COMMUNITY HEALTH CHOICE, INC.

PROVIDER NEWSLETTER

V3-2014

IN THIS ISSUE

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COMMUNITY HEALTH CHOICE

COMMUNITY CARES.

APPROPRIATE ANTIBIOTIC USE

Community Health Choice is dedicated to promoting appropriate and safe use of medications and improving health outcomes. Inappropriate antimicrobial use has been a major contributing factor to the development of antibiotic resistance among common pathogens.

We are providing a summary of clinical practice guidelines from the American Academy of Pediatrics (AAP) and Infectious Disease Society of America (IDSA) to assist you with the appropriate use of antibiotics in your clinical decision-making process. Appropriate use of antibiotics are necessary to promote positive clinical outcomes and minimize development of antibiotic resistance in the community.

The AAP clinical practice guideline for the diagnosis and management of acute otitis media published in 2013, for initial immediate or delayed antibiotic treatment, recommends amoxicillin as first-line treatment or amoxicillin/clavulanate as second-line if patient received amoxicillin in the previous 30 days. In patients with penicillin allergy, AAP recommends alternatives; cefdinir, cefuroxime, cefpodoxime or ceftriaxone.

Community is dedicated to promoting appropriate and safe use of medications and improving health outcomes.

Clinical practice guideline published in IDSA 2012 for the diagnosis and management of group A streptococcal pharyngitis recommends penicillin or amoxicillin as the drug of choice for those non-allergic to these agents. A first generation cephalosporin is recommended for penicillin-allergic individuals (if not anaphylactically sensitive), clindamycin or clarithromycin for 10 days or azithromycin for 5 days.

A guideline is also available for management of community-acquired pneumonia (CAP) in children. Pediatric patients with mild infections can be managed with oral medications. The IDSA clinical practice guideline published in 2011 recommends amoxicillin as the first-line therapy for previously healthy, immunized infants and preschool children with mild to moderate CAP that is suspected to be of bacterial origin. Amoxicillin is also first-line therapy for previously healthy, immunized school-aged children and adolescents with mild to moderate CAP for *S. pneumoniae*.

According to the clinical practice guideline published in AAP 2011, it is important to appropriately diagnose and treat acute urinary tract infections (UTIs). The most common pathogen in children is *E. coli*. Increased rates of *E. coli* resistance have made amoxicillin a less acceptable choice of treatment. The recommended initial antibiotic for most children with UTI is amoxicillin with clavulanate or trimethoprim/sulfamethoxazole. Alternatives include cephalosporins. Your local hospital should be able to provide susceptibility patterns for your local community.

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MEDICAL DIRECTOR'S CORNER

S. pneumoniae and *H influenza* are responsible for a large percentage of cases of acute bacterial rhinosinusitis (ABRS) in children. When sinusitis is considered of bacterial origin, amoxicillin is recommended as first line therapy. If observation was the initial management, AAP 2012 clinical practice guideline then recommends amoxicillin with or without clavulanate. If initial management is amoxicillin, high-dose amoxicillin-clavulanate is second-line therapy if there is worsening or lack of improvement at 72 hours. Alternatives for penicillin allergic patients are listed in the guideline. Second and third generation oral cephalosporins are no longer recommended for empiric monotherapy of ABRS due to variable rates of resistance among *S. pneumoniae*.

We have provided a summary of the guidelines to assist you in appropriate antibiotic prescribing. Please refer to the full guidelines and feel free to contact Community if you have questions or concerns.

References:

Bradley, John, Byington, Carrie, Alverson, Brian, Carter, Edward, and Harrison, Christopher. "The Management of Community-Acquired Pneumonia in Infants and Children Older Than 3 Months of Age: Clinical Practice Guidelines by the Pediatric Infectious Diseases Society and the Infectious Diseases Society of America " Clinical Infectious Diseases (August 2011): e1-e52.

Chow, Anthony, Benninger, Michael, Brook, Itzhak, Brozek, Jan, Goldstein, Ellie, Hicks, Lauri, Pankey, George, Seleznick, Mitchel, Volture, Gregory, Wald, Ellen, and File, Thomas. "IDSA Clinical Practice Guideline for Acute Bacterial Rhinosinusitis in Children and Adults" Clinical Infectious Diseases (March 20, 2012): e1-41.

