SFHP will process the request and send a Notice of Action (NOA) letter explaining the decision. **Some exceptions apply, and SFHP may **delay** the decision.*
Authorization type	Also known as **Episode Type** and displays as **OP** for **Outpatient** requests and **IP** for **Inpatient** requests. **OP and IP are links that enter the episode when selected*

Episode number	An internal reference number. Providers do not need to use this information. **Use the **Authorization Number** to refer to specific requests*
Episode status	Delineates whether a request needs review and displays as OpenRequest unless none of the service codes require prior authorization.
Authorization number	The unique identifier assigned to a request.
Service ID	A reference number SFHP uses internally for stay and service lines. Providers do not need to use this information.
Service Code	The **CPT** or **HCPCS** service code.
Requested #	The number of units requested for each code.
Assigned #	The number of units SFHP approved for each code. **The system may automatically approve certain codes*
Denied #	The number of units SFHP denied for each code, if any.
Auth Start Date	The first date services can occur. **This date does not need to match the date of service.*
Auth end date	The last date services can occur. **This date does not need to match the date of service*
Service type	Reference categories SFHP uses internally for code groupings.
Frequency	A default field. Providers do not need to use this information.
Decision	An immediate determination whether to cover or review the service. The system will display one of the following decisions: • **Approved** if the service qualifies for auto-approval. • **Pending** if the service requires SFHP review. • **Authorization Not Required** if the service can go directly to claims without review

In the Request Details screen, select **Episode Abstract** to review a summary page of the request.

To see the full authorization request and access additional functions, such as adding notes or documents, select the **Authorization Type** link: **OP** or **IP**.

Retrospective Outpatient Requests

Retrospective services have a date of service in the past. SFHP reviews retrospective requests under certain circumstances, such retroactive eligibility or non-disclosure of coverage at the time of service. Submit retrospective requests within 30 days of the date of service for SFHP to review.

1. To create a retrospective request, select **Menu** then **New Request**.
2. **Search** for the member.
3. Select the **gear** icon ⚙ next to the member's name to **View Member Abstract.**
4. Verify **Member Eligibility** in the **Policy Details** section above.
5. Select the **Add Request** drop-down in the **Action** column.
    - Search results may display multiple eligibility rows. The rows can have both current and past **Coverage End Dates**.
    - Select the row that corresponds to the retrospective date of service and **Add Request**.
6. Select **Outpatient** in the drop-down to open the **Outpatient Request** screen.
7. Make the following selections in the **Episode Details** section:
    - **Request Type**: Retrospective
    - **Request Priority**: Routine
        - Retrospective requests cannot have an expedited priority

    ⚠ SFHP cannot process submissions that have both retrospective and prospective dates of service listed together. Request **Prior Authorization** and **Retrospective** services separately.
    - **Time Request** is a read-only field that displays the timeframe during which SFHP will review a request. SFHP reviews retrospective requests within 30 days.
    - **Reason for Request** defaults to **Office Visits;** change if applicable.
        - **Reason for Request** may automatically change if the first service code entered is associated with a different reason than the one selected.
        - SFHP may also update the **Reason for Request** if needed.
8. Verify the selected **eligibility** segment shown in the **Policy Details** section is the correct coverage for the service.
    - Select **Change Coverage** for the following reasons

- *Medicare* or *COB* appears as the set coverage.
  - SFHP processes authorization requests using the Medi-Cal, Medi-Medi, or Healthy Workers HMO eligibility segments only and *not* Medicare or COB.
- The date(s) of service fall outside the dates of the eligibility segment.
  - **Example**: a retrospective date of service occurred before the current eligibility and requires selection of a termed eligibility segment.
- The selected eligibility doesn't cover the requested service.
  - **Example:** Healthy Workers HMO doesn't cover a service but Medi-Cal does

- In the **Change Coverage** screen, select the correct eligibility segment then **Save**.

9. Search for a **Diagnosis** by entering the ICD-10 code or its description.
   - Add at least 1 diagnosis code.
10. Select **Attach Providers**.
    - Attach 1 **Requesting Provider** and 1 **Rendering Provider.**
      - ⚠ Only attach *1 of each provider type.* Deactivate any additional providers by using the gear icon ⚙.
      - ⚠ Enter providers before entering service codes.
      - Entering providers before the service code allows the system to determine network eligibility and whether a code requires prior authorization.

ENTER PROVIDERS

Steps ↓	**Attaching the *same* Requesting and Rendering providers**	**Steps ↓**	**Attaching *different* Requesting and Rendering providers**
1	Search for the Provider.	1	Search for the **Requesting** Provider.
2	Select **Multiple Attach** *2 times* from the gear ⚙ icon.	2	Select **Multiple Attach** from the gear ⚙ icon.
3	The 2 matching provider rows will appear above the **Add** button	3	Search again for the **Rendering** Provider.
4	Leave 1 of the provider roles as **Requesting;** change the other provider role to **Rendering**.	4	Select **Multiple Attach** from the gear ⚙ icon a second time to attach the **Rendering** provider.
5	Select **Attach** at the bottom.	5	Change Provider Role from **Requesting** to **Rendering** for the second provider.

			*The provider role defaults to **Requesting** and needs to be changed to **Rendering** manually when applicable.*

11. Add **Contacts.**
    - SFHP requires a **Phone Contact** and a **Fax Contact** for processing.
    - ⚠ Use **Requesting Provider** as the **Fax Contact** type; other contact types will not fax letters.
    - Use any contact type for the **Phone Contact**.

ENTER CONTACTS

Fax Steps ↓	**Add Fax Contact**	**Phone Steps ↓**	**Add Phone Contact**
1	Enter **Name** & **Clinic/Department**	1	Leave already entered **Name**
2	Select the **Contact Type** dropdown. Type "req" into search and select **Requesting Provider** from the list.	2	Select **Uncheck All** from the **Contact Type** dropdown to remove the previous selection.
3	Select **Fax** in the **Phone Type** field	3	Type "pro" into the search and select **Provider** from the list *Can select other **Contact Types** for **Phone Contacts** if applicable*
4	Enter **Fax** number in the **Phone Number** field	4	Select **Phone** in the **Phone Type** field *Do not select **FAX** for phone numbers.*
5	Select **Add.** *Contact record displays above the **Add** button.*	5	Enter the phone number
6	Clear the **Contact Type, Phone Type**, and **Phone Number** fields before entering the next **Contact**		Select **Add.** Once all contact records are added, select **Save**.

