Dear Partner,

Welcome to the WelbeHealth PACE provider network! We look forward to working together to unlock the potential of our most vulnerable elderly.

This welcome packet is intended to provide everything you need as a member of our WelbeHealth PACE network, including resources that you may find helpful as we begin to work together. We value our partnership and strive to make it easy for you to deliver quality care to our participants. We have developed several tools to help ensure your experience is positive and successful:

- The WelbeHealth PACE Provider Manual contains key information such as claims submission, authorization process, provider responsibilities, and more. A direct link to the WelbeHealth PACE Provider Manual can be accessed here.
- Our Quick Reference Guide is a simple tool which outlines basic instructions on how to work with us, where to submit claims, and key contact information to schedule appointments. We encourage you to share this guide with your office staff.

We anticipate being dream partners for you, providing comprehensive high-touch care management and all-inclusive insurance coverage. As a part of our network, you will benefit from our robust interdisciplinary approach and clinical support as we deploy our team to coordinate all appointment scheduling, transport participants to and from appointments with you, ensure adherence to follow-ups and next steps, and virtually eliminate no shows and late shows.

WelbeHealth PACE is excited to serve the community with quality and compassion and we look forward to working alongside you to care for our frail seniors!

Sincerely,

WelbeHealth PACE Network team

Attachments:

- Provider Manual Link
- Provider Manual Attestation – To be signed and returned within 10 days of receipt.
- Quick Reference Guide
- Authorization Form

Provider Attestation

I confirm that _____ has signed an agreement with WelbeHealth PACE and by my signature below, as the authorized representative of the Provider and/or Group, hereby attest that I understand my responsibilities as a WelbeHealth Partner.

By checking the boxes below, I attest that I have received and reviewed the following items:

WelbeHealth PACE Provider Manual: I fully understand that the information contained in the Provider Manual is intended to train Provider partners in navigating various services, policies, and procedures on behalf of the WelbeHealth PACE program. I further acknowledge that the Provider Manual shall be utilized as a resource to access important information, including claims and referral instructions, in addition to the policies included in the presiding Agreement with Coastline PACE.	☐
Quick Reference Guide: I have received a copy and will share this copy with all office staff.	☐
Scheduling: I understand that the Welbe Advocate Hub will coordinates and manage all appointments for PACE participants.	☐
Clinical Documentation Process: I understand clinical case notes must be submitted following every PACE participant visit directly to PACE clinical E-fax within (7) business days. STAT/Urgent orders consult notes should be sent within (2) business days.	☐
Authorizations: I understand that WelbeHealth provides an authorization upon referral and any additional visits and/or services must be requested but submitting an Authorization Request Form.	☐
Credentialing: I have gathered and submitted all Provider and/or Group information requested by WelbeHealth for credentialing purposes, including but not limited: - Provider Roster - Complete and signed W9 Form	☐
I am aware of who is my assigned Network Associate is, and understand I can reach out to them directly on the event I have any questions or items I need to discuss.	☐

_____ _____

Signature of Authorized Representative

Printed Name of Authorized Representative

_____ _____

Date Signed

Authorized Representative's Title

Quick Reference Guide
For Providers

Welbe Health

Our mission is to unlock the full potential of our most vulnerable seniors.
We do it through PACE (Program of All-Inclusive Care for the Elderly), a longstanding Medicare and Medicaid program that provides medical and social services enabling older adults to actively live in the community.

We operate as a comprehensive health plan and managed care provider, serving seniors living within our communities.