Finnell, Maria, Carroll, Aaron, Downs, Stephen, and Subcommittee on UTI. "Diagnosis and Management of an Initial UTI in Febrile Infants and Young Children" Pediatrics 128 (August 28, 2011): e749-e770.

Lieberthal, Allan, Carroll, Aaron, Chonmaitree, Tasnee, Ganiats, Theodore, "The Diagnosis and Management of Acute Otitis Media" Pediatrics 131 (February 25, 2013): e964-e999.

Shulman, Stanford, Bisno, Alan, Clegg, Herbert, Gerber, Michael, Kaplan, Edward, Lee, Grace, Martin, Judith, and Van Beneden, Chris. "Clinical Practice Guideline for the Diagnosis and Management of Group A Stretococcal Pharyngitis: 2012 Update by the Infectious Diseases Society of America" Clinical Infectious Diseases (September 9, 2012): 1-17.

Wald, Ellen, Applegate, Kimberley, Bordley, Clay, Darrow, David and Glode, Mary. "Clinical Practice Guideline for the Diagnosis and Management of Acute Bacterial Sinusitis in Children Aged 1 to 18 years" Pediatrics 132 (July 2013): e262-e280.

MEDICAL DIRECTOR CHANGES

DR. DEAN CANNON
Medical Director

Community welcomes our new Medical Director, Dr. Dean Cannon. After obtaining his M.D. from the Louisiana State University School of Medicine in 1998, he completed a pediatric residency at the University of Florida. He is board certified in general pediatrics and is also a Fellow of the American Academy of Pediatrics.

Dr. Cannon practiced in Jacksonville, Florida until he moved to the Houston area in early 2009. While continuing to see patients, he also gained health plan experience as a Medical Director for the Texas STAR Health program (Medicaid coverage for foster care children), managed by another Texas MCO.

Dr. Aashish Shah has left Community for a new opportunity in Baltimore, MD. We thank him for his years of service. He was instrumental in our new approach to our Commitment to Quality.

PROVIDER ENGAGEMENT PLATFORM

In the last issue of our Provider Newsletter, as well as in our recent PCP and OB/GYN Lunch & Learn presentations, Community unveiled the four (4) components of our new Provider Engagement Platform:

1. **Provider Network Strategy Statement,**
2. **Provider Network Participation Criteria,**
3. **Provider Communication & Interaction Guidelines, and**
4. **Pay-for-Quality/Provider Incentive Plan.**

As a reminder for those who may not have seen our last newsletter, please remember that it is available under the resources section of our Provider Web site at CommunityCares.com. For those who read the newsletter and provided us with feedback regarding our Provider Engagement Platform, thank you. We received numerous comments indicating the Platform's approach is yet another positive step toward continually improving the service we provide and relationships we build with our participating Providers.

The feedback we received also identified the need to continually clarify the Engagement Platform as it impacts some of our participating Providers. In reply to some of the specific and most common questions received, we provide the following:

1. What direct impact, if any, will this new Provider Engagement Platform have for my practice or my facility?

- The most tangible and immediate direct impact for physicians' offices will result from the **July 1, 2014** implementation of Community's new **PHYSICIAN PARTICIPATION CRITERIA**, as noted in our last newsletter. Please review these criteria identified again at your convenience on pages 3-7 of our Volume 2, 2014 newsletter. We implemented the Physician Participation Criteria in July 2014 and will now begin to evaluate the status of each physician's compliance with this criteria. Our team will then contact those physicians who do not meet these criteria in order to discuss continued participation in Community's Provider Network.

- Currently, Community is revising its overall approach to Provider education and creating a comprehensive **2015 PROVIDER EDUCATION PLAN**. We will publish more details regarding this new approach for Provider education in our Volume 4 edition of the 2014 newsletter. As a preview, our new approach will:

    - transition from "departmental" to "organizational" accountability,
    - involve significantly greater input from participating Providers,
    - establish in-process and outcome measures to measure Community's performance,
    - clearly align with our Provider Engagement Platform,
    - expand the various modes and frequency of our educational efforts, and
    - allow for recognition or reward for those Providers engaged in our efforts.