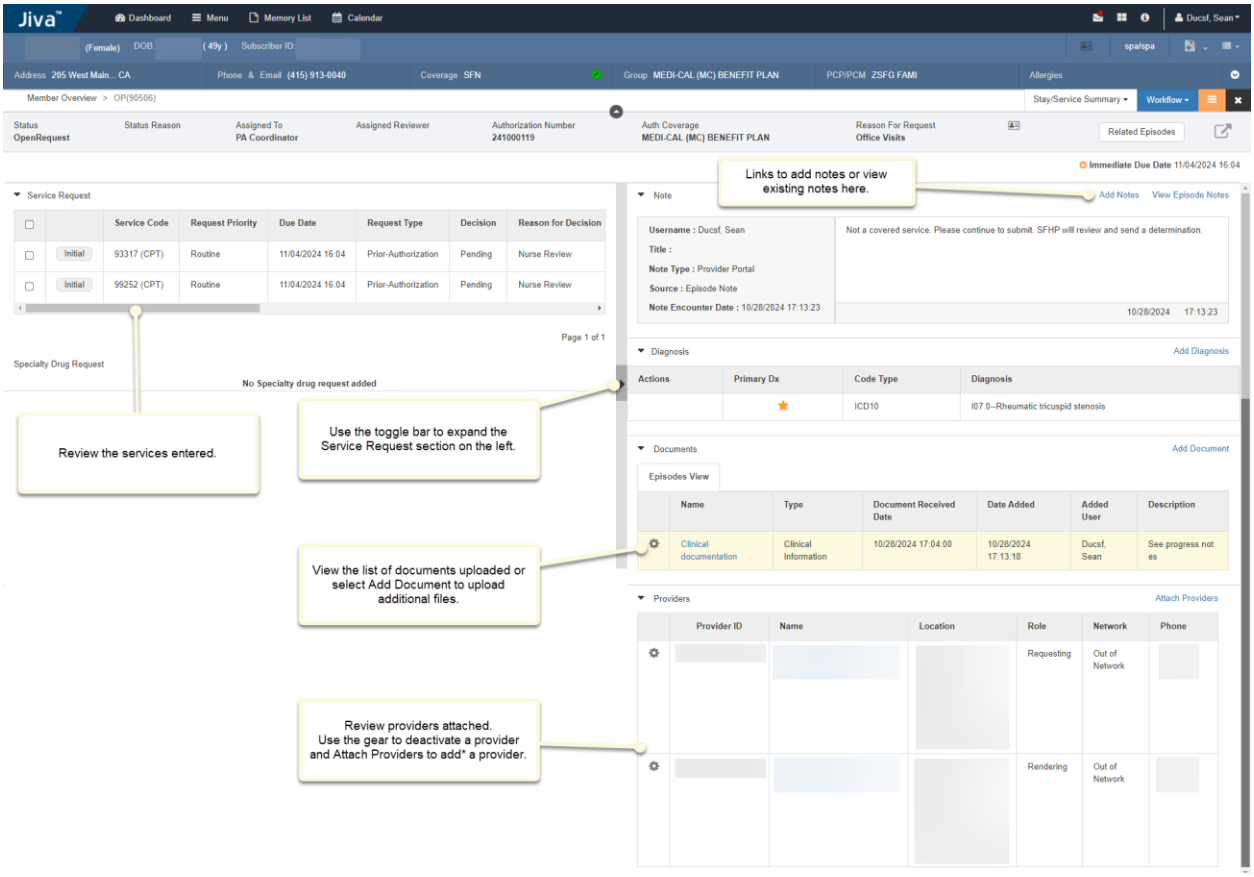
12. Enter one or more **Service Codes**.
    - Attach providers before adding service codes.

- Select ***Authorization Request via Provider Portal*** from the **Service Type** dropdown.
- **Place of Service** is optional to enter
- **Code Type** defaults to **CPT**. Select **HCPCS** from the dropdown if applicable.
- Search for services by the code or the description.
- Select the blue popup after entering a code in order to add it.
- Add a **Modifier** if applicable.
- Add at least 1 unit to the **Requested #** field; do not enter "0".
- The **Start Date** defaults to today's date (the day of entry)
  - Date(s) of service can occur on any day or days between the **start date** and **end date.**
  - No need to make the **Start Date** the date of service.
- Enter any **end date** as a placeholder; the system will auto-calculate the correct date once saved.
- Once all service codes are entered, select **Add**.
  - Added services display in the **Service Request** table.
  - Cannot modify service codes once added
  - Delete and reenter incorrect codes by selecting the circle-backslash ⊘ icon to the left of the code.

13. Add supporting **documentation**.
    - Select the **Browse** button to upload a file.
    - Enter the **Document Title, Type,** and **Description**.
14. Leave a **note** with information pertinent to the request.
15. Select **Provider Portal** as the note type.
    - Do not select **Provider Portal – Urgent Justification.**
    - Retrospective requests cannot have an expedited priority
16. Select **Submit** to send to SFHP.
    - **Save as Draft** does not send the request to SFHP.
    - To see **Draft Requests**, go to the **Dashboard** and click the **Pending Submission** bar in the **Work in Progress** widget.
    - Select **Cancel** to remove the request if applicable.

Episode View in Jiva

Jiva calls **Authorizations**, ***Episodes***. After submitting an Episode, view the request details in the **Episode-Centric View (ECV)**. Here the episode appears in 3 different main parts: **Auth Banner** across the top, **Stay and Service Requests** on the left, and **Authorization Info** on the right.