Contact Information	PROVIDER SERVICES: (650) 336-0300 VISIT HTTPS://WELBEHEALTH.COM/PARTNER/ FOR ADDITIONAL RESOURCES	
	SCHEDULING & AUTHORIZATIONS WELBEHUBREQUEST@WELBEHEALTH.COM	PROVIDER RELATIONS PROVIDERS@WELBEHEALTH.COM
Claims	P.O. BOX 30760 TAMPA, FL 33630-3760 ELECTRONIC PAYER ID: WBHCA	
Authorizations	Submit to FAX: (209) 729-5854 or Provider Portal. ➢ All initial referrals by WelbeHealth are automatically authorized. ➢ Additional visits and/or services must be requested by completing a PACE authorization form and faxing it or via the WelbeHealth Provider Portal. Authorizations submitted via the portal will be reviewed by our Utilization Management department within five (5) business days.	
WelbeHealth Provider Portal	To create an account, please visit https://welbehealth.quickcap.net ➢ Submit and check status of claims/authorizations ➢ Verify eligibility	
Scheduling Appointments	➢ The Welbe Advocate Hub is responsible for scheduling all appointments on behalf of participants. To prevent no-shows, please do not schedule with participants or their family members.	
Clinical Documentation	➢ **Clinical documentation must be submitted following every visit directly to the respective PACE Clinic fax within (7) business days.** STAT/Urgent orders consult notes should be sent within (2) business days.	
PACE Centers	COASTLINE PACE 1220 East 4th St., Long Beach, CA 90802 MAIN LOCAL (562) 206-1681 CLINIC FAX (855) 712-7837	PACIFIC PACE 50 Alessandro Pl. Suite A20, Pasadena, CA 91105 MAIN LOCAL (626) 314-1411 CLINIC FAX (855) 245-2961
	SIERRA PACE 582 East Harding Way, Stockton, CA 95204 MAIN LOCAL (209) 442-6077 CLINIC FAX (844) 548-3818	SEQUOIA PACE 1649 Van Ness Ave., Fresno, CA 3721 MAIN LOCAL (559) 777-6722 CLINIC FAX (833) 963-2082

Welbe Health

Authorization Request Form

For any questions regarding this authorization, scheduling or verification of In Network Providers please contact:

Telephone: (650) 336-0300 or **Email:** WelbeHubRequest@welbehealth.com

Notice: WelbeHealth has a 14-day calendar day turnaround time on routine authorization requests beginning on date of receipt. Urgent requests will be processed within 2-7 business days upon receipt of a complete form and based on medical necessity as outlined in supporting documentation. Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.

Market

Please select a market below. All requests should be sent to (209) 729-5854.

- ☐ Coastline (LAC): 1220 E. 4th Street Long Beach, CA 90814 | Phone: (562) 206-1681 | Fax: (855) 712-7837
- ☐ Sierra PACE (STN): 582 E. Harding Way Stockton, CA 5204 | Phone: (209) 442-6077 | Fax: (844) 548-3818
- ☐ Pacific PACE (PAC): 50 Alessandro Pl. a20, Pasadena, CA 91105 | Phone: (626) 314-1411 | Fax: (855) 245-2961
- ☐ Sequoia PACE (SEQ): 1649 Van Ness Ave, Fresno, CA 93721 | Phone: (559) 777-6722 | Fax: (833) 963-2082

Type of Request

☐ New ☐ Post Service ☐ Modification

If this request is to modify an exisiting authorization please provide authorization #:

_____

Urgency

Requests submitted as an urgent referral when standard timeframes could seriously jeopardize the partcipant's life or health or ability to attain, maintain or regain maximum function.

☐ Urgent ☐ Routine

Member Information

Full Name:

Date of Birth:

ID Number:

Servicing Provider/Referred To

***Required if requesting services will be authorized to someone other than referring**

☐ MD ☐ Vendor ☐ Lab ☐ Facility ☐ Other

Name:

Address:

Phone:

NPI:

Referring Provider

Full Name:

Specialty:

Requesting Office Information

Contact:

Phone: ***Ext.***

Fax:

Place of Service

☐ ASC ☐ Long Term Care ☐ In - Office ☐ Home Visit

☐ Home Care Agency ☐ Outpatient Hospital ☐ Inpatient Hospital

☐ Other (Explain):_____

Date of Service and Location address (if scheduled):

Please enter all codes requested with a description:

ICD-10 Primary Dx Code:

ICD-10 Additional Dx Code (s):

CPT/HCPCS Code (s):

If applicable NDC(s):

CPT/HCPCS Code Description:

# of Units being requested:

☐ Hours ☐ Days ☐ Months ☐ Visits ☐ Dosage

If applicable:

Service Start Date:

Service End Date:

Patient Clinical Information Needed

History and physical and/or consultation notes including:

Clinical findings (i.e., pertinent symptoms and duration)	Prior conservative treatments, duration, and response
Comorbidities	Past and present diagnostic testing and results
Activity and functional limitations	Treatment plan (i.e., surgical intervention)
Family history if applicable	Consultation and medical clearance report(s), when applicable
Reason for procedure/test/device, when applicable	Radiology report(s) and interpretation (i.e., MRI, CT, discogram)
Pertinent past procedural and surgical history	Laboratory results