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2. How is Community going to incorporate feedback from participating Providers on its operations or new initiatives, specifically those initiatives that directly impact a Provider's office?

Community's Provider Network Strategy Statement, the first component of our Provider Engagement Platform, references our commitment to collaborative and synergetic partnerships, transparent communications, and input from Providers in our operational decision-making. While we are considering numerous means by which we will incorporate input from our participating Providers, two key initiatives are pivotal:

- Community is in the process of more clearly defining our various **Provider Listening Posts**. These listening posts may include either specific tools or forums where Community might receive Provider feedback, i.e. our annual Provider Satisfaction Survey, various educational events such as the PCP or OB/GYN Lunch & Learn presentations, Community's Provider Communication service line, face-to-face meetings, etc. Subsequently, it is our intent to input Provider feedback from each Listening Post into a single database that allows improved tracking and analysis of the feedback received in order to assist us with continual service improvements across the organization.
- Community developed a **PROVIDER ENGAGEMENT PANEL**, comprised of key leadership from our organization and participating Providers representing Primary Care & Specialty Care Physicians as well as Ancillary and Hospital Providers. The Panel meets quarterly and provides input on key operational or strategic initiatives currently under consideration by Community. The Provider Engagement Panel most recently provided review and input on the design and development of our 2015 Provider Education Plan noted earlier in this article. We thank the following individuals for their participation on first panel meeting:

Nicole Bloom	Cynthia McNeil, MD	Juan Olivares, MD
George Kuhn, MD	Annette Mooney	Bonnie Smith

3. How will we know that Community is committed to the components of this new Provider Engagement Platform?

As participating Providers, your engagement and feedback remains crucial as we continue to implement and strengthen components of our Provider Engagement Platform. If your individual experiences identify opportunities or generate ideas for Community's improved performance, our expectation is that you share those ideas through direct participation in our scheduled educational events, contact with Provider Communications team at **713.295.2295** or notify your Provider Relations Representative.

Over the course of the next several months, we will enhance and broaden the modes and frequency by which we listen, but it is up to you as the Provider to share positive feedback so that we can continue those processes that you support or conversely to share the constructive feedback on those processes that complicate or challenge the day-to-day operations of your office. If you continue providing valuable feedback, the good as well as the not-so-good, you will continue to see positive change and Community's commitment to the new Provider Engagement Platform will be evident.

NEW PARTNERSHIP WITH UT HEALTH NEONATOLOGISTS

Community Health Choice is proud to announce that we have contracted with the Department of Pediatrics at the University of Texas Health and Science Center at Houston (UT Health) to have access to neonatologists to help guide quality decisions for our Care Management neonatal population. The Chairman of the Department, Eric Eichenwald, MD who has 26 years of experience and is board certified in Neonatal-Perinatal Medicine, is leading this team. UT neonatologists will provide guidance that expands Community's uniform approach to following complex neonatal conditions by assisting with monthly education on neonatal issues for our staff and quarterly education to our Community-associated Providers. Community plans to include issues around concurrent reviews, appeals and the standards of care for this important population.

WHAT IS MCMC?

The Medical Care Management Committee (MCMC) serves as Community's clinical quality physician peer review committee which includes physician representation from private practices and from one or more medical schools, each of whom participates in Community's Provider Network.

The committee meets monthly—a minimum of 10 times per year. The MCMC reports to Community's Board of Directors and is responsible for peer review, as well as credentialing and re-credentialing decisions for all Provider types applying to join Community's Provider Network. In addition, MCMC provides expertise on new medical technology, clinical practice guidelines, clinical, and credentialing policies and procedures.

PREVENTIVE HEALTH AND YOUR PIP PROGRAM

Several measures in the Provider Incentive Program are preventive measures that need to be performed in a timely manner. These measures were selected because they are standards of care that improve health outcomes.