**Adding a provider is not needed if there are already 2 providers attached. For OP requests, there should be 1 Requesting and 1 Rendering only. For IP requests, there should be 1 Requesting and 1 Inpatient Facility only. Do not attach more than 2 providers.*

Auth Banner

The Auth Banner displays important details across the top of the page

LABEL	DESCRIPTION
STATUS	Episodes created on the portal show a status of **OpenRequest**. SFHP will change this to one of the following: **Open** before review, **Closed** after review, or **Voided** for various reasons.
STATUS REASON	Explains why the status is open, closed, or voided. Providers will most often see variations of **Approved**, **Denied**, **Authorization not Required**, or **Voided.**
ASSIGNED TO	Displays the worklist the episode appears in or the name of the person working on the request.
ASSIGNED REVIEWER	If an episode requires review by a physician, the physician's name displays here.
AUTHORIZATION NUMBER	Unique identifier assigned to an episode

AUTH COVERAGE	Type of insurance applied to the episode: **Medi-Cal**, **Medi-Medi**, or **Healthy Worker's HMO**. **If Medicare or COB display here, change the eligibility*
REASON FOR REQUEST	The kind of service the member will receive, such as **Office Visit** or **Surgeries with Anesthesia**.
AUTHORIZED REPRESENTATIVE ICON	Contact information of those authorized to make requests/decisions for the member.
RELATED EPISODE LINK	SFHP will link certain related requests, such as those that require separate episodes for services and facility fees.
EPISODE DETAILS LINK	Popup opens showing a condensed view of the following fields: **Status**, **Status Reason**, **Primary Dx**, **Facility**, **Provider**, **Assigned To**, **Assigned Reviewer**, **Authorization Number**, **Auth Coverage**, and **Reason for Request**.

Stay/Service Request

Details related to the **Service Codes** or **Stay Lines** display in the pane on the left. Expand this section by clicking on the vertical toggle bar in the middle.

LABEL	DESCRIPTION
STAY REQUEST	Overnight stay for inpatient/planned admissions
LEVEL OF CARE	Type of care required during a stay, such as **Acute Rehab** or **Med-Surge**.
SERVICE REQUEST	Type of visit or procedure for **Outpatient** and **Planned Admission** requests.
SERVICE CODE	**CPT** or **HCPCS** billing code.
REQUEST PRIORITY	**Expedited** for urgent service and **Routine** for all other services. **Expedited requests are those that would pose an imminent threat to the member's health if not processed within an urgent timeframe.*
REQUEST RECEIVED DATE	Date SFHP received the request for services; this is also the date the provider submits the service.
AUTH START DATE	The first date services can occur. **This date does not need to match the date of service.*
AUTH END DATE	The last date services can occur. **This date does not need to match the date of service*
DUE DATE	Date by which SFHP will complete review and notify the provider of the decision by fax.

	**5 business days for routine requests and up to 72 hours for expedited requests.*
REQUEST TYPE	Select **Concurrent Review** for members admitted to an inpatient facility, **Prior-Authorizations** for outpatient services requested before the service date, and **Retrospective** for services that occurred in the past.
DECISION	An immediate determination whether to cover or review the service. The system will display one of the following decisions: • **Approved** if the service qualifies for auto-approval. • **Pending** if the service requires SFHP review. • **Authorization Not Required** if the service claims can be reimbursed without review.
REASON FOR DECISION	Explains why SFHP rendered a decision, such as **Auto-Approval**, **Meets Guidelines**, or **Not a Benefit**.
REQUESTED #	Number of units requested for each code.
ASSIGNED #	Number of units SFHP approved for each code. **The system may automatically approve certain codes*
DENIED #	Number of units SFHP denied for each code.
MODIFIER	Used only for DME equipment: enter **RR** for rental equipment and **NU** for purchase of new equipment.

Auth Information

The right pane displays additional auth details and is divided into 4 sections: **Notes**, **Diagnosis**, **Documents**, and **Providers**.

LABEL	DESCRIPTION
NOTE	Shows the last note entered along with related information, such as **Username** and **Note Type**.
ADD NOTES	Enter a new note in the episode.
VIEW EPISODE NOTES	Opens a new window that displays all notes entered within the episode.
DIAGNOSIS	View entered diagnoses
ADD DIAGNOSIS	Enter additional diagnoses

ACTIONS	Deactivate a diagnosis by clicking on the circle-backslash ⊘ icon.
ADD DOCUMENT	Upload additional documents
EPISODE VIEW	View documents attached to the episode
MEMBER VIEW	View documents attached to the member and not necessarily associated with an episode.
PROVIDERS	**Requesting Provider** and **Rendering Provider**; attach *1 of each provider type*. Deactivate any additional providers using the gear ⚙ icon.

Inpatient Prior Authorizations (Planned Admissions)

SFHP considers inpatient procedures requested prior to the service date as **Planned Admissions**. Request **Planned Admissions** from the **Provider Portal** before the member is admitted. If already admitted, the request should go to the SFHP **Concurrent Review** team and not the **Prior Authorizations** team. SFHP does not require prior authorization for emergency services.

- Determine **Member Eligibility**
  - Search results may display multiple eligibility rows. The rows can have both current and past **Coverage End Dates**.
  - Select any row to **Add Request**. The system will automatically apply the most recent coverage regardless of the selection.
- Select the **Add Request** drop-down in the **Action** column.
- Select **Inpatient** in the drop-down to open the **Inpatient Request** screen.
- Make the following selections in the **Episode Details** section:
  - **Request Type**: Prior-Authorization
    - This field defaults to **Concurrent Review**; Change to **Prior-Authorization** for **Planned Admissions**.
    - Prior authorization requests must have an admission date in the future. If already admitted, submit the request for **concurrent review** either via the portal or by faxing a face sheet to **(415) 547-7822**.
    - Cannot select **Retrospective** for planned admissions
      - ♦ If a member has already discharged, send to the **Concurrent Review** team for retrospective review.
  - **Request Priority**: *Routine* or *Expedited*.
    - Select **expedited** if the service is medically urgent and would pose an imminent threat to the member's health if not performed within an urgent timeframe.
    - Select **routine** for all other service types.

- ⚠ Elective or non-medically urgent surgeries and procedures submitted as **Expedited** due to imminent service dates do not meet expedited guidelines per the Department of Healthcare Services (DHCS). SFHP will downgrade these requests to a **Routine** priority.

