PROVIDER RELATIONS

Field Staff Forms

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Field Staff Forms

Weekly Activity Report (To report weekly field visits performed and other tasks related to field work)

Field Report (Completed for every field visit made by an analyst)

Unisys Field Visit Report-Acknowledgement of On-Site Visit Form (Signed by provider staff and field analyst when field visit is conducted)

SURS Internal Referral (To report possible provider abuse/fraud to the SURS Unit)

WEEKLY ACTIVITY REPORT

ANALYST _____ WEEK ENDING _____

	DATE		SOURCE					ACTIVITY
	REQ	VISIT	DHH	PROV	UNI	DROP IN	NEW PROV	PROVIDER*/DHH**/IN-HOUSE/TIME OFF
1			☐	☐	☐	☐	☐	
			KIDMED ☐		CommunityCARE ☐		HIPAA ☐	
			Comments:					
2			☐	☐	☐	☐	☐	
			KIDMED ☐		CommunityCARE ☐		HIPAA ☐	
			Comments:					
3			☐	☐	☐	☐	☐	
			KIDMED ☐		CommunityCARE ☐		HIPAA ☐	
			Comments:					
4			☐	☐	☐	☐	☐	
			KIDMED ☐		CommunityCARE ☐		HIPAA ☐	
			Comments:					
5			☐	☐	☐	☐	☐	
			KIDMED ☐		CommunityCARE ☐		HIPAA ☐	
			Comments:					
6			☐	☐	☐	☐	☐	
			KIDMED ☐		CommunityCARE ☐		HIPAA ☐	
			Comments:					
7			☐	☐	☐	☐	☐	
			KIDMED ☐		CommunityCARE ☐		HIPAA ☐	
			Comments:					
8			☐	☐	☐	☐	☐	
			KIDMED ☐		CommunityCARE ☐		HIPAA ☐	
			Comments:					
9			☐	☐	☐	☐	☐	
			KIDMED ☐		CommunityCARE ☐		HIPAA ☐	
			Comments:					
10			☐	☐	☐	☐	☐	
			KIDMED ☐		CommunityCARE ☐		HIPAA ☐	
			Comments:					

*** If provider visit, indicate provider number, provider name, and city/state**
****If DHH meeting, indicate type of meeting**

Comments:

FIELD REPORT

ANALYST: _____ REQUEST DATE: _____

PROVIDER NAME: _____ APPOINTMENT DATE: _____

PROVIDER NUMBER: _____ APPOINTMENT TIME: _____

PROVIDER ADDRESS: _____

PROVIDER TYPE: _____ APPOINTMENT LENGTH: _____

PROVIDER CONTACT: _____ PHONE NUMBER: _____

SOURCE: State ☐ Provider ☐ Unisys ☐ Drop-In ☐ New Provider ☐

(*If State Request, Name of Requester: _____)

ISSUES/TRAINING ITEMS

	MEDICAID	CROSSOVERS
Claims Status	☐	☐
RA/Reconciliation	☐	☐
Billing Procedures	☐	☐
Claim Form Completion	☐	☐
Forms	☐	☐
Adjustments/Voids	☐	☐
Policy Questions	☐	☐
Recipient Eligibility	☐	☐
Reimbursement	☐	☐
Prior Authorization	☐	☐
TPL	☐	☐
EMC	☐	☐
Timely Filing	☐	☐
Community Care	☐	☐
Other		
Provider has manual & training pkt.	☐YES	☐NO
Provider keeps RAs for 5 years	☐YES	☐NO
Provider attended last workshop	☐YES	☐NO
Eligibility verification—MEVS	☐YES	☐NO
Eligibility verification—REVS	☐YES	☐NO
Provider reconciles RAs timely	☐YES	☐NO
Has current ICD-9 coding book	☐YES	☐NO
Has current CPT coding book	☐YES	☐NO

ADDITIONAL NEEDS	
EMC Prospect	☐
Follow-up	☐
Manual	☐
Training Packet	☐
Claim Forms	☐
Adj. Forms	☐
Provider Hist.	☐
Global List	☐
Carrier Codes	☐
Fee Schedule	☐
PA-01	☐
PA-02	☐
158-A	☐
PCF-01	☐
PCF-02	☐
Newsletter____	☐
Enrollment Pkt.	
EFT Form	
RA Copy_____	☐
Other	
Provider file info up to date	☐ Y ☐ N
Frequent/recent billing staff	☐ Y ☐ N
Referred provider to DHH	☐ Y ☐ N

Denials Discussed														

Analyst Signature: _____ Date: _____

Revised 1/10/2000