Provider Type	Measure	Who's Included	What's a Timely Checkup?	What's it Worth Annually?
PCP	Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life (W34)	STAR and CHIP Members aged 3-6, enrolled since Jan. 1, 2014	On or before Dec. 31, 2014	4%
	Adolescent Well-Care Visits (AWC)	STAR and CHIP Members aged 12-21, enrolled since Jan. 1, 2014	On or before Dec. 31, 2014	4%
OB	Prenatal Care	STAR Members who deliver with Community, enrolled for at least 42 days prior to and 56 days after delivery	• First trimester, if enrolled during first trimester • Within 42 days of enrollment, if not enrolled during first trimester	3%
	Postpartum Care	STAR Members who deliver with Community, enrolled for at least 42 days prior to and 56 days after delivery	Between 21 and 56 days after delivery	3%

The measures listed above are Healthcare Effectiveness Data and Information Set (HEDIS) measures, written by the National Committee for Quality Assurance. They may be slightly different from previous measures of performance, but because they are widely used, they allow you to compare your performance with that of Providers across the nation.

Specifically, in the PCP measures listed above, the timeframe for timely checkups are different from those that you have been used to for Texas Health Steps (STAR Members) and Well-Child checkups (CHIP members). While Texas Health Steps and Well-Child checkups are anchored around the Member's birthday, the HEDIS measures are based on the calendar year. Therefore, the deadline for PCP measures listed here is **December 31, 2014**.

Read on to see how Community's new Wellness Services team is helping you succeed in these measures!

INTRODUCING WELLNESS SERVICES AT COMMUNITY HEALTH CHOICE

WHAT DO WE DO?

- Help Members make wellness, prenatal, and postpartum appointments.
- Screen pregnant Members for enrollment in our Care Management's high-risk perinatal program.
- Educate Members on specific preventive health care needs.

HOW DOES IT HELP YOU?

- We help track your patients that need preventive care or care management.
- Our calls help you improve your performance in the Provider Incentive Program.

HOW CAN YOU HELP US HELP YOU?

- If Community calls you to request an appointment for a Member, schedule those Members **as soon as possible**.
- Call us to notify Community of newly pregnant Members so that we can reach out to them.

For more information, call Thuy Pham at 713.295.6745.

WELCOME, DAWN HAYNES

Introducing our newest Provider Relations Outreach Representative, Dawn Haynes. Dawn earned a Bachelor of Arts from Texas A.M. University and enjoys reading, yoga, and getting caught in the rain. Welcome Dawn!

LUNCH & LEARN SCHEDULE

Mark your calendars to attend a Lunch & Learn presentation. Details will be announced via blast fax and on our Web site!

Harris Service Area
December 10

Jefferson Service Area
December 11

NEW PAYABLE DIAGNOSIS CODE FOR ECULIZUMAB INJECTION (SOLIRIS)

The Health and Human Services Commission will implement a new payable diagnosis code for eculizumab injection (Soliris), procedure code J1300. Effective for dates of service on or after **August 1, 2014**, procedure code J1300 eculizumab injection (Soliris) may be billed with diagnosis code 28311 (Hemolytic-Uremic Syndrome, aHUS) in addition to the currently covered diagnosis 2832 (Paroxymal nocturnal hemoglobinuria (PHN)). Eculizumab (Soliris) is used to treat clients with atypical Hemolytic Uremic Syndrome and aHUS is a rare and chronic blood disease that can lead to kidney failure and is also associated with increased risk of death and stroke. This addition applies to clients of all ages in the office or outpatient hospital setting.

LONG-ACTING REVERSIBLE CONTRACEPTION (LARC) PRODUCTS

Effective for dates of service on or after **August 1, 2014**, long-acting reversible contraception (LARC) products will be available as a pharmacy benefit of Texas. These LARC products will only become available through a limited number of specialty pharmacies that work with LARC manufacturers. These pharmacies will be listed on the Vendor Drug Program Web site at www.txvendordrug.com/formulary/larc.shtml.

...will be able to return unused and unopened LARC products to the manufacturer's third-party processor

Providers who prescribe and obtain LARC products through the specialty pharmacies listed will be able to return unused and unopened LARC products to the manufacturer's third-party processor. Prescribers should refer to the manufacturer for specific instructions. General buy-back instructions are also available at TxVendorDrug.com.