    - **Time Request:** 5 Business Days for **Routine** or 24 Hours for **Expedited**
        - This field will automatically populate a timeframe based on the selected priority
    - **Admit Type:** Planned Admission
    - **Reason for Request**: *Acute Inpatient* (age 21+) or *Pediatric/Neonatal* (age <21)
    - Select **Change Coverage** for the following reasons:
        - *Medicare* or *COB* appears as the set coverage.
            - SFHP processes authorization requests using the **Medi-Cal**, **Medi-Medi**, or **Healthy Workers HMO** eligibility segments only and *not* Medicare or COB.
        - The date(s) of service fall outside the dates of the eligibility segment
            - Select the eligibility segment that corresponds with the date of service
        - The selected eligibility doesn't cover the requested service
            - **Example**: Healthy Workers HMO doesn't cover a service, but Medi-Cal does. Change to the Medi-Cal eligibility segment.
    - **Save** after selecting the correct eligibility segment if applicable.
- Search for a **Diagnosis** by entering the **ICD-10** code or its description.
    - Episodes require at least 1 valid diagnosis code.
- Select **Attach Providers**.
    - Attach one **Requesting Provider** and one **Rendering Provider**
    - ⚠ Only attach *1 of each provider type*. Deactivate any additional providers by using the gear ⚙ icon.
    - ⚠ Enter providers before entering service codes.
        - The system needs to determine eligibility (in-network vs. out-of-network) to determine whether a service code requires prior authorization, and the providers must be entered before the service code for the system to do this.

Steps ↓	**Attaching the *same* Requesting and Rendering providers**	**Steps ↓**	**Attaching *different* Requesting and Rendering providers**

1	Search for the Provider.	1	Search for the **Requesting** Provider.
2	Select **Multiple Attach** *2 times* from the gear ⚙ icon.	2	Select **Multiple Attach** from the gear ⚙ icon.
3	The 2 matching provider rows will appear above the **Add** button	3	Search again for the **Rendering** Provider.
4	Leave 1 of the provider roles as **Requesting;** change the other provider role to **Rendering**.	4	Select **Multiple Attach** from the gear ⚙ icon a second time to attach the **Rendering** provider.
5	Select "Attach" at the bottom.	5	Change Provider Role from **Requesting** to **Rendering** for the second provider. *The provider role defaults to **Requesting** and needs to be changed to **Rendering** manually when applicable.*

- Add **Contacts**: SFHP requires a **Phone Contact** and a **Fax Contact** for processing.
- Use **Requesting Provider** as the **Fax Contact** type; other contact types will not fax letters.
- Use any contact type for the **Phone Contact**
- Follow the steps in the table below to add contacts:

ENTER CONTACTS

Fax Steps ↓	**Add Fax Contact**	**Phone Steps ↓**	**Add Phone Contact**
1	Enter **Name** & **Clinic/Department**	1	Leave already entered **Name**
2	Select the **Contact Type** dropdown. Type "req" into search and select **Requesting Provider** from the list.	2	Select **Uncheck All** from the **Contact Type** dropdown to remove the previous selection.
3	Select **Fax** in the **Phone Type** field	3	Type "pro" into the search and select **Provider** from the list *Can select other **Contact Types** for **Phone Contacts** if applicable*

4	Enter **Fax** number in the **Phone Number** field	4	Select **Phone** in the **Phone Type** field *Do not select **FAX** for phone numbers.*
5	Select **Add.** *Contact record displays below the **Add** button.*	5	Enter the phone number
6	Clear the **Contact Type, Phone Type**, and **Phone Number** fields before entering the next **Contact**		Select **Add.** Once all contact records are added, select **Save**.

    - Edit newly added **Contacts** from the gear ⚙ icon if applicable.
- Select the following **Stay Request** details:
    - **Service Type:** Planned Admission
    - **Expected Admit Date**: Day admission is scheduled for
        - If not scheduled yet, add an approximate
        - Leave Actual Admit Date blank
- Enter at least one service code.
    - Attach providers before adding service codes.
    - **Service Type:** Planned Admission
    - Place of Service is an optional field
    - **Code Type** defaults to **CPT**; select **HCPCS** from the dropdown if applicable.
    - Search by **Service Code** or its description.
        - Select the code in the blue popup to add
    - Modifiers are used for **Durable Medical Equipment** only and not required.
    - Add at least 1 to **Requested #** (units) field; do not add "0".
    - **Start Date** defaults to the **Expected Admit Date**.
    - Enter any **end date** as a placeholder; the system will auto-calculate the correct date once saved.
        - Planned admissions typically last 3 months
        - Certain services, such as transplants, last 12 months
    - Once service details are entered, select **Add**.
        - Added services display in the **Service Request** table.
        - Cannot modify service codes once added.
        - Delete and reenter incorrect codes by selecting the circle-backslash ⊘ icon to the left of the code
    - Add supporting **documentation**.

  - Select the Browse button to upload a file.
  - Enter the **Document Title**, **Type**, and **Description**.
- Leave a **Note** with information pertinent to the request.
  - Select **Note Type**, ***Provider Portal***.
    - Select ***Provider Portal – Urgent Justification*** for expedited requests *in addition to* the **Provider Portal** note.
- Select **Submit** to send to SFHP.
  - **Saving as Draft** does not send the request to SFHP.
  - To see Draft Requests, go to the Dashboard and click on the **Pending Submission** bar in the **Work in Progress** widget.
    - Select **Cancel** to remove the request if applicable.

Request Details

Once submitted, the Request Details page displays information about the authorization. The system may have changed some of the information after submission to meet SFHP processing guidelines.

Label	Description
Expected decision date	Date by which SFHP will process the request and send a Notice of Action (NOA) letter explaining the decision. **Some exceptions apply, and SFHP may **delay** the decision.*
Authorization Type	Also known as **Episode Type** and displays as **OP** for **Outpatient** requests and **IP** for **Inpatient** requests. **__OP__ and __IP__ are links that enter the episode when selected*
Episode number	An internal reference number. Providers do not need to use this information. **Use the **Authorization Number** to refer to specific requests*
Episode status	Delineates whether a request needs review and displays as OpenRequest unless none of the service codes require prior-authorization.
Authorization number	The unique identifier assigned to a request.

Service ID	A reference number SFHP uses internally for stay and service lines. Providers do not need to use this information.
Service Code	The CPT or HCPCS service code.
Requested #	The number of units requested for each code.
Assigned #	The number of units SFHP approved for each code. **The system may automatically approve certain codes*
Denied #	The number of units SFHP denied for each code.
Auth Start Date	The first date services can occur. **This date does not need to match the date of service.*
Auth end date	The last date services can occur. **This date does not need to match the date of service*
Service Type	A reference number SFHP uses internally for code groupings. Providers do not need to use this information.
Frequency	A default field. Providers do not need to use this information.
Decision	An immediate determination whether to cover or review the service. The system will display one of the following decisions: • **Approved** if the service qualifies for auto-approval. • **Pending** if the service requires SFHP review. • **Authorization Not Required** if the service can go directly to claims without review

In the Request Details screen, select **Episode Abstract** to review a summary page of the request.
To see the full authorization request and access additional functions, such as adding notes or documents, select the **Authorization Type** link: **OP** or **IP**.

Inpatient Admissions

Requests for authorization after the member has been admitted can be submitted via the Provider Portal, or a face sheet can be faxed to (415) 547-7822. No prior authorization is required for emergency department or urgent care center services.

Concurrent Review

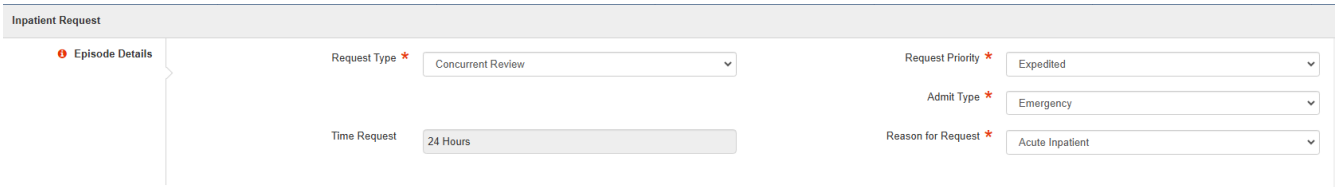
All acute inpatient hospital stays where the member is currently in-house are considered concurrent and processed as expedited.

1. After reviewing **Member Eligibility**, select the **Add Request** drop-down in the **Action** column.
    - Note that the member may have multiple rows displayed in the search results, some of which may have a Coverage End Date in the past. The Add Request option can be selected from any row because the authorization request will automatically get created using the member's most recent coverage.
2. Select **Inpatient** in the drop-down. The **Inpatient Request** screen is opened.
3. In the **Episode Details** section, select:
    - **Request Type**: Concurrent Review
        - For Planned Admission requests, see **Prior Authorizations**.
        - If the member is already discharged, see **Retrospective Review**.
    - **Request Priority**: Expedited

⚠ If an authorization was already given for the elective admission, a new request should not be submitted. Fax the face sheet to (415) 547-7822.

    - **Time Request:** 24 Hours
        - This is a read-only field which displays the time in which a response can be expected.
    - **Admit Type:**
        - **Behavioral:** Psychiatric care only
            - Psychiatric emergency medical conditions do not require authorization from SFHP.
        - **Born on Admission:** The member (if enrolled) or member's child (if not enrolled) was born during the admission
        - **Direct Admission:** Admission originating from the community or health facility
        - **Emergency:** Admission originating from the hospital's ED
        - **Planned Admission:** Do not use this for Concurrent Review requests
            - Only the Request Type of Prior-Authorization can be used with this Admit Type.
        - **Transfer from Acute Hospital:** Admission originating from an acute hospital
    - **Reason for Request:**
        - **Acute Inpatient:** Acute admission for a member 21+ years of age.

– **Pediatric/Neonatal:** Acute admission for a member <21 years of age.
– **Maternity:** Acute admission which resulted in delivery
– These should not be used for Concurrent Review requests:
  - Acute Rehab
  - Carve-Out
  - Custodial Care: See
  - Gender-Affirming Services
  - Hospice
  - Skilled Nursing Facility
  - Transplant



4. Search for a **Diagnosis** by ICD-10 code or description.
   - At least one diagnosis code must be added.
5. Add one **Requesting Provider** and one **Inpatient Facility**.
   - Only **1** of each should be added. Do not add more than these 2 providers.

Steps	Attaching the same provider for Requesting and Inpatient Facility	Attaching different providers for Requesting and Inpatient Facility
1	Search for the Provider.	Search for the Requesting Provider.
2	Select “Multiple Attach” twice from the gear icon.	Select “Multiple Attach” from the gear icon.
3	Change provider role from “Requesting” to “Inpatient Facility” on one of the providers listed.	Search for the Inpatient Facility. *Note: The role is defaulted to “Requesting”, so this must be changed.*
4	Select “Attach” at the bottom.	Change Provider Role from *Requesting* to *Inpatient Facility*.
5		Select “Multiple Attach” from the gear icon again. Select “Attach”.

6. Add **Contacts** for Phone and Fax using the Contact Type of *Requesting Provider*.
   - The authorization request cannot be submitted until both Phone and Fax contact records are added.

  - For the **Fax** contact record, the **Contact Type** of ***Requesting Provider*** must be used.
    - This Contact Type is associated with the letter, so selecting Requesting Provider for the fax record reduces processing time.
  - For the Phone contact record, any Contact Type can be selected from the look-up.

7. Select the following **Stay Request** details:
   - **Service Type:** Medical Care
   - **Actual Admit Date**

⚠ Do not enter Service Codes. This is used for Planned Admission requests only.