After **August 1, 2014**, LARC will remain a medical benefit and Providers will continue to have the option to receive reimbursement for LARC as a clinician-administered drug.

HHSC approved letter: 20140820 PH-0814-090 LARC Prescriber Letter_to state_final

FLU VACCINES 2014

For the 2014 flu season, HHSC allows STAR Members 18 years of age and older the option of obtaining a flu shot at a Navitus participating pharmacy. At this time, the following pharmacies are participating:

Major chains: Albertsons, Safeway, Kmart, Kroger, The Medicine Shoppe, Target, Walgreens, CVS, and H-E-B

Independent Affiliates: AccessHealth, Third Party Station, Leadernet, and Good Neighbor

IMPORTANT: *STAR Members under age 18, CHIP Members, and CHIP Perinate Members (any age) cannot receive a flu shot at a participating pharmacy.*

EDI FORMAT FOR LISTING RENDERING PHYSICIANS' NAMES: 2310B LOOP

Claims submitted either electronically or on paper need to have a rendering physician's name listed. The exceptions are RHC, FQHC, and all ancillary groups. Providers can refer to the Availity link for additional information.

Page 121: PRV Rendering Provider Specialty Information

https://apps.availity.com/availity/AvHelp/Glossary/Loops_and_Segments_in_EDI_Claims_X12_837_Files.htm

Loop Rendering Provider Name

Pos: 2500 Repeat: 1
Optional
Loop: 2310B Elements: N/A

User Option (Usage): Situational

Purpose: To supply the full name of an individual or organizational entity

Loop Summary:

Pos	Id	Segment Name	Req	Max Use	Repeat	Usage
2500	NM1	Rendering Provider Name	O	1		Situational
2550	PRV	Rendering Provider Specialty Information	O	1		Situational

Industry Notes:

1. This loop is required when the Rendering Provider NM1 information is different than that carried in either the Billing Provider NM1 or the Pay-to Provider NM1 in the 2010AA/AB loops respectively.
2. Information in Loop ID-2310 applies to the entire claim unless overridden on a service line by the presence of Loop ID-2420 with the same value in NM101.

TMHP Example:

NM1*82*1*BEATTY*GARY*C**SR*XX*1234567890~
PRV*PE*PXC*1223G0001X~
REF*G2*123456789~

ns0:TS837_2310B_Loop

---------NM101_EntityIdentifierCode -

---------NM102_EntityTypeQualifier -

---------NM103_RenderingProviderLastorOrganizationName -

---------NM104_RenderingProviderFirstName -

---------NM108_IdentificationCodeQualifier -

---------NM109_RenderingProviderIdentifier -

---------PRV01_ProviderCode - PE

---------PRV02_ReferenceIdentificationQualifier

HHSC NOTIFICATION: INTERIM OUTPATIENT TYPE OF BILL

Several MCOs are allowing hospital Providers to bill outpatient services using Patient Status 30 along with an interim Type of Bill (132, 133, and 134).

HHSC recognizes that CMS allows this billing practice for Medicare claims; however, this should not occur for Texas Medicaid. While patient status 30 (Still Patient or Expected to Return for Outpatient Services) can be used when the patient will return to the hospital for treatment (e.g. chemotherapy, dialysis, etc.), the Type of Bill should reflect an outpatient service - 131, 135, 136 or 137.

The HHSC Encounters team has confirmed that managed care claims submitted with a type of bill 132, 133, and 134 are not considered clean claims and should not be paid. Furthermore, there is a fatal edit in place which prevents any paid or denied encounters with type of bill 132, 133, and 134 from entering the warehouse.

MCOs currently allowing hospitals to bill in this manner should discontinue doing so immediately and make necessary contract revisions and system changes related to this practice. Provider education is also expected prior to making these changes.

Also, the use of patient status 30 on Home Health claims submitted with claim type 33X needs to be aware of the above billing situation as well.

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0801.pdf

DEADLINE FOR ICD-10 ALLOWS HEALTH CARE INDUSTRY AMPLE TIME TO PREPARE FOR CHANGE

Deadline set for October 1, 2015

The U.S. Department of Health and Human Services (HHS) issued a rule finalizing **October 1, 2015** as the new compliance date for health care Providers, health plans, and health care clearinghouses to transition to ICD-10, the tenth revision of the International Classification of Diseases. This deadline allows Providers, insurance companies and others in the health care industry time to ramp up their operations to ensure their systems and business processes are ready to go on **October. 1, 2015.**

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The ICD-10 codes on a claim are used to classify diagnoses and procedures on claims submitted to Medicare and private insurance payers. By enabling more detailed patient history coding, ICD-10 can help to better coordinate a patient's care across Providers and over time. ICD-10

> **"ICD-10 codes will provide better support for patient care, and improve disease management, quality measurement and analytics,"**

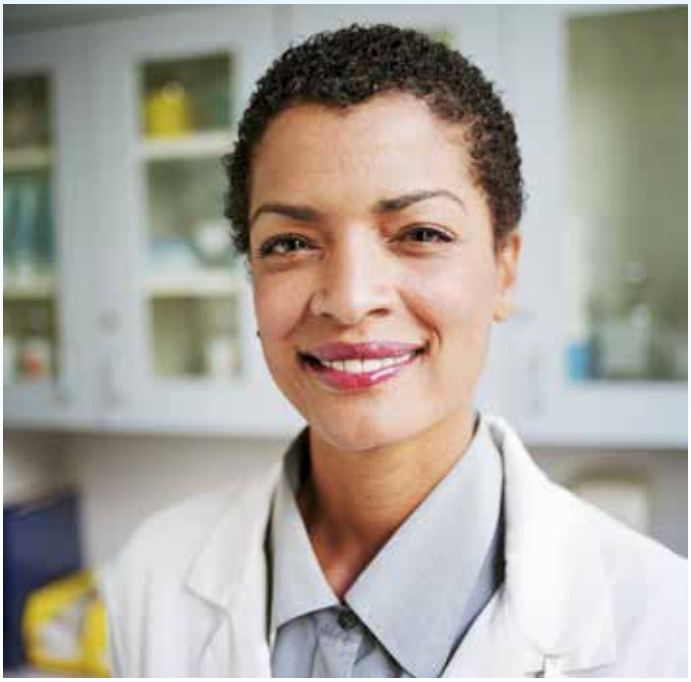
improves quality measurement and reporting, facilitates the detection and prevention of fraud, waste, and abuse, and leads to greater accuracy of reimbursement for medical services. The code set's granularity will improve data capture and analytics of public health surveillance and reporting, national quality reporting, research and data analysis, and provide detailed data to enhance health care delivery. Health care Providers and specialty groups in the United States provided extensive input into the development of ICD-10, which includes more detailed codes for the conditions they treat and reflects advances in medicine and medical technology.

"ICD-10 codes will provide better support for patient care, and improve disease management, quality measurement, and analytics," said Marilyn Tavenner, Administrator of the Centers for Medicare & Medicaid Services (CMS). "For patients under the care of multiple Providers, ICD-10 can help promote care coordination."

Using ICD-10, doctors can capture much more information, meaning they can better understand important details about the patient's health than with ICD-9-CM. Moreover, the level of detail that is provided for by ICD-10 means researchers and public health officials can better track diseases and health outcomes. ICD-10 reflects improved diagnosis of chronic illness and identifies underlying causes, complications of disease, and conditions that contribute to the complexity of a disease. Additionally, ICD-10 captures the severity and stage of diseases such as chronic kidney disease, diabetes, and asthma.

The previous revision, ICD-9-CM, contains outdated, obsolete terms that are inconsistent with current medical practice, new technology and preventive services.

ICD-10 represents a significant change that impacts the entire health care Community. As such, much of the industry has already invested resources toward the implementation of ICD-10. CMS has implemented a comprehensive testing approach, including end-to-end testing in 2015, to help ensure Providers are ready. While many Providers, including physicians, hospitals, and health plans,



have completed the necessary system changes to transition to ICD-10, the time offered by Congress and this rule ensure all Providers are ready.