8. Upload the face sheet in the **documents**.
   - Select the Browse button to upload the file from your local drive.
   - Enter the Document Title, Type, and Description.
9. Leave a **note**.
   - Select the **Note Type** of ***Provider Portal***.
10. Select **Submit**.
    - The request is only sent to SFHP once **Submit** is selected.
      - If **Save as Draft** is selected, the request is not sent to SFHP.
        - To see your Draft Requests, click on the *Pending Submission* bar in the *Work in Progress* widget on the Dashboard.
      - If **Cancel** is selected, the request is removed and not saved or sent to SFHP.

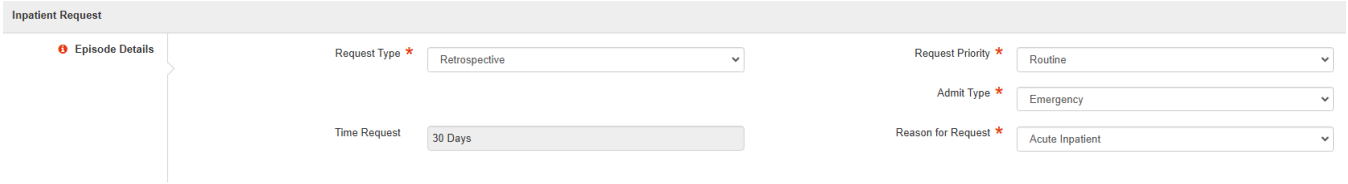
Retrospective Review

For inpatient admissions, notification after the member's discharge follows the retrospective authorization request process.

1. After reviewing **Member Eligibility**, select the **Add Request** drop-down in the **Action** column.
   - Note that the member may have multiple rows displayed in the search results, some of which may have a Coverage End Date in the past. The Add Request option can be selected from any row because the authorization request will automatically get created using the member's most recent coverage.
2. Select **Inpatient** in the drop-down. The **Inpatient Request** screen is opened.
3. In the **Episode Details** section, select:
   - **Request Type**: Retrospective
     - If the member is currently admitted, see **Concurrent Review**.
   - **Request Priority**: Routine

⚠ If the admission was for a pre-approved elective procedure, a new request should not be submitted. Fax the face sheet to (415) 547-7822.

- **Time Request:** 30 Calendar Days
  - This is a read-only field which displays the time in which a response can be expected.
- **Admit Type:**
  - **Behavioral:** Psychiatric care only
    - Psychiatric emergency medical conditions do not require authorization from SFHP.
  - **Born on Admission:** The member (if enrolled) or member's child (if not enrolled) was born during the admission
  - **Direct Admission:** Admission originating from the community or health facility
  - **Emergency:** Admission originating from the hospital's ED
  - **Planned Admission:** Do not use this for Retrospective requests
    - Only the Request Type of Prior-Authorization can be used with this Admit Type.
  - **Transfer from Acute Hospital:** Admission originating from an acute hospital
- **Reason for Request:**
  - **Acute Inpatient:** Acute admission for member 21+ years of age.
  - **Acute Rehab:** Admission to acute rehab facility or transfer to acute rehab unit.
  - **Carve-Out:** Do not use this for Retrospective requests
  - **Custodial Care – Maxine add here**
  - **Gender-Affirming Services**
  - **Hospice**
  - **Maternity:** Acute admission which resulted in delivery
  - **Pediatric/Neonatal:** Acute admission for member <21 years of age.
  - **Skilled Nursing Facility – Jen add here**
  - **Transplant**



4. Search for a **Diagnosis** by ICD-10 code or description.

- At least one diagnosis code must be added.

5. Add one **Requesting Provider** and one **Inpatient Facility**.
   - Only **1** of each should be added. Do not add more than these 2 providers.

Steps	Attaching the same provider for Requesting and Inpatient Facility	Attaching different providers for Requesting and Inpatient Facility
1	Search for the Provider.	Search for the Requesting Provider.
2	Select "Multiple Attach" twice from the gear ⚙ icon.	Select "Multiple Attach" from the gear ⚙ icon.
3	Change provider role from "Requesting" to "Inpatient Facility" on one of the providers listed.	Search for the Inpatient Facility. *Note: The role is defaulted to "Requesting", so this must be changed.*
4	Select "Attach" at the bottom.	Change Provider Role from *Requesting* to *Inpatient Facility*.
5		Select "Multiple Attach" from the gear ⚙ icon again. Select "Attach".

6. Add **Contacts** for Phone and Fax using the Contact Type of *Requesting Provider*.
   - The authorization request cannot be submitted until both Phone and Fax contact records are added.
     - For the **Fax** contact record, the **Contact Type** of ***Requesting Provider*** must be used.
       - This Contact Type is associated with the letter, so selecting Requesting Provider for the fax record reduces processing time.
     - For the Phone contact record, any Contact Type can be selected from the look-up.
7. Select the following **Stay Request** details:
   - **Service Type**
   - **Actual Admit Date**

⚠ Do not enter Service Codes. This is used for Planned Admission requests only.

8. Upload the face sheet in the **documents**.
   - Select the Browse button to upload the file from your local drive.
   - Enter the Document Title, Type, and Description.
9. Leave a **note**.

- Select the **Note Type** of ***Provider Portal***.

10. Select **Submit**.
    - The request is only sent to SFHP once **Submit** is selected.
        - If **Save as Draft** is selected, the request is not sent to SFHP.
            - To see your Draft Requests, click on the *Pending Submission* bar in the *Work in Progress* widget on the Dashboard.
        - If **Cancel** is selected, the request is removed and not saved or sent to SFHP.

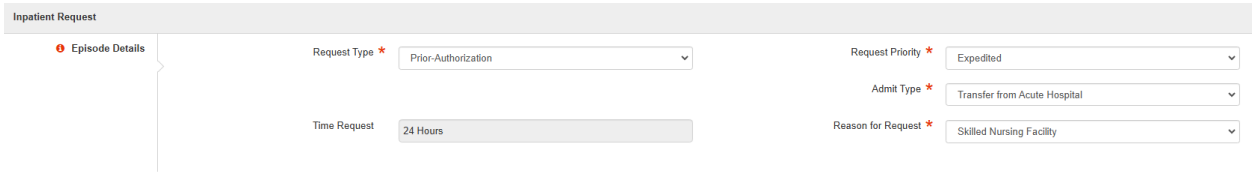
Post-Acute

In most cases, prior authorization should be obtained for transfer to or placement in a Skilled Nursing Facility. The pre-authorized length of stay varies based on individual member need.

1. After reviewing **Member Eligibility**, select the **Add Request** drop-down in the **Action** column.
    - Note that the member may have multiple rows displayed in the search results, some of which may have a Coverage End Date in the past. The Add Request option can be selected from any row because the authorization request will automatically get created using the member's most recent coverage.
2. Select **Inpatient** in the drop-down. The **Inpatient Request** screen is opened.
3. In the **Episode Details** section, select:
    - **Request Type**: Prior-Authorization
        - For Acute Planned Admission requests, see **Prior Authorizations**.
        - If the member is already discharged from the nursing facility, see **Retrospective Review**.
    - **Request Priority**: Expedited
        - If the member is awaiting discharge from an acute hospital, select Expedited; otherwise, select Routine.

⚠ If an authorization was already given for the nursing facility admission, a new request should not be submitted. Once the member is admitted, fax the face sheet to (415) 547-7822.

    - **Time Request:** 24 Hours
        - This is a read-only field which displays the time in which a response can be expected.
    - **Admit Type:** Transfer from Acute Hospital
    - **Reason for Request:** Skilled Nursing Facility



4. Search for a **Diagnosis** by ICD-10 code or description.
    - At least one diagnosis code must be added.
5. Add one **Requesting Provider** and one **Inpatient Facility**.
    - Only **1** of each should be added. Do not add more than these 2 providers.

Steps	**Attaching the same provider for Requesting and Inpatient Facility**	**Attaching different providers for Requesting and Inpatient Facility**
1	Search for the Provider.	Search for the Requesting Provider.
2	Select “Multiple Attach” twice from the gear icon.	Select “Multiple Attach” from the gear icon.
3	Change provider role from “Requesting” to “Inpatient Facility” on one of the providers listed.	Search for the Inpatient Facility. *Note: The role is defaulted to “Requesting”, so this must be changed.*
4	Select “Attach” at the bottom.	Change Provider Role from *Requesting* to *Inpatient Facility*.
5		Select “Multiple Attach” from the gear icon again. Select “Attach”.

6. Add **Contacts** for Phone and Fax using the Contact Type of *Requesting Provider*.
    - The authorization request cannot be submitted until both Phone and Fax contact records are added.
        - For the **Fax** contact record, the **Contact Type** of ***Requesting Provider*** must be used.
            - This Contact Type is associated with the letter, so selecting Requesting Provider for the fax record reduces processing time.
        - For the Phone contact record, any Contact Type can be selected from the look-up.
7. Select the following **Stay Request** details:
    - **Service Type**
    - **Expected Admit Date**

Do not enter Service Codes. This is used for Planned Admission requests only.

8. Upload supporting **documents**.
    - Select the Browse button to upload the file from your local drive.
    - Enter the Document Title, Type, and Description.
9. Leave a **note**.
    - Select the **Note Type** of ***Provider Portal***.
10. Select **Submit**.
    - The request is only sent to SFHP once **Submit** is selected.
        - If **Save as Draft** is selected, the request is not sent to SFHP.
            - To see your Draft Requests, click on the *Pending Submission* bar in the *Work in Progress* widget on the Dashboard.
        - If **Cancel** is selected, the request is removed and not saved or sent to SFHP.

Long-Term Care

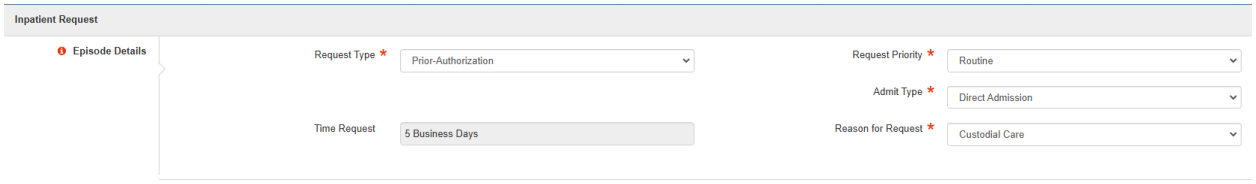
Authorization is required for members receiving long-term custodial care.

1. After reviewing **Member Eligibility**, select the **Add Request** drop-down in the **Action** column.
    - Note that the member may have multiple rows displayed in the search results, some of which may have a Coverage End Date in the past. The Add Request option can be selected from any row because the authorization request will automatically get created using the member's most recent coverage.
2. Select **Inpatient** in the drop-down. The **Inpatient Request** screen is opened.
3. In the **Episode Details** section, select:
    - **Request Type**: Prior-Authorization
        - For SNF admission requests from an acute care hospital, see **Post-Acute**.
        - If the member is already discharged from the nursing facility, see **Retrospective Review**.
    - **Request Priority**: Routine

If the member is currently admitted in a nursing facility, a new request should not be submitted. Call the LTC team at 1(415) 615-4530 for assistance with these members.

    - **Time Request:** 5 Business Days
        - This is a read-only field which displays the time in which a response can be expected.
    - **Admit Type:** Direct Admission

- **Reason for Request:** Custodial Care
  - Do not select Skilled Nursing Facility for long-term custodial care requests.



4. Search for a **Diagnosis** by ICD-10 code or description.
   - At least one diagnosis code must be added.
5. Add one **Requesting Provider** and one **Inpatient Facility**.
   - Only **1** of each should be added. Do not add more than these 2 providers.

Steps	Attaching the same provider for Requesting and Inpatient Facility	Attaching different providers for Requesting and Inpatient Facility
1	Search for the Provider.	Search for the Requesting Provider.
2	Select "Multiple Attach" twice from the gear icon.	Select "Multiple Attach" from the gear icon.
3	Change provider role from "Requesting" to "Inpatient Facility" on one of the providers listed.	Search for the Inpatient Facility. *Note: The role is defaulted to "Requesting", so this must be changed.*
4	Select "Attach" at the bottom.	Change Provider Role from *Requesting* to *Inpatient Facility*.
5		Select "Multiple Attach" from the gear icon again. Select "Attach".