For additional information about ICD-10, please visit: http://www.cms.gov/ICD10

http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2014-Press-releases-items/2014-07-31.html

COMMUNITY HAS GONE GREEN!

Want our newsletter sent directly to your inbox? Go to the homepage of our Provider portal at CommunityCares.com and sign up to have our newsletters sent to your e-mail.

CONTACT INFORMATION

MEDICAL AFFAIRS

Sr. Medical Director
Dr. Fred Buckwold: 713.295.2319

Medical Director
Dr. Dean Cannon

Utilization Management
Phone: 713.295.2221
Fax: 713.295.2283 or 84

Care Management: Asthma, Diabetes, High-Risk Pregnancy
713.295.2303

CLAIMS

- Inquiries
- Adjudication

CommunityCares.com or 713.295.2295
Community will accommodate three claims per call.

MAILED CLAIMS

To the attention of: Corrected Claims

Community Health Choice, Inc.
P.O. Box 301404
Houston, TX 77230

REFUND LOCKBOX

Amegy Bank
P.O. Box 4605
Houston, TX 77210-4605

ELECTRONIC CLAIMS *(CHIP & STAR)*

Submit directly through Community's online claims portal:
CommunityCares.com >
Provider Tools > Claims Center
Payer ID: 48145

Emdeon	1.800.735.8254
SSI	1.800.820.4774
Availity	1.800.282.4548
TKSoftware	1.402.593.6542
RelayHealth	1.563.585.4411
Gateway EDI	1.800.969.3666
Practice Insight	713.333.6000
TMHP (STAR only)	www.tmhp.com

ELECTRONIC CLAIMS-UB, CMS-1500 (HIM)

Submit Directly through Community's Online Claims Portal:
CommunityCares.com >
Provider Tools > Claims Center

Emdeon: 1.800.735.8254
Payer ID: 60495

PHARMACY

Navitus Health Solutions
1.877.908.6023
www.navitus.com

ADVERSE DETERMINATIONS & APPEALS

Community Health Choice, Inc.
Attn: Appeals
2636 South Loop West, Suite 900
Houston, TX 77054
All appeals must be in writing and accompanied by medical records.

MEMBER SERVICES & SPECIALIST SCHEDULING

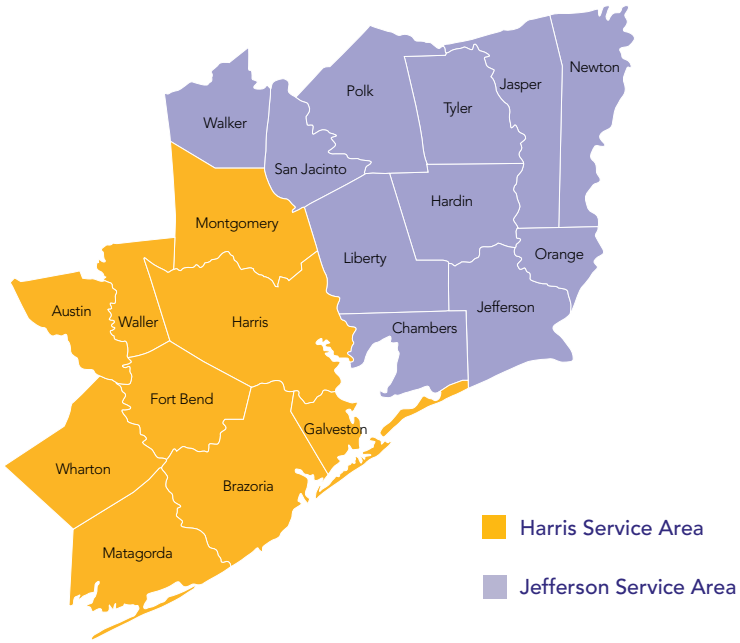
713.295.2294 or 1.888.760.2600

PROVIDER RELATIONS

For general questions or to submit your updates:

- CommunityCares.com
- ProviderRelations@CHCHealth.org
- Contact your Provider Relations Representative.

SERVICE AREA MAP



TEXAS STAR PROGRAM
Your Health Plan ■ Your Choice

CHIP We've got your kids covered.

URAC ACCREDITED HEALTH PLAN