6. Add **Contacts** for Phone and Fax using the Contact Type of *Requesting Provider*.
   - The authorization request cannot be submitted until both Phone and Fax contact records are added.
     - For the **Fax** contact record, the **Contact Type** of ***Requesting Provider*** must be used.
       - This Contact Type is associated with the letter, so selecting Requesting Provider for the fax record reduces processing time.
     - For the Phone contact record, any Contact Type can be selected from the look-up.
7. Select the following **Stay Request** details:
   - **Service Type**

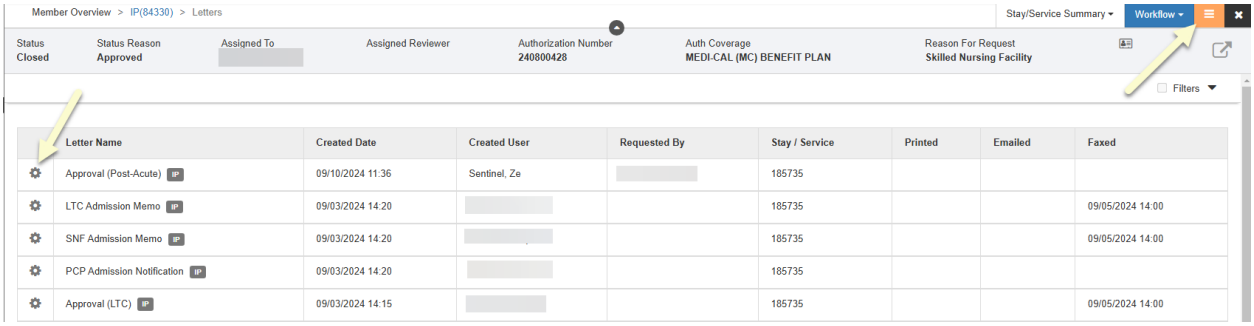
- **Expected Admit Date**

⚠ Do not enter Service Codes. This is used for Planned Admission requests only.

8. Upload supporting **documents**.
    - Select the Browse button to upload the file from your local drive.
    - Enter the Document Title, Type, and Description.
9. Leave a **note**.
    - Select the **Note Type** of ***Provider Portal***.
10. Select **Submit**.
    - The request is only sent to SFHP once **Submit** is selected.
        - If **Save as Draft** is selected, the request is not sent to SFHP.
            - To see your Draft Requests, click on the *Pending Submission* bar in the *Work in Progress* widget on the Dashboard.
        - If **Cancel** is selected, the request is removed and not saved or sent to SFHP.

Letters and Messages

Letters can be viewed in the Correspondence menu once they are faxed by SFHP to your provider.



Note that processing time may vary based on the request type and priority, and provision of sufficient clinical documentation to conduct utilization review. For example, for retrospective requests decisions are rendered, and notification letters are sent within 30 calendar days or, if additional information is requested, within 45 calendar days.

Interpreting Pop-Up Messages in Jiva

Pop-up messages that display in Jiva Provider Portal are intended guide or inform you on successfully completing an authorization request.

Providers must be attached before entering service codes.

Hard-stop message that displays when attempting to add a service without first attaching providers.

For Outpatient requests, a Requesting and Rendering Provider must be attached. For Inpatient requests, a Requesting Provider and Inpatient Facility must be attached. Service Codes are not needed for Inpatient requests, unless the Admit Type is a Planned Admission.

Please attach both Requesting and Rending provider roles.

Soft-stop message that displays when attempting to attach two Providers with the same Provider Role or an invalid provider for the Episode Type, such as Inpatient Facility for an Outpatient request. For example, this message will show when there are two Requesting or two Rendering providers.

For Outpatient requests, one Requesting and one Rendering Provider must be attached. For Inpatient requests, one Requesting Provider and one Inpatient Facility must be attached.

Please add Requesting Provider Contact for Phone and Fax

Hard-stop message that displays when attempting to submit a request without both Phone and Fax contact records entered. Contacts are required because SFHP needs to know which number to call for questions and where to send faxes.

It is imperative that the **Requesting Provider** Contact Type be used, especially for the fax record. Follow these steps to enter contact records in the request:

Steps	Add Fax Contact	Add Phone Contact
1	Enter Name and Clinic/Department	After selecting Add from the Fax record, the Name and Clinic/Department remain.
2	Select the **Contact Type** look-up and in the search bar, enter “req” to select **Requesting Provider** from the list.	Select the **Contact Type** look-up, select “Uncheck All” to remove the Requesting Provider. Search for and select the applicable type (i.e. **Provider**).
3	In the Telephone section, select the **Phone Type** of **FAX**.	Select the applicable **Phone Type**. *Do not select FAX for phone numbers.*
4	In the Phone Number field, enter the **Fax Number**.	Enter the **Phone Number**.
5	Select **Add.**	Select **Add.**

	The contact record is added to a list below. The fields are not cleared, but a new record can be entered in the same screen.	Once all contact records are added, select **Save**.

Please enter at least one service request.

Hard-stop message that displays when attempting to submit an Outpatient request without at least one service added. All service codes should be added before submitting the request.

If codes are missing from a request which has not yet been processed, please do not submit a separate request in the portal as these will need to be merged, which can increase processing time. Please contact SFHP at 1(415) 547-7810 to add codes to an existing open request.

Not a covered service. Please continue to submit. SFHP will review and send a determination.

Soft-stop message that displays when entering a service code which is not a Medi-Cal covered service. The request should still be submitted because the service may be covered upon further review. This message also gets saved as an Episode Note.

Service code(s) included in list of Experimental/Investigational list. Please enter note.

Soft-stop message that displays when entering a service code which is considered experimental or investigational. The request should still be submitted with a note and supporting clinical documentation to justify the request. This message gets saved as an Episode Note.

This code is not found in the Fee Schedule (silent code). Please continue to submit. SFHP will review and send a determination.

Soft-stop message that displays when entering a service code which does not have a specified fee for Medi-Cal. The request should still be submitted because the service may be covered upon further review. This message gets saved as an Episode Note.